Harvard Pilgrim Health Care
Prescription Drug List

PREMIUM FORMULARY
THREE-TIER DRUG LIST (2017)

IN ALPHABETICAL ORDER

This list is subject to change at any time.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

About Harvard Pilgrim's formulary
Harvard Pilgrim's formulary is a list of therapeutically safe and effective medications for treating most common medical conditions. The list is continually updated to incorporate the most recent decisions of Harvard Pilgrim's Pharmacy Services Department and our Pharmacy &Therapeutics Committee.

Harvard Pilgrim's 3-Tier Prescription Drug Program
Covered medications are categorized in one of the three tiers described below. Our tiered benefit structure encourages patients and physicians to discuss pharmaceutical treatment options and choose the drug that is therapeutically appropriate. This kind of patient/physician dialogue is an important component in promoting quality, cost-effective care.

How to use this three-tier prescription drug list
The following list is **alphabetical**, with the tier indicated to the right of the drug name. Follow these simple steps to find out what tier a covered medication you are currently taking is on:

1. Under "Drug," look up the name of your medication.
2. Once you find the medication, check the tier number to the right of the drug name.
    - $0 indicates that the drug may be covered at $0 copayment for some benefit plans.
    - Tier 1 ($) consists primarily of generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 2 may also include brand-name drugs that Harvard Pilgrim has determined to be more effective, less costly or to have fewer side effects than similar medications.
    - Tier 2 ($$) consists primarily of brand-name drugs without generic equivalents. These drugs have been selected by the plan based on review of the relative safety, effectiveness and cost of the many brand-name drugs on the market. In some cases, Tier 2 may include generic drugs determined to be more costly than their brand-name alternatives.
    - Tier 3 ($$$) consists of drugs that the plan has not included in Tier 1 or Tier 2.
    - MD: Medical
    - N/C: Drug is not covered.

Please note: Some plans may require you to pay a deductible for prescription medications before copayments and/or coinsurance apply. Refer to your **Prescription Drug Brochure** for details.

DRUG NAME	TIER	LIMITATIONS/ * NOTES
1		
1ST CHOICE THIN LANCETS	2	HSA*
1ST TIER COMFORTOUCH 28G LANCT	2	HSA*
1ST TIER COMFORTOUCH 30G LANCT	2	HSA*
8		
8-MOP 10 MG CAPSULE	3	
A		
ABACAVIR 20 MG/ML SOLUTION	2	
ABACAVIR 300 MG TABLET	1	
ABACAVIR-LAMIVUDINE 600-300 MG	2	
ABACAVIR-LAMIVUDINE-ZIDOV TAB	1	
ABILIFY 1 MG/ML SOLUTION	3	
ABILIFY 10 MG TABLET	3	
ABILIFY 15 MG TABLET	3	
ABILIFY 2 MG TABLET	3	
ABILIFY 20 MG TABLET	3	
ABILIFY 30 MG TABLET	3	
ABILIFY 5 MG TABLET	3	
ABILIFY DISCMELT 10 MG TABLET	3	
ABILIFY DISCMELT 15 MG TABLET	3	
ABSORICA 10 MG CAPSULE	3	
ABSORICA 20 MG CAPSULE	3	
ABSORICA 25 MG CAPSULE	3	
ABSORICA 30 MG CAPSULE	3	
ABSORICA 35 MG CAPSULE	3	
ABSORICA 40 MG CAPSULE	3	
ABSTRAL 100 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 200 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 300 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 400 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 600 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 800 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ACAMPROSATE CALC DR 333 MG TAB	1	
ACANYA GEL PUMP	2	
ACARBOSE 100 MG TABLET	1	HSA*
ACARBOSE 25 MG TABLET	1	HSA*
ACARBOSE 50 MG TABLET	1	HSA*
ACCOLATE 10 MG TABLET	3	HSA*
ACCOLATE 20 MG TABLET	3	HSA*
ACCU-CHEK ACTIVE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK AVIVA PLUS TEST STRP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK AVIVA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ACCU-CHEK CMFRT CURVE STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK COMPACT PLUS STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK COMPACT STRIPS	3	Prior Authorization required;Max. 204 per 30 days
ACCU-CHEK FASTCLIX LANCETS	2	HSA*
ACCU-CHEK GUIDE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK MULTICLIX LANCETS	2	HSA*
ACCU-CHEK SAFE-T-PRO 23G LANCT	2	HSA*
ACCU-CHEK SAFE-T-PRO PLUS 23G	2	HSA*
ACCU-CHEK SMARTVIEW TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK SOFTCLIX LANCETS	2	HSA*
ACCUPRIL 10 MG TABLET	3	HSA*
ACCUPRIL 20 MG TABLET	3	HSA*
ACCUPRIL 40 MG TABLET	3	HSA*
ACCUPRIL 5 MG TABLET	3	HSA*
ACCURETIC 10-12.5 MG TABLET	3	HSA*
ACCURETIC 20-12.5 MG TABLET	3	HSA*
ACCURETIC 20-25 MG TABLET	3	HSA*
ACCUTREND GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACE AEROSOL CLOUD ENHANCER	MD	
ACEBUTOLOL 200 MG CAPSULE	1	HSA*
ACEBUTOLOL 400 MG CAPSULE	1	HSA*
ACEON 4 MG TABLET	3	HSA*
ACEON 8 MG TABLET	3	HSA*
ACETAMIN-CAFF-DIHYDROCOD 320.5	1	
ACETAMIN-CAFF-DIHYDROCOD 325	1	
ACETAMINOP-CODEINE 120-12 MG/5	1	
ACETAMINOPH-CAFF-DIHYDROCODEIN	1	
ACETAMINOPHEN-COD #2 TABLET	1	
ACETAMINOPHEN-COD #3 TABLET	1	
ACETAMINOPHEN-COD #4 TABLET	1	
ACETAMINOPHN-COD 360-36 MG SOL	1	
ACETASOL HC EAR DROPS	1	
ACETAZOLAMIDE 125 MG TABLET	1	
ACETAZOLAMIDE 250 MG TABLET	1	
ACETAZOLAMIDE ER 500 MG CAP	1	
ACETIC ACID 2% EAR SOLUTION	1	
ACETYLCYSTEINE 10% VIAL	1	
ACETYLCYSTEINE 20% VIAL	1	
ACID REDUCER 20 MG TABLET	1	
ACIPHEX DR 20 MG TABLET	3	
ACIPHEX SPRINKLE DR 10 MG CAP	3	
ACIPHEX SPRINKLE DR 5 MG CAP	3	
ACITRETIN 10 MG CAPSULE	1	
ACITRETIN 17.5 MG CAPSULE	1	
ACITRETIN 25 MG CAPSULE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ACTEMRA 162 MG/0.9 ML SYRINGE	3	Prior Authorization required;Max. 3.6 ML(s) in 30 days SPP*: Must use CVS Specialty
ACTI-LANCE LITE 28G LANCETS	2	HSA*
ACTI-LANCE SPECIAL 17G LANCETS	2	HSA*
ACTI-LANCE UNIVERS 23G LANCETS	2	HSA*
ACTICLATE 150 MG TABLET	3	
ACTICLATE 75 MG TABLET	3	
ACTIGALL 300 MG CAPSULE	3	
ACTIMMUNE 100 MCG/0.5 ML VIAL	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
ACTIQ 1,200 MCG LOZENGE	3	Prior Authorization required;Max. 120 per 30 days
ACTIQ 1,600 MCG LOZENGE	3	Prior Authorization required;Max. 120 per 30 days
ACTIQ 200 MCG LOZENGE	3	Prior Authorization required;Max. 120 per 30 days
ACTIQ 400 MCG LOZENGE	3	Prior Authorization required;Max. 120 per 30 days
ACTIQ 600 MCG LOZENGE	3	Prior Authorization required;Max. 120 per 30 days
ACTIQ 800 MCG LOZENGE	3	Prior Authorization required;Max. 120 per 30 days
ACTIVELLA 0.5-0.1 MG TABLET	3	
ACTIVELLA 1 MG-0.5 MG TABLET	3	
ACTONEL 150 MG TABLET	3	Max. 1 in 30 days HSA*
ACTONEL 30 MG TABLET	3	Max. 1 per day HSA*
ACTONEL 35 MG TABLET	3	Max. 4 per 28 days HSA*
ACTONEL 5 MG TABLET	3	Max. 1 per day HSA*
ACTOPLUS MET 15 MG-500 MG TAB	3	HSA*
ACTOPLUS MET 15 MG-850 MG TAB	3	HSA*
ACTOPLUS MET XR 15-1,000 MG TB	2	HSA*
ACTOPLUS MET XR 30-1,000 MG TB	2	HSA*
ACTOS 15 MG TABLET	3	HSA*
ACTOS 30 MG TABLET	3	HSA*
ACTOS 45 MG TABLET	3	HSA*
ACUICYN EYELID-EYELASH CLEANSR	3	
ACULAR 0.5% EYE DROPS	3	
ACULAR LS 0.4% OPHTH SOL	3	
ACURA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACUVAIL 0.45% OPHTH SOLUTION	3	Max. 1 per day
ACYCLOVIR 200 MG CAPSULE	1	
ACYCLOVIR 200 MG/5 ML SUSP	1	
ACYCLOVIR 400 MG TABLET	1	
ACYCLOVIR 5% OINTMENT	1	Max. 15 GM(s) in 30 days
ACYCLOVIR 800 MG TABLET	1	
ACZONE 5% GEL	3	
ACZONE 7.5% GEL PUMP	3	
ADALAT CC 30 MG TABLET	3	HSA*
ADALAT CC 60 MG TABLET	3	HSA*
ADALAT CC 90 MG TABLET	3	HSA*
ADAPALENE 0.1% CREAM	1	Prior Authorization required for members 30 and older
ADAPALENE 0.1% GEL	1	Prior Authorization required for members 30 and older
ADAPALENE 0.1% LOTION	1	Prior Authorization required for members 30 and older
ADAPALENE 0.3% GEL	1	Prior Authorization required for members 30 and older

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ADAPALENE-BNZYL PEROX 0.1-2.5%	2	Prior Authorization required for members 30 and older
ADCIRCA 20 MG TABLET	2	Prior Authorization required;Max. 2 per day SPP*: Must use CVS Specialty
ADDERALL 10 MG TABLET	3	Max. 60 Days Supply
ADDERALL 12.5 MG TABLET	3	Max. 60 Days Supply
ADDERALL 15 MG TABLET	3	Max. 60 Days Supply
ADDERALL 20 MG TABLET	3	Max. 60 Days Supply
ADDERALL 30 MG TABLET	3	Max. 60 Days Supply
ADDERALL 5 MG TABLET	3	Max. 60 Days Supply
ADDERALL 7.5 MG TABLET	3	Max. 60 Days Supply
ADDERALL XR 10 MG CAPSULE	3	Max. 60 Days Supply
ADDERALL XR 15 MG CAPSULE	3	Max. 60 Days Supply
ADDERALL XR 20 MG CAPSULE	3	Max. 60 Days Supply
ADDERALL XR 25 MG CAPSULE	3	Max. 60 Days Supply
ADDERALL XR 30 MG CAPSULE	3	Max. 60 Days Supply
ADDERALL XR 5 MG CAPSULE	3	Max. 60 Days Supply
ADDYI 100 MG TABLET	3	Covered for females only;Prior Authorization required;Max. 1 per day
ADEFOVIR DIPIVOXIL 10 MG TAB	1	
ADEMPAS 0.5 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 1 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 1.5 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 2 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 2.5 MG TABLET	2	SPP*: Must use CVS Specialty
ADENOVIRUS TYPE 4 & 7 EC TABS	3	
ADENOVIRUS TYPE 4 EC TABLET	3	
ADENOVIRUS TYPE 7 EC TABLET	3	
ADLYXIN 10-20 MCG STARTER PACK	3	Max. 4 ML(s) per 28 days;Step Therapy required HSA*
ADLYXIN 20 MCG MAINTENANCE PK	3	Max. 4 ML(s) per 28 days;Step Therapy required HSA*
ADOXA 150 MG CAPSULE	3	
ADRENACLICK 0.15 MG AUTO-INJCT	3	Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
ADRENACLICK 0.3 MG AUTO-INJECT	3	Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
ADRENALIN 1 MG/ML NASAL SOLN	3	
ADVAIR 100-50 DISKUS	2	Max. 60 in 30 days HSA*
ADVAIR 250-50 DISKUS	2	Max. 60 in 30 days HSA*
ADVAIR 500-50 DISKUS	2	Max. 60 in 30 days HSA*
ADVAIR HFA 115-21 MCG INHALER	2	Max. 12 GM(s) in 30 days HSA*
ADVAIR HFA 230-21 MCG INHALER	2	Max. 12 GM(s) in 30 days HSA*
ADVAIR HFA 45-21 MCG INHALER	2	Max. 12 GM(s) in 30 days HSA*
ADVANCED TRAVEL 28G LANCETS	2	HSA*
ADVANCED TRAVEL 30G LANCETS	2	HSA*
ADVATE 2,401-3,600 UNIT VIAL	MD	SPP*: Must use CVS Specialty
ADVICOR 1,000 MG-20 MG TABLET	2	HSA*
ADVICOR 1,000 MG-40 MG TABLET	2	HSA*
ADVICOR 500 MG-20 MG TABLET	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ADVICOR 750 MG-20 MG TABLET	2	HSA*
ADVOCATE 26G LANCETS	2	HSA*
ADVOCATE 26G LANCETS	2	HSA*
ADVOCATE 30G LANCETS	2	HSA*
ADVOCATE REDI-CODE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ADVOCATE REDI-CODE+ TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ADVOCATE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ADYNOVATE 1,251-2,500 UNIT VL	MD	SPP*: Must use CVS Specialty
ADZENYS XR-ODT 12.5 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 15.7 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 18.8 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 3.1 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 6.3 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 9.4 MG TABLET	3	Max. 60 Days Supply
AEROCHAMBER MINI	MD	
AEROCHAMBER MV HOLD CHAMBER	MD	
AEROCHAMBER PLUS FLOW-VU	MD	
AEROCHAMBER PLUS FLOW-VU SMALL	MD	
AEROCHAMBER PLUS W-FLOWSIGNAL	MD	
AEROCHAMBER PLUS Z STAT MEDIUM	MD	
AEROCHAMBER Z-STAT PLUS W-FLOW	MD	
AEROGEAR ASTHMA ACTION KIT	MD	
AEROSPAN 80 MCG INHALER	3	HSA*
AEROTRACH HOLDING CHAMBER	MD	
AEROVENT PLUS HOLDING CHAMBER	MD	
AFEDITAB CR 30 MG TABLET	1	HSA*
AFEDITAB CR 60 MG TABLET	1	HSA*
AFINITOR 10 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR 2.5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR 5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR 7.5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR DISPERZ 2 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR DISPERZ 3 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR DISPERZ 5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFLURIA 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
AFLURIA 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
AFLURIA QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
AFLURIA QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
AFREZZA 12 UNIT CARTRIDGE	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 30-4 UNIT / 60-8 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 4 UNIT CARTRIDGE	3	Prior Authorization required;Max. 6 per day HSA*
AFREZZA 4 UNIT/8 UNIT/12 UNIT	3	Prior Authorization required;Max. 15 per day HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AFREZZA 60-4 UNIT / 30-8 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 60-8 UNIT / 30-12 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 8 UNIT CARTRIDGE	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 90-4 UNIT / 90-8 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFSTYLA 500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
AFTERA 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
AGAMATRIX AMP TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
AGGRENOX 25 MG-200 MG CAPSULE	3	HSA*
AGRYLIN 0.5 MG CAPSULE	3	HSA*
AIRDUO RESPICLICK 113-14 MCG	3	Prior Authorization required;Max. 60 in 30 days PA NTM*; HSA*
AIRDUO RESPICLICK 232-14 MCG	3	Prior Authorization required;Max. 60 in 30 days PA NTM*; HSA*
AIRDUO RESPICLICK 55-14 MCG	3	Prior Authorization required;Max. 60 in 30 days PA NTM*; HSA*
AIRZONE PEAK FLOW METER	MD	
AKNE-MYCIN 2% OINTMENT	2	
AKTIPAK 3%-5% GEL POUCH	3	Prior Authorization required
AKYNZEO 300-0.5 MG CAPSULE	3	Max. quantity of 1 per fill;Max. 3 in 30 days MQC*: 1 cap/copay, Max. 3 caps/28 day-supply
ALA-CORT 1% CREAM	1	
ALA-CORT 2.5% CREAM	1	
ALA-QUIN 3-0.5% CREAM	3	
ALA-SCALP 2% LOTION	1	
ALAGESIC LQ ORAL SOLUTION	1	
ALBENZA 200 MG TABLET	3	
ALBUSTIX REAGENT STRIPS	3	
ALBUTEROL 5 MG/ML SOLUTION	1	HSA*
ALBUTEROL SUL 0.63 MG/3 ML SOL	1	HSA*
ALBUTEROL SUL 1.25 MG/3 ML SOL	1	HSA*
ALBUTEROL SUL 2.5 MG/3 ML SOLN	1	HSA*
ALBUTEROL SULF 2 MG/5 ML SYRUP	1	HSA*
ALBUTEROL SULFATE 2 MG TAB	1	HSA*
ALBUTEROL SULFATE 4 MG TAB	1	HSA*
ALBUTEROL SULFATE ER 4 MG TAB	1	HSA*
ALBUTEROL SULFATE ER 8 MG TAB	1	HSA*
ALCAINE 0.5% EYE DROPS	1	
ALCLOMETASONE DIPR 0.05% OINT	1	
ALCLOMETASONE DIPRO 0.05% CRM	1	
ALDACTAZIDE 25-25 TABLET	3	HSA*
ALDACTAZIDE 50-50 TABLET	3	HSA*
ALDACTONE 100 MG TABLET	3	HSA*
ALDACTONE 25 MG TABLET	3	HSA*
ALDACTONE 50 MG TABLET	3	HSA*
ALDARA 5% CREAM	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALECENSA 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ALENDRONATE SOD 70 MG/75 ML	1	Max. 75 ML(s) per 7 days HSA*
ALENDRONATE SODIUM 10 MG TAB	1	HSA*
ALENDRONATE SODIUM 35 MG TAB	1	Max. 4 per 28 days HSA*
ALENDRONATE SODIUM 40 MG TAB	1	HSA*
ALENDRONATE SODIUM 5 MG TABLET	1	HSA*
ALENDRONATE SODIUM 70 MG TAB	1	Max. 4 per 28 days HSA*
ALEVICYN ANTIPRURITIC GEL	3	
ALEVICYN ANTIPRURITIC SG GEL	3	
ALEVICYN DERMAL SPRAY	3	
ALFENTANIL 500 MCG/ML AMPUL	1	
ALFENTANIL 500 MCG/ML AMPULE	3	
ALFUZOSIN HCL ER 10 MG TABLET	1	Max. 1 per day
ALINIA 100 MG/5 ML SUSPENSION	3	
ALINIA 500 MG TABLET	3	
ALKERAN 2 MG TABLET	3	CH*
ALLERGIST PACK 26GX1/2" 1 ML	3	
ALLERGIST PACK 26GX3/8" 1 ML	3	
ALLERGIST PACK 27GX1/2" 1 ML	3	
ALLERGY SYRINGE 1 ML 27GX1/2"	3	
ALLERGY SYRINGE 1 ML 27GX3/8"	3	
ALLOPURINOL 100 MG TABLET	1	
ALLOPURINOL 300 MG TABLET	1	
ALLZITAL 25-325 MG TABLET	3	
ALMOTRIPTAN MALATE 12.5 MG TAB	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ALMOTRIPTAN MALATE 6.25 MG TAB	1	Max. quantity of 12 per fill MQC*: 12 tabs/copay
ALOCRIL 2% EYE DROPS	3	
ALODOX CONVENIENCE KIT	3	
ALOGLIPTIN 12.5 MG TABLET	3	Step Therapy required HSA*
ALOGLIPTIN 25 MG TABLET	3	Step Therapy required HSA*
ALOGLIPTIN 6.25 MG TABLET	3	Step Therapy required HSA*
ALOGLIPTIN-METFORMIN 12.5-1000	3	HSA*
ALOGLIPTIN-METFORMIN 12.5-500	3	HSA*
ALOGLIPTIN-PIOGLIT 12.5-15 MG	3	HSA*
ALOGLIPTIN-PIOGLIT 12.5-30 MG	3	HSA*
ALOGLIPTIN-PIOGLIT 12.5-45 MG	3	HSA*
ALOGLIPTIN-PIOGLIT 25-15 MG TB	3	HSA*
ALOGLIPTIN-PIOGLIT 25-30 MG TB	3	HSA*
ALOGLIPTIN-PIOGLIT 25-45 MG TB	3	HSA*
ALOMIDE 0.1% EYE DROPS	3	
ALORA 0.025 MG PATCH	3	
ALORA 0.05 MG PATCH	3	
ALORA 0.075 MG PATCH	3	
ALORA 0.1 MG PATCH	3	
ALOSETRON HCL 0.5 MG TABLET	1	Covered for females only

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALOSETRON HCL 1 MG TABLET	1	Covered for females only
ALPHAGAN P 0.1% DROPS	2	
ALPHAGAN P 0.15% EYE DROPS	3	
ALPHANATE 2,000-800 UNIT VIAL	MD	SPP*: Must use CVS Specialty
ALPHANINE SD 1,500 UNITS VIAL	MD	SPP*: Must use CVS Specialty
ALPRAZOLAM 0.25 MG TABLET	1	
ALPRAZOLAM 0.5 MG TABLET	1	
ALPRAZOLAM 1 MG TABLET	1	
ALPRAZOLAM 1 MG/ML ORAL CONC	3	
ALPRAZOLAM 2 MG TABLET	1	
ALPRAZOLAM ER 0.5 MG TABLET	1	
ALPRAZOLAM ER 1 MG TABLET	1	
ALPRAZOLAM ER 2 MG TABLET	1	
ALPRAZOLAM ER 3 MG TABLET	1	
ALPRAZOLAM ODT 0.25 MG TAB	1	
ALPRAZOLAM ODT 0.5 MG TAB	1	
ALPRAZOLAM ODT 1 MG TAB	1	
ALPRAZOLAM ODT 2 MG TAB	1	
ALPROLIX 3,000 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
ALREX 0.2% EYE DROPS	3	
ALSUMA 6 MG/0.5 ML AUTO-INJECT	2	Max. quantity of 3 per fill MQC*: 6 injections/copay
ALTABAX 1% OINTMENT	3	
ALTACAINE 0.5% EYE DROPS	1	
ALTACE 1.25 MG CAPSULE	3	HSA*
ALTACE 10 MG CAPSULE	3	HSA*
ALTACE 2.5 MG CAPSULE	3	HSA*
ALTACE 5 MG CAPSULE	3	HSA*
ALTAFLUOR EYE DROPS	1	
ALTAVERA-28 TABLET	0	ACA*
ALTERNATE SITE 26G LANCETS	2	HSA*
ALTOPREV 20 MG TABLET	2	HSA*
ALTOPREV 40 MG TABLET	2	HSA*
ALTOPREV 60 MG TABLET	2	HSA*
ALUNBRIG 30 MG TABLET	3	Prior Authorization required;Max. 6 per day CH*; SPP*: CVS Specialty
ALUVEA 39% CREAM	3	
ALVESCO 160 MCG INHALER	3	HSA*
ALVESCO 80 MCG INHALER	3	HSA*
ALYACEN 1-35-28 TABLET	0	ACA*
ALYACEN 7-7-7-28 TABLET	0	ACA*
AMABELZ 0.5 MG-0.1 MG TABLET	1	
AMABELZ 1 MG-0.5 MG TABLET	1	
AMANTADINE 100 MG CAPSULE	1	
AMANTADINE 100 MG TABLET	1	
AMANTADINE 50 MG/5 ML SOLUTION	1	
AMARYL 1 MG TABLET	3	HSA*
AMARYL 2 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AMARYL 4 MG TABLET	3	HSA*
AMBIEN 10 MG TABLET	3	Step Therapy required STA*: 18 and older
AMBIEN 5 MG TABLET	3	Step Therapy required STA*: 18 and older
AMBIEN CR 12.5 MG TABLET	3	Step Therapy required STA*: 18 and older
AMBIEN CR 6.25 MG TABLET	3	Step Therapy required STA*: 18 and older
AMBITUSSIN AC LIQUID	1	
AMCINONIDE 0.1% CREAM	1	
AMCINONIDE 0.1% LOTION	1	
AMCINONIDE 0.1% OINTMENT	1	
AMERGE 1 MG TABLET	3	Max. quantity of 15 per fill;Step Therapy required MQC*: 15 tabs/copay
AMERGE 2.5 MG TABLET	3	Max. quantity of 6 per fill;Step Therapy required MQC*: 2.5mg: Max. 6 tabs/copay
AMETHIA 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
AMETHIA LO TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
AMETHYST 90-20 MCG TABLET	3	
AMICAR 0.25 GRAM/ML ORAL SOLN	2	
AMICAR 1,000 MG TABLET	2	
AMICAR 500 MG TABLET	2	
AMILORIDE HCL 5 MG TABLET	1	HSA*
AMILORIDE HCL-HCTZ 5-50 MG TAB	1	HSA*
AMINOCAPROIC ACID 1,000 MG TAB	1	
AMINOCAPROIC ACID 25% SOLUTION	1	
AMINOCAPROIC ACID 500 MG TAB	1	
AMIODARONE HCL 100 MG TABLET	1	
AMIODARONE HCL 200 MG TABLET	1	
AMIODARONE HCL 400 MG TABLET	1	
AMITIZA 24 MCG CAPSULES	2	
AMITIZA 8 MCG CAPSULE	2	
AMITRIPTYLINE HCL 10 MG TAB	1	
AMITRIPTYLINE HCL 100 MG TAB	1	
AMITRIPTYLINE HCL 150 MG TAB	1	
AMITRIPTYLINE HCL 25 MG TAB	1	
AMITRIPTYLINE HCL 50 MG TAB	1	
AMITRIPTYLINE HCL 75 MG TAB	1	
AMLOD-VALSA-HCTZ 10-160-12.5MG	1	HSA*
AMLOD-VALSA-HCTZ 10-160-25 MG	1	HSA*
AMLOD-VALSA-HCTZ 10-320-25 MG	1	HSA*
AMLOD-VALSA-HCTZ 5-160-12.5 MG	1	HSA*
AMLOD-VALSA-HCTZ 5-160-25 MG	1	HSA*
AMLODIPINE BESYLATE 10 MG TAB	1	HSA*
AMLODIPINE BESYLATE 2.5 MG TAB	1	HSA*
AMLODIPINE BESYLATE 5 MG TAB	1	HSA*
AMLODIPINE-ATORVAST 10-10 MG	1	HSA*
AMLODIPINE-ATORVAST 10-20 MG	1	HSA*
AMLODIPINE-ATORVAST 10-40 MG	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AMLODIPINE-ATORVAST 10-80 MG	1	HSA*
AMLODIPINE-ATORVAST 2.5-10 MG	1	HSA*
AMLODIPINE-ATORVAST 2.5-20 MG	1	HSA*
AMLODIPINE-ATORVAST 2.5-40 MG	1	HSA*
AMLODIPINE-ATORVAST 5-10 MG	1	HSA*
AMLODIPINE-ATORVAST 5-20 MG	1	HSA*
AMLODIPINE-ATORVAST 5-40 MG	1	HSA*
AMLODIPINE-ATORVAST 5-80 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 10-20 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 10-40 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 2.5-10	1	HSA*
AMLODIPINE-BENAZEPRIL 5-10 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 5-20 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 5-40 MG	1	HSA*
AMLODIPINE-OLMESARTAN 10-20 MG	2	HSA*
AMLODIPINE-OLMESARTAN 10-40 MG	2	HSA*
AMLODIPINE-OLMESARTAN 5-20 MG	2	HSA*
AMLODIPINE-OLMESARTAN 5-40 MG	2	HSA*
AMLODIPINE-VALSARTAN 10-160 MG	1	HSA*
AMLODIPINE-VALSARTAN 10-320 MG	1	HSA*
AMLODIPINE-VALSARTAN 5-160 MG	1	HSA*
AMLODIPINE-VALSARTAN 5-320 MG	1	HSA*
AMMONIUM LACTATE 12% CREAM	1	
AMMONIUM LACTATE 12% LOTION	1	
AMNESTEEM 10 MG CAPSULE	1	
AMNESTEEM 20 MG CAPSULE	1	
AMNESTEEM 40 MG CAPSULE	1	
AMOX-CLAV 200-28.5 MG TAB CHEW	1	
AMOX-CLAV 200-28.5 MG/5 ML SUS	1	
AMOX-CLAV 250-125 MG TABLET	1	
AMOX-CLAV 250-62.5 MG/5 ML SUS	1	
AMOX-CLAV 400-57 MG TAB CHEW	1	
AMOX-CLAV 400-57 MG/5 ML SUSP	1	
AMOX-CLAV 500-125 MG TABLET	1	
AMOX-CLAV 600-42.9 MG/5 ML SUS	1	
AMOX-CLAV 875-125 MG TABLET	1	
AMOX-CLAV ER 1,000-62.5 MG TAB	1	
AMOXAPINE 100 MG TABLET	1	
AMOXAPINE 150 MG TABLET	1	
AMOXAPINE 25 MG TABLET	1	
AMOXAPINE 50 MG TABLET	1	
AMOXICILLIN 125 MG TAB CHEW	1	
AMOXICILLIN 125 MG/5 ML SUSP	1	
AMOXICILLIN 200 MG/5 ML SUSP	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AMOXICILLIN 250 MG CAPSULE	1	
AMOXICILLIN 250 MG TAB CHEW	1	
AMOXICILLIN 250 MG/5 ML SUSP	1	
AMOXICILLIN 400 MG/5 ML SUSP	1	
AMOXICILLIN 500 MG CAPSULE	1	
AMOXICILLIN 500 MG TABLET	1	
AMOXICILLIN 875 MG TABLET	1	
AMOXICILLIN ER 775 MG TABLET	1	
AMPICILLIN 125 MG/5 ML SUSP	1	
AMPICILLIN 250 MG CAPSULE	1	
AMPICILLIN 250 MG/5 ML SUSP	1	
AMPICILLIN 500 MG CAPSULE	1	
AMPYRA ER 10 MG TABLET	3	Max. 2 per day SPP*: Must use CVS Specialty
AMRIX ER 15 MG CAPSULE	3	
AMRIX ER 30 MG CAPSULE	3	
AMTURNIDE 150-5-12.5 MG TAB	2	Max. 1.5 per day HSA*
AMTURNIDE 300-10-12.5 MG TAB	2	Max. 1 per day HSA*
AMTURNIDE 300-10-25 MG TAB	2	Max. 1 per day HSA*
AMTURNIDE 300-5-12.5 MG TAB	2	Max. 1 per day HSA*
AMTURNIDE 300-5-25 MG TAB	2	Max. 1 per day HSA*
AMYL NITRITE AMPUL	1	
ANACAINE OINTMENT	3	
ANADROL-50 TABLET	3	Max. 30 Days Supply
ANAFRANIL 25 MG CAPSULE	3	
ANAFRANIL 50 MG CAPSULE	3	
ANAFRANIL 75 MG CAPSULE	3	
ANAGRELIDE HCL 0.5 MG CAPSULE	1	HSA*
ANAGRELIDE HCL 1 MG CAPSULE	1	HSA*
ANALPRAM HC 1% CREAM	3	
ANALPRAM HC 2.5%-1% CREAM	3	
ANALPRAM HC 2.5%-1% LOTION	2	
ANAPROX 275 MG TABLET	3	
ANAPROX DS 550 MG TABLET	3	
ANASTROZOLE 1 MG TABLET	1	CH*; HSA*
ANCOBON 250 MG CAPSULE	3	
ANCOBON 500 MG CAPSULE	3	
ANDRODERM 2 MG/24HR PATCH	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 2 per day
ANDRODERM 4 MG/24HR PATCH	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 1 per day
ANDROGEL 1% GEL PUMP	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 300 GM(s) in 30 days
ANDROGEL 1%(2.5G) GEL PACKET	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 2.5 GM(s) per day
ANDROGEL 1%(5G) GEL PACKET	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 GM(s) per day
ANDROGEL 1.62% GEL PUMP	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 150 GM(s) in 30 days
ANDROGEL 1.62%(1.25G) GEL PCKT	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 1.25 GM(s) per day
ANDROGEL 1.62%(2.5G) GEL PCKT	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 5 GM(s) per day
ANDROID 10 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required
ANDROXY 10 MG TABLET	1	Max. 30 Days Supply
ANGELIQ 0.25 MG-0.5 MG TABLET	3	
ANGELIQ 0.5 MG-1 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ANORO ELLIPTA 62.5-25 MCG INH	2	Max. quantity of 60 per fill;Max. 60 in 30 days HSA*
ANTABUSE 250 MG TABLET	3	
ANTABUSE 500 MG TABLET	3	
ANTARA 130 MG CAPSULE	3	HSA*
ANTARA 30 MG CAPSULE	3	HSA*
ANTARA 43 MG CAPSULE	3	HSA*
ANTARA 90 MG CAPSULE	3	HSA*
ANTIPYRINE-BENZOCAINE EAR DROP	3	
ANTIPYRINE-BENZOCAINE OTIC SOL	1	
ANUCORT-HC 25 MG SUPPOSITORY	1	
ANUSOL-HC 2.5% CREAM	3	
ANUSOL-HC 25 MG SUPPOSITORY	3	
ANZEMET 100 MG TABLET	3	Max. quantity of 6 per fill MQC*: 3 tabs/copay
ANZEMET 50 MG TABLET	3	Max. quantity of 6 per fill MQC*: 6 tabs/copay
APEXICON E 0.05% CREAM	3	
APIDRA 100 UNITS/ML VIAL	3	HSA*
APIDRA SOLOSTAR 100 UNITS/ML	3	HSA*
APLENZIN ER 174 MG TABLET	3	Step Therapy required STA*: 18 and older
APLENZIN ER 348 MG TABLET	3	Step Therapy required STA*: 18 and older
APLENZIN ER 522 MG TABLET	3	Step Therapy required STA*: 18 and older
APOKYN 30 MG/3 ML CARTRIDGE	3	
APRACLONIDINE HCL 0.5% DROPS	1	
APREPITANT 125 MG CAPSULE	2	Max. 30 Days Supply;Max. quantity of 1 per fill MQC*: 1 cap/copay
APREPITANT 125-80-80 MG PACK	2	Max. 30 Days Supply;Max. quantity of 3 per fill MQC*: 1 pack/copay
APREPITANT 40 MG CAPSULE	2	Max. 30 Days Supply;Max. quantity of 4 per fill MQC*: 4 caps/copay
APREPITANT 80 MG CAPSULE	2	Max. 30 Days Supply;Max. quantity of 2 per fill MQC*: 2 caps/copay
APRI 28 DAY TABLET	0	ACA*
APRISO ER 0.375 GRAM CAPSULE	2	
APTENSIO XR 10 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 15 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 20 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 30 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 40 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 50 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 60 MG CAPSULE	3	Max. 60 Days Supply
APTIOM 200 MG TABLET	3	
APTIOM 400 MG TABLET	3	
APTIOM 600 MG TABLET	3	
APTIOM 800 MG TABLET	3	
APTIVUS 100 MG/ML SOLUTION	3	
APTIVUS 250 MG CAPSULE	3	
AQUA GLYCOLIC HC 2% KIT	3	
ARALAST NP 1,000 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ARANELLE 28 TABLET	0	ACA*
ARANESP 10 MCG/0.4 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.6 per fill SPP*: CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ARANESP 100 MCG/0.5 ML SYRINGE	3	Prior Authorization required;Max. quantity of 2 per fill SPP*: CVS Specialty
ARANESP 100 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 150 MCG/0.3 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.2 per fill SPP*: CVS Specialty
ARANESP 150 MCG/0.75 ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 200 MCG/0.4 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.6 per fill SPP*: CVS Specialty
ARANESP 200 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 25 MCG/0.42 ML SYRING	3	Prior Authorization required;Max. quantity of 1.68 per fill SPP*: CVS Specialty
ARANESP 25 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 300 MCG/0.6 ML SYRINGE	3	Prior Authorization required;Max. quantity of 2.4 per fill SPP*: CVS Specialty
ARANESP 300 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 40 MCG/0.4 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.6 per fill SPP*: CVS Specialty
ARANESP 40 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 500 MCG/1 ML SYRINGE	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 60 MCG/0.3 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.2 per fill SPP*: CVS Specialty
ARANESP 60 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARAVA 10 MG TABLET	3	
ARAVA 20 MG TABLET	3	
ARBINOXA 4 MG TABLET	1	
ARBINOXA 4 MG/5 ML LIQUID	1	
ARCAPTA NEOHALER 75 MCG CAP	3	Max. 1 per day HSA*
ARICEPT 10 MG TABLET	3	
ARICEPT 23 MG TABLET	3	
ARICEPT 5 MG TABLET	3	
ARICEPT ODT 10 MG TABLET	3	
ARICEPT ODT 5 MG TABLET	3	
ARIMIDEX 1 MG TABLET	3	CH*; HSA*
ARIPIPRAZOLE 1 MG/ML SOLUTION	1	
ARIPIPRAZOLE 10 MG TABLET	1	
ARIPIPRAZOLE 15 MG TABLET	1	
ARIPIPRAZOLE 2 MG TABLET	1	
ARIPIPRAZOLE 20 MG TABLET	1	
ARIPIPRAZOLE 30 MG TABLET	1	
ARIPIPRAZOLE 5 MG TABLET	1	
ARIPIPRAZOLE ODT 10 MG TABLET	1	
ARIPIPRAZOLE ODT 15 MG TABLET	1	
ARIXTRA 10 MG/0.8 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
ARIXTRA 2.5 MG/0.5 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
ARIXTRA 5 MG/0.4 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
ARIXTRA 7.5 MG/0.6 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
ARMODAFINIL 150 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMODAFINIL 200 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMODAFINIL 250 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMODAFINIL 50 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMONAIR RESPICLICK 113 MCG	3	Prior Authorization required HSA*; PA NTM*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ARMONAIR RESPICLICK 232 MCG	3	Prior Authorization required HSA*; PA NTM*
ARMONAIR RESPICLICK 55 MCG	3	Prior Authorization required HSA*; PA NTM*
ARMOUR THYROID 120 MG TABLET	3	
ARMOUR THYROID 15 MG TABLET	3	
ARMOUR THYROID 180 MG TABLET	3	
ARMOUR THYROID 240 MG TABLET	3	
ARMOUR THYROID 30 MG TABLET	3	
ARMOUR THYROID 300 MG TABLET	3	
ARMOUR THYROID 60 MG TABLET	3	
ARMOUR THYROID 90 MG TABLET	3	
ARNUITY ELLIPTA 100 MCG INH	3	HSA*
ARNUITY ELLIPTA 200 MCG INH	3	HSA*
AROMASIN 25 MG TABLET	3	CH*; HSA*
ARTHROTEC 50 MG-200 MCG TAB	3	
ARTHROTEC 75 MG-200 MCG TAB	3	
ARYMO ER 15 MG TABLET	3	Max. 3 per day
ARYMO ER 30 MG TABLET	3	Max. 3 per day
ARYMO ER 60 MG TABLET	3	Max. 3 per day
ASACOL HD DR 800 MG TABLET	3	
ASCOMP WITH CODEINE CAPSULE	1	
ASEPTO BULB SYRINGES GLASS	3	
ASHLYNA 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
ASMANEX HFA 100 MCG INHALER	2	HSA*
ASMANEX HFA 200 MCG INHALER	2	HSA*
ASMANEX TWISTHALER 110 MCG #30	2	HSA*
ASMANEX TWISTHALER 220 MCG #14	2	HSA*
ASMANEX TWISTHALER 220 MCG #30	2	HSA*
ASMANEX TWISTHALER 220 MCG #60	2	HSA*
ASMANEX TWISTHALR 220 MCG #120	2	HSA*
ASPIR-LOW EC 81 MG TABLET	0	ACA*
ASPIR-TRIN EC 325 MG TABLET	0	ACA*
ASPIRIN 300 MG SUPPOSITORY	0	ACA*
ASPIRIN 325 MG TABLET	0	ACA*
ASPIRIN 600 MG SUPPOSITORY	0	ACA*
ASPIRIN 81 MG CHEWABLE TABLET	0	ACA*
ASPIRIN EC 325 MG TABLET	0	ACA*
ASPIRIN EC 500 MG TABLET	0	ACA*
ASPIRIN EC 650 MG TABLET	0	ACA*
ASPIRIN EC 81 MG TABLET	0	ACA*
ASPIRIN EC 975 MG TABLET	0	ACA*
ASPIRIN-CAFF-DIHYDROCODEIN CAP	1	
ASPIRIN-DIPYRIDAM ER 25-200 MG	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ASSESS PEAK FLOW METER	MD	
ASSURE 4 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASSURE COMFORT 30G LANCETS	2	HSA*
ASSURE HAEMOLANCE PLUS 18G	2	HSA*
ASSURE HAEMOLANCE PLUS 21G	2	HSA*
ASSURE HAEMOLANCE PLUS 25G	2	HSA*
ASSURE HAEMOLANCE PLUS 28G	2	HSA*
ASSURE HAEMOLANCE PLUS BLADE	2	HSA*
ASSURE LANCE 25G LANCETS	2	HSA*
ASSURE LANCE 28G LANCETS	2	HSA*
ASSURE LANCE PLUS 21G LANCETS	2	HSA*
ASSURE LANCE PLUS 25G LANCETS	2	HSA*
ASSURE LANCE PLUS 30G LANCETS	2	HSA*
ASSURE PLATINUM TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASSURE PRISM MULTI TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASSURE PRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASTAGRAF XL 0.5 MG CAPSULE	3	
ASTAGRAF XL 1 MG CAPSULE	3	
ASTAGRAF XL 5 MG CAPSULE	3	
ASTELIN 137 MCG NASAL SPRAY	3	
ASTEPRO 0.15% NASAL SPRAY	3	
ASTHMA CHECK PEAK FLOW MTR	MD	
ASTHMAMENTOR PEAK FLOW MTR	MD	
ASTHMAPACK CHILDREN'S CARE KIT	MD	
ATACAND 16 MG TABLET	3	HSA*
ATACAND 32 MG TABLET	3	HSA*
ATACAND 4 MG TABLET	3	HSA*
ATACAND 8 MG TABLET	3	HSA*
ATACAND HCT 16-12.5 MG TAB	3	HSA*
ATACAND HCT 32-12.5 MG TAB	3	HSA*
ATACAND HCT 32-25 MG TABLET	3	HSA*
ATELVIA DR 35 MG TABLET	3	Max. 4 per 28 days HSA*
ATENOLOL 100 MG TABLET	1	HSA*
ATENOLOL 25 MG TABLET	1	HSA*
ATENOLOL 50 MG TABLET	1	HSA*
ATENOLOL-CHLORTHALIDONE 100-25	1	HSA*
ATENOLOL-CHLORTHALIDONE 50-25	1	HSA*
ATIVAN 0.5 MG TABLET	3	
ATIVAN 1 MG TABLET	3	
ATIVAN 2 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ATOMOXETINE HCL 10 MG CAPSULE	2	
ATOMOXETINE HCL 100 MG CAPSULE	2	
ATOMOXETINE HCL 18 MG CAPSULE	2	
ATOMOXETINE HCL 25 MG CAPSULE	2	
ATOMOXETINE HCL 40 MG CAPSULE	2	
ATOMOXETINE HCL 60 MG CAPSULE	2	
ATOMOXETINE HCL 80 MG CAPSULE	2	
ATOPICLAIR CREAM	3	
ATORVASTATIN 10 MG TABLET	0	ACA*
ATORVASTATIN 20 MG TABLET	0	ACA*
ATORVASTATIN 40 MG TABLET	1	HSA*
ATORVASTATIN 80 MG TABLET	1	HSA*
ATOVAQUONE 750 MG/5 ML SUSP	1	
ATOVAQUONE-PROGUANIL 250-100	1	
ATOVAQUONE-PROGUANIL 62.5-25	1	
ATRALIN 0.05% GEL	3	Prior Authorization required for members 30 and older
ATRAPRO DERMAL SPRAY	3	
ATRAPRO HYDROGEL	3	
ATRIPLA TABLET	2	
ATROPINE 0.01%-NS EYE DROPS	1	
ATROPINE 1% EYE DROPS	1	
ATROPINE 1% EYE OINTMENT	1	
ATROPINE CARE 1% EYE DROPS	1	
ATROVENT 0.03% SPRAY	3	
ATROVENT 0.06% SPRAY	3	
ATROVENT HFA INHALER	2	HSA*
AUBAGIO 14 MG TABLET	3	Max. 1 per day SPP*: Must use CVS Specialty
AUBAGIO 7 MG TABLET	3	Max. 1 per day SPP*: Must use CVS Specialty
AUBRA-28 TABLET	0	ACA*
AUGMENTIN 125-31.25 MG/5 ML	2	
AUGMENTIN 250-62.5 MG/5 ML	3	
AUGMENTIN 500-125 TABLET	3	
AUGMENTIN 875-125 TABLET	3	
AUGMENTIN ES-600 SUSPENSION	3	
AUGMENTIN XR 1,000-62.5 TAB	3	
AURODEX OTIC SOLUTION	1	
AUROGUARD OTIC SOLUTION	3	
AURORA SUPER THIN 30G LANCETS	2	HSA*
AURSTAT ANTI-ITCH HYDROGEL KIT	3	
AURYXIA 210 MG TABLET	3	
AUSTEDO 12 MG TABLET	3	Prior Authorization required;Max. 2 per day LDD*: Cardinal Health Specialty (888) 662-9779; PA NTM*
AUSTEDO 6 MG TABLET	3	Prior Authorization required;Max. 2 per day LDD*: Cardinal Health Specialty (888) 662-9779; PA NTM*
AUSTEDO 9 MG TABLET	3	Prior Authorization required;Max. 2 per day LDD*: Cardinal Health Specialty (888) 662-9779; PA NTM*
AUVI-Q 0.15 MG AUTO-INJECTOR	3	Prior Authorization required;Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
AUVI-Q 0.3 MG AUTO-INJECTOR	3	Prior Authorization required;Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
AVALIDE 150-12.5 MG TABLET	3	HSA*

AVALIDE 300-12.5 MG TABLET	3	HSA*
AVANDAMET 2 MG-1,000 MG TAB	2	HSA*
AVANDAMET 2 MG-500 MG TABLET	2	HSA*
AVANDAMET 4 MG-1,000 MG TABLET	2	HSA*
AVANDAMET 4 MG-500 MG TABLET	2	HSA*
AVANDARYL 4 MG-1 MG TABLET	2	HSA*
AVANDARYL 4 MG-2 MG TABLET	2	HSA*
AVANDARYL 4 MG-4 MG TABLET	2	HSA*
AVANDARYL 8 MG-2 MG TABLET	2	HSA*
AVANDARYL 8 MG-4 MG TABLET	2	HSA*
AVANDIA 2 MG TABLET	2	HSA*
AVANDIA 4 MG TABLET	2	HSA*
AVANDIA 8 MG TABLET	2	HSA*
AVAPRO 150 MG TABLET	3	HSA*
AVAPRO 300 MG TABLET	3	HSA*
AVAPRO 75 MG TABLET	3	HSA*
AVAR CLEANSER	3	
AVAR LS 10%-2% FOAM	3	
AVAR LS CLEANSER	3	
AVAR-E EMOLLIENT CREAM	3	
AVAR-E LS CREAM	3	
AVC 15% CREAM	2	
AVELOX 400 MG TABLET	3	
AVELOX ABC PACK 400 MG TAB	3	
AVENOVA LID-LASH SPRAY	3	
AVIANE-28 TABLET	0	ACA*
AVIDOXY 100 MG TABLET	3	
AVINZA 120 MG CAPSULE	3	Max. 2 per day
AVINZA 30 MG CAPSULE	3	Max. 2 per day
AVINZA 45 MG CAPSULE	3	Max. 2 per day
AVINZA 60 MG CAPSULE	3	Max. 2 per day
AVINZA 75 MG CAPSULE	3	Max. 2 per day
AVINZA 90 MG CAPSULE	3	Max. 2 per day
AVITA 0.025% CREAM	1	Prior Authorization required for members 30 and older
AVITA 0.025% GEL	1	Prior Authorization required for members 30 and older
AVITENE FLOUR	3	
AVITENE SHEET 35MMX35MM	3	
AVITENE SHEET 70MMX35MM	3	
AVITENE SHEET 70MMX70MM	3	
AVO CREAM TOPICAL EMULSION	1	
AVODART 0.5 MG SOFTGEL	3	
AVONEX 30 MCG VIAL KIT	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
AVONEX PEN 30 MCG/0.5 ML KIT	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
AVONEX PREFILLED SYR 30 MCG KT	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
AXERT 12.5 MG TABLET	3	Max. quantity of 6 per fill;Step Therapy required MQC*: 6 tabs/copay
AXERT 6.25 MG TABLET	3	Max. quantity of 12 per fill;Step Therapy required MQC*: 12 tabs/copay
AXID 15 MG/ML ORAL SOLUTION	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AXIRON 30 MG/ACTUATION SOLN	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 180 ML(s) in 30 days
AYGESTIN 5 MG TABLET	3	
AZASAN 100 MG TABLET	2	
AZASAN 75 MG TABLET	2	
AZASITE 1% EYE DROPS	3	
AZATHIOPRINE 50 MG TABLET	1	
AZELASTINE 0.1% (137 MCG) SPRY	1	
AZELASTINE 0.15% NASAL SPRAY	1	
AZELASTINE HCL 0.05% DROPS	1	
AZELEX 20% CREAM	2	
AZILECT 0.5 MG TABLET	3	
AZILECT 1 MG TABLET	3	
AZITHROMYCIN 1 GM PWD PACKET	1	
AZITHROMYCIN 100 MG/5 ML SUSP	1	
AZITHROMYCIN 200 MG/5 ML SUSP	1	
AZITHROMYCIN 250 MG TABLET	1	
AZITHROMYCIN 500 MG TABLET	1	
AZITHROMYCIN 600 MG TABLET	1	
AZOPT 1% EYE DROPS	2	
AZOR 10-20 MG TABLET	3	HSA*
AZOR 10-40 MG TABLET	3	HSA*
AZOR 5-20 MG TABLET	3	HSA*
AZOR 5-40 MG TABLET	3	HSA*
AZULFIDINE 500 MG TABLET	3	
AZULFIDINE ENTAB 500 MG	3	
AZURETTE 28 DAY TABLET	0	ACA*

B

B-12 KIT	1	
BACITRACIN 500 UNIT/GM OPHTH	1	
BACITRACIN-POLYMYXIN EYE OINT	1	
BACLOFEN 10 MG TABLET	1	
BACLOFEN 20 MG TABLET	1	
BACMIN CAPLET	1	
BACTRIM 400-80 MG TABLET	3	
BACTRIM DS TABLET	3	
BACTROBAN 2% CREAM	3	
BACTROBAN 2% OINTMENT	3	
BACTROBAN NASAL 2% OINTMENT	3	
BALSALAZIDE DISODIUM 750 MG CP	1	
BALZIVA 28 TABLET	0	ACA*
BANZEL 200 MG TABLET	2	
BANZEL 40 MG/ML SUSPENSION	2	
BANZEL 400 MG TABLET	2	
BARACLUDE 0.05 MG/ML SOLUTION	2	
BARACLUDE 0.5 MG TABLET	3	
BARACLUDE 1 MG TABLET	3	
BASAGLAR 100 UNIT/ML KWIKPEN	3	Prior Authorization required HSA*
BAXDELA 450 MG TABLET	3	Prior Authorization required;Max. 2 per day
BAYER ADVANCED 500 MG TABLET	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BAYER PLUS 500 MG CAPLET	0	ACA*
BD 1 ML SYRINGE WITH NEEDLE	3	
BD 1 ML SYRINGE-NEEDLE 25GX5/8	3	
BD 10 ML SYRINGE	3	
BD 10 ML SYRINGE 20GX1"	3	
BD 10 ML SYRINGE 20GX1-1/2"	3	
BD 10 ML SYRINGE 21GX1"	3	
BD 10 ML SYRINGE 21GX1-1/2"	3	
BD 10 ML SYRINGE 22GX1"	3	
BD 10 ML SYRINGE 22GX1-1/2"	3	
BD 10 ML SYRINGE WITH NEEDLE	3	
BD 20 ML SYRINGE	3	
BD 20 ML SYRINGE BULK	3	
BD 3 ML SYRINGE 18GX1-1/2"	3	
BD 3 ML SYRINGE 20GX1-1/2"	3	
BD 3 ML SYRINGE 25GX1"	3	
BD 3 ML SYRINGE 25GX1-1/2"	3	
BD 3 ML SYRINGE WITH NEEDLE	3	
BD 5 ML SYRINGE 20GX1"	3	
BD 5 ML SYRINGE 20GX1-1/2"	3	
BD 5 ML SYRINGE 21GX1"	3	
BD 5 ML SYRINGE 21GX1-1/2"	3	
BD 5 ML SYRINGE 22GX1"	3	
BD 5 ML SYRINGE 22GX1-1/2"	3	
BD 5 ML SYRINGE WITH NEEDLE	3	
BD 60 ML SYRINGE	3	
BD ALLERGIST SYRINGE	3	
BD ALLERGIST TRAY	3	
BD ALLERGIST TRAY	3	
BD ALLERGY SYRINGE 1 ML 28G	3	
BD ALLERGY SYRINGE-NEEDLE 1 ML	3	
BD BULK SYRINGE 1 ML	3	
BD BULK SYRINGE 10 ML	3	
BD BULK SYRINGE 20 ML	3	
BD BULK SYRINGE 3 ML	3	
BD BULK SYRINGE 5 ML	3	
BD BULK SYRINGE 60 ML	3	
BD CATHETER TIP SYRINGE 60 ML	3	
BD ECLIPSE LUER-LOK SYR 3 ML	3	
BD ECLIPSE SYR 1 ML 25GX5/8	3	
BD ECLIPSE SYR 3 ML 22GX1-1/2"	3	
BD ECLIPSE SYRINGE 3 ML 21GX1"	3	
BD ECLIPSE SYRINGE 3 ML 22GX1"	3	
BD ECLIPSE SYRINGE 3 ML 25GX1"	3	
BD GLASPAK 1 ML SYRINGE	3	
BD GLASPAK 10 ML SYRINGE	3	
BD GLASPAK 2.5 ML SYRINGE	3	
BD GLASPAK 5 ML SYRINGE	3	
BD INSULIN SYR 0.5 ML 6MMX31G	2	HSA*
BD INSULIN SYR 1 ML 6MMX31G	2	HSA*
BD INTEGRA RETRA NEEDLE 23GX1"	3	
BD INTEGRA SYR 3 ML 21GX1 1/2"	3	
BD INTEGRA SYR 3 ML 22GX1 1/2"	3	
BD INTEGRA SYR 3 ML 25GX5/8"	3	
BD INTEGRA SYRINGE 1 ML 25GX1"	3	
BD INTEGRA SYRINGE 3 ML 21GX1"	3	
BD INTEGRA SYRINGE 3 ML 23GX1"	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BD INTEGRA SYRINGE 3 ML 25GX1"	3	
BD INTERLINK SYR 15G W-CANNULA	3	
BD INTERLINK SYR 17G W-CANNULA	3	
BD INTERLINK SYR 17G W-CANNULA	3	
BD LUER-LOK 5 ML SYRINGE	3	
BD LUER-LOK SYR 3 ML 25GX5/8"	3	
BD LUER-LOK SYRINGE 1ML 20GX1"	3	
BD LUER-LOK SYRINGE 20 ML	3	
BD LUER-LOK SYRINGE 3 ML	3	
BD LUER-LOK SYRINGE 5 ML	3	
BD LUER-LOK TIP SYRINGE 30 ML	3	
BD LUERSLIP SYRINGE 1 ML	3	
BD MEDSAVER 1 ML SYR-NEEDLE	3	
BD MEDSAVER SYRINGE	3	
BD MICROTAINER 21G LANCETS	2	HSA*
BD MICROTAINER 30G LANCETS	2	HSA*
BD MICROTAINER LANCETS	2	HSA*
BD NEEDLE 18GX1 1/2"	3	
BD NEEDLE 19GX1 1/2"	3	
BD NEEDLE 20GX1 1/2"	3	
BD NEEDLE 21GX1 1/2"	3	
BD NEEDLE 21GX1"	3	
BD NEEDLE 22GX1 1/2"	3	
BD NEEDLE 22GX1"	3	
BD NEEDLE 22GX3/4"	3	
BD NEEDLE 23GX1 1/2"	3	
BD NEEDLE 23GX1"	3	
BD NEEDLE 24GX1"	3	
BD NEEDLE 25GX1"	3	
BD NEEDLE 25GX5/8"	3	
BD NEEDLE 26GX0.625"	3	
BD NEEDLES 16GX1"	3	
BD NEEDLES 16GX1.5"	3	
BD NEEDLES 18GX1"	3	
BD NEEDLES 18GX1.5"	3	
BD NEEDLES 18GX1.5"	3	
BD NEEDLES 19GX1"	3	
BD NEEDLES 19GX1.5"	3	
BD NEEDLES 20GX1"	3	
BD NEEDLES 20GX1"	3	
BD NEEDLES 20GX1.5"	3	
BD NEEDLES 20GX1.5"	3	
BD NEEDLES 21GX1"	3	
BD NEEDLES 21GX1.5"	3	
BD NEEDLES 21GX2"	3	
BD NEEDLES 22GX1"	3	
BD NEEDLES 22GX1.5"	3	
BD NEEDLES 22GX1.5"	3	
BD NEEDLES 23GX0.75"	3	
BD NEEDLES 23GX1.25"	3	
BD NEEDLES 25GX0.625"	3	
BD NEEDLES 25GX0.875"	3	
BD NEEDLES 25GX1.5"	3	
BD NEEDLES 26GX0.375"	3	
BD NEEDLES 26GX0.5"	3	
BD NEEDLES 27GX0.5"	3	
BD NEEDLES 27GX1X1.25"	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BD NEEDLES 30GX0.5"	3	
BD NEEDLES 30GX1"	3	
BD NOKOR ADMIX NEEDLE 18GX1.5"	3	
BD PRECISIONGLIDE 3 ML 22GX3/4	3	
BD PRECISIONGLIDE NEEDLE 25G	3	
BD SAFETYGLIDE 3 ML SYRINGE	3	
BD SAFETYGLIDE 3 ML SYRINGE	3	
BD SAFETYGLIDE ALLERGY 27G SYR	3	
BD SAFETYGLIDE ALLERGY SYRINGE	3	
BD SAFETYGLIDE SYR 22GX1.5"	3	
BD SAFETYGLIDE SYR 22GX1.5"	3	
BD SAFETYGLIDE TB 1 ML SYR	3	
BD SLIP TIP 5 ML SYRINGE	3	
BD SLIP TIP 60 ML SYRINGE	3	
BD SLIP-TIP SYRINGE 20 ML	3	
BD SYR 0.3 ML 6MMX31G (1/2)	2	HSA*
BD SYRINGE 10 ML	3	
BD SYRINGE 2 ML	3	
BD SYRINGE 20 ML	3	
BD SYRINGE 3 ML	3	
BD SYRINGE 3 ML	3	
BD SYRINGE 30 ML	3	
BD SYRINGE 30 ML	3	
BD SYRINGE 5 ML	3	
BD SYRINGE 50 ML	3	
BD SYRINGE GLASS 3 ML	3	
BD SYRINGE WITH CANNULA	3	
BD SYRINGE-SAFETY GLIDE	3	
BD SYRINGE-SAFETY GLIDE	3	
BD TB SYRINGE 21GX1"	3	
BD TB SYRINGE 22GX1"	3	
BD TB SYRINGE 25GX5/8"	3	
BD TB SYRINGE 26GX3/8"	3	
BD TB SYRINGE 27GX1/2"	3	
BD TB SYRNGE 27GX1/2"	3	
BD TUBERCULIN 1 ML SYRINGE	3	
BD ULTRA-FINE 33G LANCETS	2	HSA*
BD ULTRA-FINE II 30G LANCETS	2	HSA*
BD ULTRA-FINE PEN NDL 4MMX32G	2	HSA*
BEAU RX SCAR CARE GEL	3	
BEBULIN 200-1,200 UNITS VIAL	MD	SPP*: Must use CVS Specialty
BECONASE AQ 0.042% SPRAY	3	
BEKYREE 28 DAY TABLET	0	ACA*
BELBUCA 150 MCG FILM	3	Max. 2 per day
BELBUCA 300 MCG FILM	3	Max. 2 per day
BELBUCA 450 MCG FILM	3	Max. 2 per day
BELBUCA 600 MCG FILM	3	Max. 2 per day
BELBUCA 75 MCG FILM	3	Max. 2 per day
BELBUCA 750 MCG FILM	3	Max. 2 per day
BELBUCA 900 MCG FILM	3	Max. 2 per day
BELLADONNA-OPIUM 16.2-30 SUPP	1	
BELLADONNA-OPIUM 16.2-60 SUPP	1	
BELSOMRA 10 MG TABLET	3	Max. 1 per day;Step Therapy required STA*: 18 and older
BELSOMRA 15 MG TABLET	3	Max. 1 per day;Step Therapy required STA*: 18 and older

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BELSOMRA 20 MG TABLET	3	Max. 1 per day;Step Therapy required STA*: 18 and older
BELSOMRA 5 MG TABLET	3	Max. 1 per day;Step Therapy required STA*: 18 and older
BENAZEPRIL HCL 10 MG TABLET	1	HSA*
BENAZEPRIL HCL 20 MG TABLET	1	HSA*
BENAZEPRIL HCL 40 MG TABLET	1	HSA*
BENAZEPRIL HCL 5 MG TABLET	1	HSA*
BENAZEPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
BENAZEPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
BENAZEPRIL-HCTZ 20-25 MG TAB	1	HSA*
BENAZEPRIL-HCTZ 5-6.25 MG TAB	1	HSA*
BENEFIX 2,000 UNIT RANGE	MD	SPP*: Must use CVS Specialty
BENICAR 20 MG TABLET	3	HSA*
BENICAR 40 MG TABLET	3	HSA*
BENICAR 5 MG TABLET	3	HSA*
BENICAR HCT 20-12.5 MG TABLET	3	HSA*
BENICAR HCT 40-12.5 MG TABLET	3	HSA*
BENICAR HCT 40-25 MG TABLET	3	HSA*
BENLYSTA 200 MG/ML AUTOINJECT	3	Prior Authorization required;Max. 4 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
BENLYSTA 200 MG/ML SYRINGE	3	Prior Authorization required;Max. 4 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
BENOXYLDOXY 30 KIT	3	
BENOXYLDOXY 60 KIT	3	
BENSAL HP 3% OINTMENT	3	
BENTYL 10 MG CAPSULE	3	
BENTYL 20 MG TABLET	3	
BENZAC AC 5% GEL	3	
BENZAC AC WASH 10% LIQUID	3	
BENZACLIN GEL 50G PUMP	3	
BENZAMYCIN GEL	3	
BENZNIDAZOLE 100 MG TABLET	3	Prior Authorization required
BENZNIDAZOLE 12.5 MG TABLET	3	Prior Authorization required
BENZODOX 30 KIT	3	
BENZODOX 60 KIT	3	
BENZONATATE 100 MG CAPSULE	1	
BENZONATATE 150 MG CAPSULE	1	
BENZONATATE 200 MG CAPSULE	1	
BENZTROPINE MES 0.5 MG TAB	1	
BENZTROPINE MES 1 MG TABLET	1	
BENZTROPINE MES 2 MG TABLET	1	
BEPREVE 1.5% EYE DROPS	3	
BESIVANCE 0.6% SUSP	3	
BETADINE 5% EYE SOLUTION	3	
BETAGAN 0.5% EYE DROPS	3	
BETAMETHASONE DP 0.05% CRM	1	
BETAMETHASONE DP 0.05% LOT	1	
BETAMETHASONE DP 0.05% OINT	1	
BETAMETHASONE DP AUG 0.05% CRM	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BETAMETHASONE DP AUG 0.05% GEL	1	
BETAMETHASONE DP AUG 0.05% LOT	1	
BETAMETHASONE DP AUG 0.05% OIN	1	
BETAMETHASONE VA 0.1% CREAM	1	
BETAMETHASONE VA 0.1% LOTION	1	
BETAMETHASONE VALER 0.1% OINTM	1	
BETAMETHASONE VALER 0.12% FOAM	1	
BETAPACE 160 MG TABLET	3	HSA*
BETAPACE 240 MG TABLET	3	HSA*
BETAPACE 80 MG TABLET	3	HSA*
BETAPACE AF 120 MG TABLET	3	HSA*
BETASERON 0.3 MG KIT	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
BETAXOLOL 10 MG TABLET	1	HSA*
BETAXOLOL 20 MG TABLET	1	HSA*
BETAXOLOL HCL 0.5% EYE DROP	1	
BETHANECHOL 10 MG TABLET	1	
BETHANECHOL 25 MG TABLET	1	
BETHANECHOL 5 MG TABLET	1	
BETHANECHOL 50 MG TABLET	1	
BETHKIS 300 MG/4 ML AMPULE	2	SPP*: Must use CVS Specialty
BETIMOL 0.25% EYE DROPS	2	
BETIMOL 0.5% EYE DROPS	2	
BETOPTIC S 0.25% EYE DROPS	2	
BEVESPI AEROSPHERE INHALER	3	
BEVYXXA 40 MG CAPSULE	3	Prior Authorization required;Max. 1 per day HSA*; PA NTM*
BEVYXXA 80 MG CAPSULE	3	Prior Authorization required;Max. 1 per day HSA*; PA NTM*
BEXAROTENE 75 MG CAPSULE	1	CH*
BEYAZ 28 TABLET	3	
BG-STAR GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
BHT POWDER	3	
BIAFINE EMULSION	3	
BIAXIN 250 MG TABLET	3	
BIAXIN 250 MG/5 ML SUSPENSION	3	
BIAXIN 500 MG TABLET	3	
BIAXIN XL 500 MG TABLET	3	
BICALUTAMIDE 50 MG TABLET	1	CH*
BIDIL TABLET	2	
BILTRICIDE 600 MG TABLET	3	
BIMATOPROST 0.03% EYE DROPS	1	
BINOSTO 70 MG TABLET EFF	3	Max. 4 per 28 days HSA*
BIONECT 0.2% CREAM	3	
BIONECT 0.2% FOAM	3	
BIONECT 0.2% GEL	3	
BIONECT 0.2% SPRAY	3	
BISOPROLOL FUMARATE 10 MG TAB	1	HSA*
BISOPROLOL FUMARATE 5 MG TAB	1	HSA*
BISOPROLOL-HCTZ 10-6.25 MG TAB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BISOPROLOL-HCTZ 2.5-6.25 MG TB	1	HSA*
BISOPROLOL-HCTZ 5-6.25 MG TAB	1	HSA*
BLEPH-10 10% EYE DROPS	1	
BLEPHAMIDE EYE DROPS	2	
BLEPHAMIDE EYE OINTMENT	2	
BLISOVI 24 FE TABLET	0	ACA*
BLISOVI FE 1-20 TABLET	0	ACA*
BLISOVI FE 1.5-30 TABLET	0	ACA*
BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
BLOOD GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
BLOOD LANCETS 30G	2	HSA*
BONIVA 150 MG TABLET	3	Max. 1 per 30 days HSA*
BONIVA 3 MG/3 ML SYRINGE	MD	HSA*; SPP*: Must use CVS Specialty
BOSULIF 100 MG TABLET	3	CH*; SPP*: CVS Specialty
BOSULIF 500 MG TABLET	3	CH*; SPP*: CVS Specialty
BOTOX 100 UNITS VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
BOTOX 200 UNITS VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
BP CLEANSING WASH	1	
BPO 4% GEL	1	
BPO 8% GEL	1	
BRAVELLE 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
BREATHERITE MDI SPACER	MD	
BREATHRITE VALVED MDI CHAMBER	MD	
BREEZE 2 DISC TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
BREO ELLIPTA 100-25 MCG INH	2	Max. 2 per day HSA*
BREO ELLIPTA 200-25 MCG INH	2	Max. 2 per day HSA*
BREVICON 28 TABLET	0	ACA*
BRIELLYN TABLET	0	ACA*
BRILINTA 60 MG TABLET	2	HSA*
BRILINTA 90 MG TABLET	2	HSA*
BRIMONIDINE 0.2% EYE DROP	1	
BRIMONIDINE TARTRATE 0.15% DRP	1	
BRINTELLIX 10 MG TABLET	3	Step Therapy required STA*: 18 and older
BRINTELLIX 20 MG TABLET	3	Step Therapy required STA*: 18 and older
BRINTELLIX 5 MG TABLET	3	Step Therapy required STA*: 18 and older
BRISDELLE 7.5 MG CAPSULE	3	Step Therapy required
BRIVIACT 10 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 10 MG/ML ORAL SOLN	3	Prior Authorization required
BRIVIACT 100 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 25 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 50 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 75 MG TABLET	3	Prior Authorization required;Max. 2 per day

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BROMFED DM COUGH SYRUP	1	
BROMFENAC SODIUM 0.09% EYE DRP	1	
BROMOCRIPTINE 2.5 MG TABLET	1	
BROMOCRIPTINE 5 MG CAPSULE	1	
BROMPHENIR-PSEUDOEPHED-DM SYR	1	
BROMSITE 0.075% EYE DROPS	3	
BROVANA 15 MCG/2 ML SOLUTION	3	HSA*
BUCALSEP SOLUTION	3	
BUDEPRION SR 150 MG TABLET	1	
BUDESONIDE 0.25 MG/2 ML SUSP	1	HSA*
BUDESONIDE 0.5 MG/2 ML SUSP	1	HSA*
BUDESONIDE 1 MG/2 ML INH SUSP	1	HSA*
BUDESONIDE 32 MCG NASAL SPRAY	1	HSA*
BUDESONIDE EC 3 MG CAPSULE	1	
BULLSEYE MINI SAFETY 21G	2	HSA*
BULLSEYE MINI SAFETY 25G LANCT	2	HSA*
BUMETANIDE 0.5 MG TABLET	1	HSA*
BUMETANIDE 1 MG TABLET	1	HSA*
BUMETANIDE 2 MG TABLET	1	HSA*
BUNAVAIL 2.1-0.3 MG FILM	3	Max. 3 per day
BUNAVAIL 4.2-0.7 MG FILM	3	Max. 3 per day
BUNAVAIL 6.3-1 MG FILM	3	Max. 2 per day
BUPAP 50 MG-300 MG TABLET	3	
BUPHENYL 500 MG TABLET	3	
BUPHENYL POWDER	3	
BUPRENORPHIN-NALOXON 8-2 MG SL	1	
BUPRENORPHINE 10 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 15 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 2 MG TABLET SL	1	
BUPRENORPHINE 20 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 5 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 7.5 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 8 MG TABLET SL	1	
BUPRENORPHN-NALOXN 2-0.5 MG SL	1	
BUPROBAN 150 MG TABLET	0	Max. 180 Days Supply;Max. 180 in 365 days ACA*
BUPROPION HCL 100 MG TABLET	1	
BUPROPION HCL 75 MG TABLET	1	
BUPROPION HCL SR 100 MG TABLET	1	
BUPROPION HCL SR 150 MG TABLET	0	Max. 180 Days Supply;Max. 180 in 365 days ACA*
BUPROPION HCL SR 150 MG TABLET	1	
BUPROPION HCL SR 200 MG TABLET	1	
BUPROPION HCL XL 150 MG TABLET	1	
BUPROPION HCL XL 300 MG TABLET	1	
BUSPIRONE HCL 10 MG TABLET	1	
BUSPIRONE HCL 15 MG TABLET	1	
BUSPIRONE HCL 30 MG TABLET	1	
BUSPIRONE HCL 5 MG TABLET	1	
BUSPIRONE HCL 7.5 MG TABLET	1	
BUTALB-ACETAMIN-CAFF 50-300-40	1	
BUTALB-ACETAMIN-CAFF 50-325-40	1	
BUTALB-ACETAMIN-CAFF 50-500-40	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BUTALB-ACETAMINOPH-CAFF-CODEIN	1	
BUTALB-ASPIRIN-CAFFE 50-325-40	1	
BUTALB-CAFF-ACETAMINOPH-CODEIN	1	
BUTALBIT-ACETAMINOPHEN-CAFF CP	1	
BUTALBITAL COMP-CODEINE #3 CAP	1	
BUTALBITAL-ACETAMINOPHN 50-300	1	
BUTALBITAL-ACETAMINOPHN 50-325	1	
BUTALBITAL-ASA-CAFFEINE CAP	1	
BUTISOL SODIUM 30 MG TABLET	3	
BUTISOL SODIUM 30 MG/5 ML ELX	3	
BUTISOL SODIUM 50 MG TABLET	3	
BUTORPHANOL 10 MG/ML SPRAY	1	
BUTRANS 10 MCG/HR PATCH	3	Max. 4 per 28 days
BUTRANS 15 MCG/HR PATCH	3	Max. 4 per 28 days
BUTRANS 20 MCG/HR PATCH	3	Max. 4 per 28 days
BUTRANS 5 MCG/HR PATCH	3	Max. 4 per 28 days
BUTRANS 7.5 MCG/HR PATCH	3	Max. 4 per 28 days
BYDUREON 2 MG PEN INJECT	2	Max. 4 per 28 days;Step Therapy required HSA*
BYDUREON 2 MG VIAL	2	Max. 4 per 28 days;Step Therapy required HSA*
BYETTA 10 MCG DOSE PEN INJ	2	Max. 2.4 ML(s) per 30 days;Step Therapy required HSA*
BYETTA 5 MCG DOSE PEN INJ	2	Max. 1.2 ML(s) per 30 days;Step Therapy required HSA*
BYSTOLIC 10 MG TABLET	2	HSA*
BYSTOLIC 2.5 MG TABLET	2	HSA*
BYSTOLIC 20 MG TABLET	2	HSA*
BYSTOLIC 5 MG TABLET	2	HSA*
BYVALSON 5 MG-80 MG TABLET	2	HSA*

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CABERGOLINE 0.5 MG TABLET	1	
CABOMETYX 20 MG TABLET	3	Max. 1 per day CH*; SPP*: CVS Specialty
CABOMETYX 40 MG TABLET	3	Max. 1 per day CH*; SPP*: CVS Specialty
CABOMETYX 60 MG TABLET	3	Max. 1 per day CH*; SPP*: CVS Specialty
CADUET 10 MG-10 MG TABLET	3	HSA*
CADUET 10 MG-20 MG TABLET	3	HSA*
CADUET 10 MG-40 MG TABLET	3	HSA*
CADUET 10 MG-80 MG TABLET	3	HSA*
CADUET 2.5 MG-10 MG TABLET	3	HSA*
CADUET 2.5 MG-20 MG TABLET	3	HSA*
CADUET 2.5 MG-40 MG TABLET	3	HSA*
CADUET 5 MG-10 MG TABLET	3	HSA*
CADUET 5 MG-20 MG TABLET	3	HSA*
CADUET 5 MG-40 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CADUET 5 MG-80 MG TABLET	3	HSA*
CAFCIT 20 MG/ML ORAL SOLN	3	
CAFERGOT TABLET	3	
CAFFEINE CIT 60 MG/3 ML ORAL	1	
CALAN 120 MG TABLET	3	HSA*
CALAN 80 MG TABLET	3	HSA*
CALAN SR 120 MG CAPLET	3	HSA*
CALAN SR 180 MG CAPLET	3	HSA*
CALAN SR 240 MG CAPLET	3	HSA*
CALCIPOTRIENE 0.005% CREAM	1	
CALCIPOTRIENE 0.005% OINTMENT	1	
CALCIPOTRIENE 0.005% SOLUTION	1	
CALCIPOTRIENE-BETAMETH DP OINT	1	
CALCITONIN-SALMON 200 UNITS SP	1	
CALCITRENE 0.005% OINTMENT	1	
CALCITRIOL 0.25 MCG CAPSULE	1	
CALCITRIOL 0.5 MCG CAPSULE	1	
CALCITRIOL 1 MCG/ML SOLUTION	1	
CALCITRIOL 3 MCG/G OINTMENT	1	
CALCIUM ACETATE 667 MG GELCAP	1	
CALCIUM ACETATE 667 MG TABLET	1	
CALQUENCE 100 MG CAPSULE	3	Prior Authorization required;Max. 2 per day CH*; PA NTM*; LDD*: Onco360 Pharmacy 1-877-662-6633
CAMBIA 50 MG POWDER PACKET	3	
CAMILA 0.35 MG TABLET	0	ACA*
CAMPRAL DR 333 MG TABLET	3	
CAMRESE 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
CAMRESE LO TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
CANASA 1,000 MG SUPPOSITORY	2	
CANDESARTAN CILEXETIL 16 MG TB	1	HSA*
CANDESARTAN CILEXETIL 32 MG TB	1	HSA*
CANDESARTAN CILEXETIL 4 MG TAB	1	HSA*
CANDESARTAN CILEXETIL 8 MG TAB	1	HSA*
CANDESARTAN-HCTZ 16-12.5 MG TB	1	HSA*
CANDESARTAN-HCTZ 32-12.5 MG TB	1	HSA*
CANDESARTAN-HCTZ 32-25 MG TAB	1	HSA*
CANTIL 25 MG TABLET	3	
CAPACET CAPSULE	1	
CAPECITABINE 150 MG TABLET	1	CH*; SPP*: CVS Specialty
CAPECITABINE 500 MG TABLET	1	CH*; SPP*: CVS Specialty
CAPEX SHAMPOO	2	
CAPHOSOL SOLUTION	3	
CAPITAL WITH CODEINE SUSP	3	
CAPRELSA 100 MG TABLET	3	CH*
CAPRELSA 300 MG TABLET	3	CH*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CAPTOPRIL 100 MG TABLET	1	HSA*
CAPTOPRIL 12.5 MG TABLET	1	HSA*
CAPTOPRIL 25 MG TABLET	1	HSA*
CAPTOPRIL 50 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 25-15 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 25-25 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 50-15 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 50-25 MG TABLET	1	HSA*
CARAC 0.5% CREAM	3	
CARAFATE 1 GM TABLET	3	
CARAFATE 1 GM/10 ML SUSP	2	
CARBAGLU 200 MG DISPER TABLET	3	LDD*: Accredo (866) 815-4717
CARBAMAZEPINE 100 MG TAB CHEW	1	
CARBAMAZEPINE 100 MG/5 ML SUSP	1	
CARBAMAZEPINE 200 MG TABLET	1	
CARBAMAZEPINE ER 100 MG CAP	1	
CARBAMAZEPINE ER 100 MG TABLET	1	
CARBAMAZEPINE ER 200 MG CAP	1	
CARBAMAZEPINE ER 200 MG TABLET	1	
CARBAMAZEPINE ER 300 MG CAP	1	
CARBAMAZEPINE ER 400 MG TABLET	1	
CARBATROL ER 100 MG CAPSULE	3	
CARBATROL ER 200 MG CAPSULE	3	
CARBATROL ER 300 MG CAPSULE	3	
CARBIDOPA 25 MG TABLET	1	
CARBIDOPA-LEVO 10-100 MG ODT	1	
CARBIDOPA-LEVO 25-100 MG ODT	1	
CARBIDOPA-LEVO 25-250 MG ODT	1	
CARBIDOPA-LEVO ER 25-100 TAB	1	
CARBIDOPA-LEVO ER 50-200 TAB	1	
CARBIDOPA-LEVODOPA 10-100 TAB	1	
CARBIDOPA-LEVODOPA 25-100 TAB	1	
CARBIDOPA-LEVODOPA 25-250 TAB	1	
CARBIDOPA-LEVODOPA-ENTA 100 MG	1	
CARBIDOPA-LEVODOPA-ENTA 125 MG	1	
CARBIDOPA-LEVODOPA-ENTA 150 MG	1	
CARBIDOPA-LEVODOPA-ENTA 200 MG	1	
CARBIDOPA-LEVODOPA-ENTA 50 MG	1	
CARBIDOPA-LEVODOPA-ENTA 75 MG	1	
CARBINOXAMINE 4 MG/5 ML LIQUID	1	
CARBINOXAMINE MALEATE 4 MG TAB	1	
CARDENE SR 30 MG CAPSULE	3	HSA*
CARDENE SR 60 MG CAPSULE	3	HSA*
CARDIOVID PLUS SOFTGEL	1	
CARDIZEM 120 MG TABLET	3	HSA*
CARDIZEM 30 MG TABLET	3	HSA*
CARDIZEM 60 MG TABLET	3	HSA*
CARDIZEM CD 120 MG CAPSULE	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CARDIZEM CD 180 MG CAPSULE	3	HSA*
CARDIZEM CD 240 MG CAPSULE	3	HSA*
CARDIZEM CD 300 MG CAPSULE	3	HSA*
CARDIZEM CD 360 MG CAPSULE	3	HSA*
CARDIZEM LA 120 MG TABLET	3	HSA*
CARDIZEM LA 180 MG TABLET	3	HSA*
CARDIZEM LA 240 MG TABLET	3	HSA*
CARDIZEM LA 300 MG TABLET	3	HSA*
CARDIZEM LA 360 MG TABLET	3	HSA*
CARDIZEM LA 420 MG TABLET	3	HSA*
CARDURA 1 MG TABLET	3	HSA*
CARDURA 2 MG TABLET	3	HSA*
CARDURA 4 MG TABLET	3	HSA*
CARDURA 8 MG TABLET	3	HSA*
CARDURA XL 4 MG TABLET	3	HSA*
CARDURA XL 8 MG TABLET	3	HSA*
CAREONE ULTRA THIN LANCET	2	HSA*
CAREPOINT LUER SLIP 1 ML SYRNG	3	
CARESENS N TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CARESENS ULTRA THIN 30G LANCET	2	HSA*
CARETOUCH TWIST 28G LANCET	2	HSA*
CARETOUCH TWIST 30G LANCET	2	HSA*
CARISOPRODL-ASPIRIN 200-325 MG	1	
CARISOPRODOL 250 MG TABLET	1	
CARISOPRODOL 350 MG TABLET	1	
CARISOPRODOL-ASPIRIN-CODEIN TB	1	
CARNITOR 330 MG TABLET	3	
CARNITOR SF 100 MG/ML ORAL SOL	3	
CAROSPIR 25 MG/5 ML SUSPENSION	3	Prior Authorization required HSA*; PA NTM*
CARTEOLOL HCL 1% EYE DROPS	1	
CARTIA XT 120 MG CAPSULE	1	HSA*
CARTIA XT 180 MG CAPSULE	1	HSA*
CARTIA XT 240 MG CAPSULE	1	HSA*
CARTIA XT 300 MG CAPSULE	1	HSA*
CARVEDILOL 12.5 MG TABLET	1	HSA*
CARVEDILOL 25 MG TABLET	1	HSA*
CARVEDILOL 3.125 MG TABLET	1	HSA*
CARVEDILOL 6.25 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CASODEX 50 MG TABLET	3	CH*
CATAFLAM 50 MG TABLET	3	
CATAPRES 0.1 MG TABLET	3	HSA*
CATAPRES 0.2 MG TABLET	3	HSA*
CATAPRES 0.3 MG TABLET	3	HSA*
CATAPRES-TTS 1 PATCH	3	HSA*
CATAPRES-TTS 2 PATCH	3	HSA*
CATAPRES-TTS 3 PATCH	3	HSA*
CAVERJECT 20 MCG VIAL	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
CAVERJECT 40 MCG VIAL	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
CAVERJECT IMPULSE 10 MCG KIT	2	Not covered for members 17 and younger; Max. 6 in 30 days
CAVERJECT IMPULSE 20 MCG KIT	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
CAYA CONTOURED DIAPHRAGM	0	ACA*
CAYSTON 75 MG INHAL SOLUTION	3	LDD*: IV Solutions. 1-800-658-6046.
CAZIANT 28 DAY TABLET	0	ACA*
CEDAX 180 MG/5 ML SUSPENSION	3	
CEDAX 400 MG CAPSULE	3	
CEFACLOR 125 MG/5 ML SUSP	1	
CEFACLOR 250 MG CAPSULE	1	
CEFACLOR 250 MG/5 ML SUSP	1	
CEFACLOR 375 MG/5 ML SUSPEN	1	
CEFACLOR 500 MG CAPSULE	1	
CEFACLOR ER 500 MG TABLET	1	
CEFADROXIL 1 GM TABLET	1	
CEFADROXIL 250 MG/5 ML SUSP	1	
CEFADROXIL 500 MG CAPSULE	1	
CEFADROXIL 500 MG/5 ML SUSP	1	
CEFDINIR 125 MG/5 ML SUSP	1	
CEFDINIR 250 MG/5 ML SUSP	1	
CEFDINIR 300 MG CAPSULE	1	
CEFDITOREN PIVOXIL 200 MG TAB	1	
CEFDITOREN PIVOXIL 400 MG TAB	1	
CEFIXIME 100 MG/5 ML SUSP	1	
CEFIXIME 200 MG/5 ML SUSP	1	
CEFPODOXIME 100 MG TABLET	1	
CEFPODOXIME 100 MG/5 ML SUSP	1	
CEFPODOXIME 200 MG TABLET	1	
CEFPODOXIME 50 MG/5 ML SUSP	1	
CEFPROZIL 125 MG/5 ML SUSP	1	
CEFPROZIL 250 MG TABLET	1	
CEFPROZIL 250 MG/5 ML SUSP	1	
CEFPROZIL 500 MG TABLET	1	
CEFTIBUTEN 180 MG/5 ML SUSP	1	
CEFTIBUTEN 400 MG CAPSULE	1	
CEFTIN 125 MG/5 ML ORAL SUSP	2	
CEFTIN 250 MG TABLET	3	
CEFTIN 250 MG/5 ML ORAL SUSP	2	
CEFTIN 500 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CEFUROXIME AXETIL 250 MG TAB	1	
CEFUROXIME AXETIL 500 MG TAB	1	
CELACYN GEL	3	
CELEBREX 100 MG CAPSULE	3	
CELEBREX 200 MG CAPSULE	3	
CELEBREX 400 MG CAPSULE	3	
CELEBREX 50 MG CAPSULE	3	
CELECOXIB 100 MG CAPSULE	1	
CELECOXIB 200 MG CAPSULE	1	
CELECOXIB 400 MG CAPSULE	1	
CELECOXIB 50 MG CAPSULE	1	
CELEXA 10 MG TABLET	3	Step Therapy required STA*: 18 and older
CELEXA 20 MG TABLET	3	Step Therapy required STA*: 18 and older
CELEXA 40 MG TABLET	3	Step Therapy required STA*: 18 and older
CELLCEPT 200 MG/ML ORAL SUSP	3	
CELLCEPT 250 MG CAPSULE	3	
CELLCEPT 500 MG TABLET	3	
CELONTIN 300 MG KAPSEAL	2	
CENESTIN 0.3 MG TABLET	2	
CENESTIN 0.45 MG TABLET	2	
CENESTIN 0.625 MG TABLET	2	
CENESTIN 0.9 MG TABLET	2	
CENESTIN 1.25 MG TABLET	2	
CENTANY 2% OINTMENT	3	
CENTANY AT 2% OINTMENT KIT	3	
CEPHALEXIN 125 MG/5 ML SUSP	1	
CEPHALEXIN 250 MG CAPSULE	1	
CEPHALEXIN 250 MG TABLET	1	
CEPHALEXIN 250 MG/5 ML SUSP	1	
CEPHALEXIN 500 MG CAPSULE	1	
CEPHALEXIN 500 MG TABLET	1	
CEPHALEXIN 750 MG CAPSULE	1	
CERACADE SKIN BARRIER EMULSION	3	
CERAMAX SKIN BARRIER CREAM	3	
CERDELGA 84 MG CAPSULE	2	SPP*: Must use CVS Specialty
CERVARIX VACCINE SYRINGE	0	Covered for females only;Not covered for members 27 and older ACA*
CESAMET 1 MG CAPSULE	3	Max. quantity of 18 per fill MQC*: 18 tabs/copay
CETACAINE ANESTHETIC LIQUID	3	
CETACAINE SPRAY	3	
CETIRIZINE HCL 1 MG/ML SOLN	1	
CETRAXAL 0.2% EAR SOLUTION	3	
CETROTIDE 0.25 MG KIT	2	Max. 30 Days Supply IVF*
CETROTIDE 3 MG KIT	2	Max. 30 Days Supply IVF*
CETYLEV 2.5 GM EFF TABLET	3	Max. quantity of 20 per fill
CETYLEV 500 MG EFF TABLET	3	Max. quantity of 20 per fill
CEVIMELINE HCL 30 MG CAPSULE	1	
CHANTIX 0.5 MG TABLET	0	Max. 182 Days Supply ACA*
CHANTIX 1 MG CONT MONTH BOX	0	Max. 182 Days Supply ACA*
CHANTIX 1 MG TABLET	0	Max. 182 Days Supply ACA*
CHANTIX STARTING MONTH BOX	0	Max. 182 Days Supply ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CHATEAL-28 TABLET	0	ACA*
CHEK-STIX STRIPS	2	
CHEMET 100 MG CAPSULE	2	
CHEMSTRIP 10 MD	2	
CHEMSTRIP 10 WITH SG	2	
CHEMSTRIP 2 GP	2	
CHEMSTRIP 50B	2	
CHEMSTRIP 7	2	
CHEMSTRIP K	2	
CHEMSTRIP MICRAL TEST STRIP	3	
CHEMSTRIP UGK	2	HSA*
CHEMSTRIP-9	2	
CHENODAL 250 MG TABLET	3	LDD*: Dohmen Life Sciences (800) 305-7881
CHERATUSSIN AC SYRUP	1	
CHERATUSSIN DAC SYRUP	1	
CHLORDIAZEPO-AMITRIPTYL 5-12.5	1	
CHLORDIAZEPOX-AMITRIPTYL 10-25	1	
CHLORDIAZEPOXIDE 10 MG CAPSULE	1	
CHLORDIAZEPOXIDE 25 MG CAPSULE	1	
CHLORDIAZEPOXIDE 5 MG CAPSULE	1	
CHLORDIAZEPOXIDE-CLIDINIUM CAP	1	
CHLORHEXIDINE 0.12% RINSE	1	
CHLOROQUINE PH 250 MG TABLET	1	
CHLOROQUINE PH 500 MG TABLET	1	
CHLOROTHIAZIDE 250 MG TABLET	1	HSA*
CHLOROTHIAZIDE 500 MG TABLET	1	HSA*
CHLORPROMAZINE 10 MG TABLET	1	
CHLORPROMAZINE 100 MG TABLET	1	
CHLORPROMAZINE 200 MG TABLET	1	
CHLORPROMAZINE 25 MG TABLET	1	
CHLORPROMAZINE 50 MG TABLET	1	
CHLORPROPAMIDE 100 MG TABLET	1	HSA*
CHLORPROPAMIDE 250 MG TABLET	1	HSA*
CHLORTHALIDONE 25 MG TABLET	1	HSA*
CHLORTHALIDONE 50 MG TABLET	1	HSA*
CHLORZOXAZONE 250 MG TABLET	1	
CHLORZOXAZONE 500 MG TABLET	1	
CHOICE-TABS TABLET	1	
CHOICEDM CLARUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CHOICEDM G20 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CHOLBAM 250 MG CAPSULE	3	
CHOLBAM 50 MG CAPSULE	3	
CHOLESTYRAMINE LIGHT PACKET	1	HSA*
CHOLESTYRAMINE PACKET	1	HSA*
CHOLINE MAG TRISAL LIQUID	1	
CHORIONIC GONAD 10,000 UNIT VL	2	Max. 30 Days Supply IVF*
CIALIS 10 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CIALIS 2.5 MG TABLET	2	Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
CIALIS 20 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
CIALIS 5 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
CICLODAN 0.77% CREAM	3	
CICLODAN 0.77% CREAM KIT	3	
CICLODAN 8% KIT	3	Prior Authorization required
CICLODAN 8% SOLUTION	3	Prior Authorization required
CICLOPIROX 0.77% CREAM	1	
CICLOPIROX 0.77% GEL	1	
CICLOPIROX 0.77% TOPICAL SUSP	1	
CICLOPIROX 1% SHAMPOO	1	
CICLOPIROX 8% SOLUTION	1	
CICLOPIROX 8% TREATMENT KIT	1	
CILOSTAZOL 100 MG TABLET	1	HSA*
CILOSTAZOL 50 MG TABLET	1	HSA*
CILOXAN 0.3% EYE DROPS	3	
CILOXAN 0.3% OINTMENT	2	
CIMETIDINE 200 MG TABLET	1	
CIMETIDINE 300 MG TABLET	1	
CIMETIDINE 300 MG/5 ML SOLN	1	
CIMETIDINE 400 MG TABLET	1	
CIMETIDINE 800 MG TABLET	1	
CIMZIA 200 MG VIAL KIT	3	Prior Authorization required SPP*: Must use CVS Specialty
CIMZIA 200 MG/ML SYRINGE KIT	3	Prior Authorization required SPP*: Must use CVS Specialty
CINRYZE 500 UNIT VIAL	MD	Prior Authorization required;Max. 2 per 3 days SPP*: Must use CVS Specialty
CIPRO 10% SUSPENSION	3	
CIPRO 250 MG TABLET	3	
CIPRO 5% SUSPENSION	3	
CIPRO 500 MG TABLET	3	
CIPRO HC OTIC SUSPENSION	3	
CIPRO XR 1,000 MG TABLET	3	
CIPRO XR 500 MG TABLET	3	
CIPRODEX OTIC SUSPENSION	2	
CIPROFLOXACIN 0.2% OTIC SOLN	1	
CIPROFLOXACIN 0.3% EYE DROP	1	
CIPROFLOXACIN 250 MG/5 ML SUSP	1	
CIPROFLOXACIN 500 MG/5 ML SUSP	1	
CIPROFLOXACIN ER 1,000 MG TAB	1	
CIPROFLOXACIN ER 500 MG TABLET	1	
CIPROFLOXACIN HCL 100 MG TAB	1	
CIPROFLOXACIN HCL 250 MG TAB	1	
CIPROFLOXACIN HCL 500 MG TAB	1	
CIPROFLOXACIN HCL 750 MG TAB	1	
CITALOPRAM HBR 10 MG TABLET	1	
CITALOPRAM HBR 10 MG/5 ML SOLN	1	
CITALOPRAM HBR 20 MG TABLET	1	
CITALOPRAM HBR 40 MG TABLET	1	
CLARAVIS 10 MG CAPSULE	1	
CLARAVIS 20 MG CAPSULE	1	
CLARAVIS 30 MG CAPSULE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLARAVIS 40 MG CAPSULE	1	
CLARINEX 0.5 MG/ML (2.5 MG/5)	3	
CLARINEX 5 MG TABLET	3	
CLARINEX-D 12 HOUR TABLET	3	
CLARINEX-D 24 HOUR TABLET	3	
CLARIS CLARIFYING WASH	3	
CLARITHROMYCIN 125 MG/5 ML SUS	1	
CLARITHROMYCIN 250 MG TABLET	1	
CLARITHROMYCIN 250 MG/5 ML SUS	1	
CLARITHROMYCIN 500 MG TABLET	1	
CLARITHROMYCIN ER 500 MG TAB	1	
CLEMASTINE 0.5 MG/5 ML SYRUP	1	
CLEMASTINE FUM 2.68 MG TAB	1	
CLEOCIN 100 MG VAGINAL OVULE	3	
CLEOCIN 2% VAGINAL CREAM	3	
CLEOCIN 75 MG/5 ML GRANULES	3	
CLEOCIN HCL 150 MG CAPSULE	3	
CLEOCIN HCL 300 MG CAPSULE	3	
CLEOCIN HCL 75 MG CAPSULE	3	
CLEOCIN T 1% GEL	3	
CLEOCIN T 1% LOTION	3	
CLEOCIN T 1% PLEDGETS	3	
CLEOCIN T 1% SOLUTION	3	
CLEVER CHEK ULTRA THIN 30G	2	HSA*
CLEVER CHOICE CHAMBER-LRG MASK	MD	
CLEVER CHOICE MICRO TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE PRO TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE TALK TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE VOICE+ TST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLIMARA 0.025 MG/DAY PATCH	3	
CLIMARA 0.0375 MG/DAY PATCH	3	
CLIMARA 0.05 MG/DAY PATCH	3	
CLIMARA 0.06 MG/DAY PATCH	3	
CLIMARA 0.075 MG/DAY PATCH	3	
CLIMARA 0.1 MG/DAY PATCH	3	
CLIMARA PRO PATCH	2	
CLIND PH-BENZOYL PEROX 1.2-5%	1	
CLINDA-TRETINOIN 1.2%-0.025%	2	Prior Authorization required for members 30 and older
CLINDACIN ETZ 1% PLEDGET	3	
CLINDACIN PAC KIT	3	
CLINDAGEL 1% GEL	3	
CLINDAMYCIN 2% VAGINAL CREAM	1	
CLINDAMYCIN 75 MG/5 ML SOLN	1	
CLINDAMYCIN HCL 150 MG CAPSULE	1	
CLINDAMYCIN HCL 300 MG CAPSULE	1	
CLINDAMYCIN HCL 75 MG CAPSULE	1	
CLINDAMYCIN PH 1% GEL	1	
CLINDAMYCIN PH 1% SOLUTION	1	
CLINDAMYCIN PHOS 1% PLEDGET	1	
CLINDAMYCIN PHOSP 1% LOTION	1	
CLINDAMYCIN PHOSPHATE 1% FOAM	1	
CLINDAMYCIN-BENZOYL PEROX 1-5%	1	
CLINDESSE 2% VAGINAL CREAM	3	
CLINPRO 5000 1.1% TOOTHPASTE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLOBETASOL 0.05% CREAM	1	
CLOBETASOL 0.05% GEL	1	
CLOBETASOL 0.05% OINTMENT	1	
CLOBETASOL 0.05% SHAMPOO	1	
CLOBETASOL 0.05% SOLUTION	1	
CLOBETASOL 0.05% TOPICAL LOTN	1	
CLOBETASOL PROP 0.05% FOAM	1	
CLOBETASOL PROP 0.05% SPRAY	1	
CLOBEX 0.05% SHAMPOO	3	
CLOBEX 0.05% SPRAY	3	
CLOBEX 0.05% TOPICAL LOTION	3	
CLOCORTOLONE PIVALATE 0.1% CRM	1	
CLODAN 0.05% KIT	3	
CLODAN 0.05% SHAMPOO	3	
CLODERM 0.1% CREAM	3	
CLOMIPHENE CITRATE 50 MG TAB	1	
CLOMIPRAMINE 25 MG CAPSULE	1	
CLOMIPRAMINE 50 MG CAPSULE	1	
CLOMIPRAMINE 75 MG CAPSULE	1	
CLONAZEPAM 0.125 MG DIS TAB	1	
CLONAZEPAM 0.25 MG ODT	1	
CLONAZEPAM 0.5 MG DIS TABLET	1	
CLONAZEPAM 0.5 MG TABLET	1	
CLONAZEPAM 1 MG DIS TABLET	1	
CLONAZEPAM 1 MG TABLET	1	
CLONAZEPAM 2 MG ODT	1	
CLONAZEPAM 2 MG TABLET	1	
CLONIDINE 0.1 MG/DAY PATCH	1	HSA*
CLONIDINE 0.2 MG/DAY PATCH	1	HSA*
CLONIDINE 0.3 MG/DAY PATCH	1	HSA*
CLONIDINE HCL 0.1 MG TABLET	1	HSA*
CLONIDINE HCL 0.2 MG TABLET	1	HSA*
CLONIDINE HCL 0.3 MG TABLET	1	HSA*
CLONIDINE HCL ER 0.1 MG TABLET	1	
CLOPIDOGREL 300 MG TABLET	1	HSA*
CLOPIDOGREL 75 MG TABLET	1	HSA*
CLORAZEPATE 15 MG TABLET	1	
CLORAZEPATE 3.75 MG TABLET	1	
CLORAZEPATE 7.5 MG TABLET	1	
CLORPRES 0.1-15 TABLET	1	HSA*
CLORPRES 0.2-15 TABLET	1	HSA*
CLORPRES 0.3-15 TABLET	1	HSA*
CLOTRIMAZOLE 1% CREAM	1	
CLOTRIMAZOLE 1% SOLUTION	1	
CLOTRIMAZOLE 10 MG TROCHE	1	
CLOTRIMAZOLE-BETAMETHASONE CRM	1	
CLOTRIMAZOLE-BETAMETHASONE LOT	1	
CLOZAPINE 100 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE 200 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE 25 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE 50 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 100 MG TABLET	1	Max. 28 Days Supply

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLOZAPINE ODT 12.5 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 150 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 200 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 25 MG TABLET	1	Max. 28 Days Supply
CLOZARIL 100 MG TABLET	3	Max. 28 Days Supply
CLOZARIL 25 MG TABLET	3	Max. 28 Days Supply
COAGUCHEK LANCETS	2	HSA*
COARTEM TABLETS	3	Max. quantity of 24 per fill MQC*: 24 tabs/copay
CODEINE SULFATE 15 MG TABLET	1	
CODEINE SULFATE 30 MG TABLET	1	
CODEINE SULFATE 30 MG/5 ML SOL	3	
CODEINE SULFATE 60 MG TABLET	1	
CODEINE-GUAIFEN 10-100 MG/5 ML	1	
COLAZAL 750 MG CAPSULE	3	
COLCHICINE 0.6 MG CAPSULE	1	
COLCHICINE 0.6 MG TABLET	1	
COLCRYS 0.6 MG TABLET	3	
COLESTID 1 GM TABLET	3	HSA*
COLESTID FLAVORED GRANULES	3	HSA*
COLESTIPOL HCL GRANULES PACKET	1	HSA*
COLESTIPOL MICRONIZED 1 GM TAB	1	HSA*
COLOCORT 100 MG ENEMA	1	
COLY-MYCIN S OTIC SUSP DROP	3	
COLYTE WITH FLAVOR PACKETS	3	
COMBIGAN 0.2%-0.5% EYE DROPS	2	
COMBIPATCH 0.05-0.14 MG PTCH	2	
COMBIPATCH 0.05-0.25 MG PTCH	2	
COMBISTIX REAGENT STRIPS	2	
COMBIVENT INHALER	2	HSA*
COMBIVENT RESPIMAT INHAL SPRAY	2	HSA*
COMBIVIR TABLET	3	
COMETRIQ 100 MG DAILY-DOSE PK	3	CH*; LDD*: Diplomat Pharmacy. 1-877-977-9118.
COMETRIQ 140 MG DAILY-DOSE PK	3	CH*; LDD*: Diplomat Pharmacy. 1-877-977-9118.
COMETRIQ 60 MG DAILY-DOSE PACK	3	CH*; LDD*: Diplomat Pharmacy. 1-877-977-9118.
COMFORT EZ SAFETY 21G LANCETS	2	HSA*
COMFORT EZ SAFETY 23G LANCETS	2	HSA*
COMFORT EZ SAFETY 28G LANCETS	2	HSA*
COMFORT LANCETS	2	HSA*
COMFORT PAC-CYCLOBENZAPRINE KT	3	
COMFORT PAC-IBUPROFEN KIT	3	
COMFORT PAC-NAPROXEN KIT	3	
COMPACT SPACE CHAMBER	MD	
COMPACT SPACE CHAMBER PLUS	MD	
COMPAZINE 10 MG TABLET	3	
COMPAZINE 25 MG SUPPOSITORY	3	
COMPAZINE 5 MG TABLET	3	
COMPLERA TABLET	3	
COMPRO 25 MG SUPPOSITORY	1	
COMTAN 200 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CONCEPTROL GEL	0	ACA*
CONCERTA ER 18 MG TABLET	3	Max. 60 Days Supply
CONCERTA ER 27 MG TABLET	3	Max. 60 Days Supply
CONCERTA ER 36 MG TABLET	3	Max. 60 Days Supply
CONCERTA ER 54 MG TABLET	3	Max. 60 Days Supply
CONDYLOX 0.5% GEL	3	
CONDYLOX 0.5% TOPICAL SOLN	3	
CONSTULOSE 10 GM/15 ML SOLN	1	
CONTOUR NEXT STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CONTOUR TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CONTROL AST TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CONTROL TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CONZIP 100 MG CAPSULE	1	
CONZIP 200 MG CAPSULE	1	
CONZIP 300 MG CAPSULE	1	
COOL GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
COPAXONE 20 MG/ML SYRINGE	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
COPAXONE 40 MG/ML SYRINGE	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
COPEGUS 200 MG TABLET	3	SPP*: Must use CVS Specialty
CORDARONE 200 MG TABLET	3	
CORDRAN 0.05% CREAM	3	
CORDRAN 0.05% LOTION	3	
CORDRAN 0.05% OINTMENT	3	
CORDRAN 4 MCG/SQ CM TAPE LARGE	3	
COREG 12.5 MG TABLET	3	HSA*
COREG 25 MG TABLET	3	HSA*
COREG 3.125 MG TABLET	3	HSA*
COREG 6.25 MG TABLET	3	HSA*
COREG CR 10 MG CAPSULE	2	HSA*
COREG CR 20 MG CAPSULE	2	HSA*
COREG CR 40 MG CAPSULE	2	HSA*
COREG CR 80 MG CAPSULE	2	HSA*
CORGARD 20 MG TABLET	3	HSA*
CORGARD 40 MG TABLET	3	HSA*
CORGARD 80 MG TABLET	3	HSA*
CORIFACT KIT	MD	SPP*: Must use CVS Specialty
CORLANOR 5 MG TABLET	2	Prior Authorization required;Max. 2 per day HSA*
CORLANOR 7.5 MG TABLET	2	Prior Authorization required;Max. 2 per day HSA*
CORMAX 0.05% SOLUTION	1	
CORNWALL SYRINGES LUER-LOK	3	
CORNWALL SYRINGES LUER-LOK	3	
CORNWALL SYRINGES LUER-LOK	3	
CORTANE-B LOTION	3	
CORTANE-B OTIC DROPS	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CORTEF 10 MG TABLET	3	
CORTEF 20 MG TABLET	3	
CORTEF 5 MG TABLET	3	
CORTENEMA 100 MG/60 ML ENEMA	3	
CORTIFOAM 10% AEROSOL	3	
CORTISONE 25 MG TABLET	1	
CORTISPORIN CREAM	3	
CORTISPORIN OINTMENT	3	
CORTISPORIN-TC EAR SUSPENSION	3	
CORVITA TABLET	3	
CORVITE TABLET	3	
CORZIDE 40-5 TABLET	3	HSA*
CORZIDE 80-5 TABLET	3	HSA*
COSENTYX 300 MG DOSE-2 PENS	3	Prior Authorization required;Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
COSENTYX 300 MG DOSE-2 SYRINGE	3	Prior Authorization required;Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
COSOPT EYE DROPS	3	
COSOPT PF EYE DROPS	3	
COTABFLU TABLET	3	
COTELLIC 20 MG TABLET	3	CH*; SPP*: CVS Specialty
COTEMPLA XR-ODT 17.3 MG TABLET	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
COTEMPLA XR-ODT 25.9 MG TABLET	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
COTEMPLA XR-ODT 8.6 MG TABLET	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
COUMADIN 1 MG TABLET	3	HSA*
COUMADIN 10 MG TABLET	3	HSA*
COUMADIN 2 MG TABLET	3	HSA*
COUMADIN 2.5 MG TABLET	3	HSA*
COUMADIN 3 MG TABLET	3	HSA*
COUMADIN 4 MG TABLET	3	HSA*
COUMADIN 5 MG TABLET	3	HSA*
COUMADIN 6 MG TABLET	3	HSA*
COUMADIN 7.5 MG TABLET	3	HSA*
COVARYX H.S. TABLET	1	Max. 30 Days Supply
COVARYX TABLET	1	Max. 30 Days Supply
COZAAR 100 MG TABLET	3	HSA*
COZAAR 25 MG TABLET	3	HSA*
COZAAR 50 MG TABLET	3	HSA*
CREON DR 12,000 UNITS CAPSULE	2	
CREON DR 24,000 UNITS CAPSULE	2	
CREON DR 3,000 UNITS CAPSULE	2	
CREON DR 36,000 UNITS CAPSULE	2	
CREON DR 6,000 UNITS CAPSULE	2	
CRESEMBA 186 MG CAPSULE	3	
CRESTOR 10 MG TABLET	3	HSA*
CRESTOR 20 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CRESTOR 40 MG TABLET	3	HSA*
CRESTOR 5 MG TABLET	3	HSA*
CRESYLATE EAR DROPS	1	
CRINONE 4% GEL	2	Max. 30 Days Supply IVF*
CRINONE 8% GEL	2	Max. 30 Days Supply IVF*
CRIXIVAN 200 MG CAPSULE	2	
CRIXIVAN 400 MG CAPSULE	2	
CROMOLYN 100 MG/5 ML ORAL CONC	1	HSA*
CROMOLYN 20 MG/2 ML NEB SOLN	1	HSA*
CROMOLYN 4% EYE DROPS	1	HSA*
CRYSELLE-28 TABLET	0	ACA*
CUPRIMINE 250 MG CAPSULE	2	Prior Authorization required
CUROSURF 120 MG/1.5 ML VIAL	3	
CUTIVATE 0.05% CREAM	3	
CUTIVATE 0.05% LOTION	3	
CUVPOSA 1 MG/5 ML SOLUTION	3	SPP*: Must use CVS Specialty
CVS ADVANCED GLUCOSE TEST STR	3	Prior Authorization required;Max. 204 per 30 days HSA*
CVS CHILD ASPIRIN 81 MG CHW TB	0	ACA*
CVS CHILDREN'S VIT D 400 UNIT	0	Not covered for members 64 and younger ACA*
CVS KETONE CARE TEST STRIPS	2	
CVS THIN 26G LANCETS	2	HSA*
CVS ULTRA THIN 30G LANCETS	2	HSA*
CYANOCOBALAMIN 1,000 MCG/ML	1	
CYCLAFEM 1-35-28 TABLET	0	ACA*
CYCLAFEM 7-7-7-28 TABLET	0	ACA*
CYCLESSA 28 DAY TABLET	3	
CYCLOBENZAPRINE 10 MG TABLET	1	
CYCLOBENZAPRINE 5 MG TABLET	1	
CYCLOBENZAPRINE 7.5 MG TABLET	1	
CYCLOGYL 0.5% EYE DROPS	3	
CYCLOGYL 1% EYE DROPS	3	
CYCLOGYL 2% EYE DROPS	3	
CYCLOMYDRIL EYE DROPS	3	
CYCLOPENTOLATE 0.5% EYE DROPS	1	
CYCLOPENTOLATE 1% EYE DROPS	1	
CYCLOPENTOLATE HCL 2% DROPS	1	
CYCLOPENTOLATE-LIDOC-PE-TROPIC	1	
CYCLOPHOSPHAMIDE 25 MG CAPSULE	2	CH*
CYCLOPHOSPHAMIDE 25 MG TAB	1	CH*
CYCLOPHOSPHAMIDE 50 MG CAPSULE	2	CH*
CYCLOPHOSPHAMIDE 50 MG TABLET	1	CH*
CYCLOSERINE 250 MG CAPSULE	1	
CYCLOSET 0.8 MG TABLET	2	HSA*
CYCLOSPORINE 100 MG CAPSULE	1	
CYCLOSPORINE 100 MG/ML SOLN	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CYCLOSPORINE 25 MG CAPSULE	1	
CYCLOSPORINE MODIFIED 100 MG	1	
CYCLOSPORINE MODIFIED 25 MG	1	
CYCLOSPORINE MODIFIED 50 MG	1	
CYMBALTA 20 MG CAPSULE	3	Step Therapy required STA*: 18 and older
CYMBALTA 30 MG CAPSULE	3	Step Therapy required STA*: 18 and older
CYMBALTA 60 MG CAPSULE	3	Step Therapy required STA*: 18 and older
CYPROHEPTADINE 2 MG/5 ML SYRUP	1	
CYPROHEPTADINE 4 MG TABLET	1	
CYRED 28 DAY TABLET	0	ACA*
CYSTADANE 1 GRAM/1.7 ML POWDER	3	LDD*: AnovoRx (888) 487-4703
CYSTAGON 150 MG CAPSULE	3	
CYSTAGON 50 MG CAPSULE	3	
CYSTARAN 0.44% EYE DROPS	3	LDD*: Walgreens Specialty.CYSTARAN Hotline: 1-877-534-9627.
CYTOMEL 25 MCG TABLET	3	
CYTOMEL 5 MCG TABLET	3	
CYTOMEL 50 MCG TABLET	3	
CYTOTEC 100 MCG TABLET	3	
CYTOTEC 200 MCG TABLET	3	
CYTRA-2 ORAL SOLUTION	1	
CYTRA-3 SYRUP	1	
CYTRA-K CRYSTALS PACKET	1	
CYTRA-K ORAL SOLUTION	1	

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D-AMPHETAMINE ER 10 MG CAPSULE	1	Max. 60 Days Supply
D-AMPHETAMINE ER 15 MG CAPSULE	1	Max. 60 Days Supply
D-AMPHETAMINE ER 5 MG CAPSULE	1	Max. 60 Days Supply
D.H.E.45 1 MG/ML AMPUL	3	
DAKLINZA 30 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
DAKLINZA 60 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
DAKLINZA 90 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
DALIRESP 500 MCG TABLET	2	HSA*
DANAZOL 100 MG CAPSULE	1	
DANAZOL 200 MG CAPSULE	1	
DANAZOL 50 MG CAPSULE	1	
DANTRIUM 100 MG CAPSULE	3	
DANTRIUM 25 MG CAPSULE	3	
DANTRIUM 50 MG CAPSULE	3	
DANTROLENE SODIUM 100 MG CAP	1	
DANTROLENE SODIUM 25 MG CAP	1	
DANTROLENE SODIUM 50 MG CAP	1	
DAPSONE 100 MG TABLET	1	
DAPSONE 25 MG TABLET	1	
DAPSONE 5% GEL	2	
DARAPRIM 25 MG TABLET	2	Prior Authorization required
DARIFENACIN ER 15 MG TABLET	1	
DARIFENACIN ER 7.5 MG TABLET	1	
DARIO BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*

DASETTA 1-35-28 TABLET	0	ACA*
DASETTA 7/7/7-28 TABLET	0	ACA*
DAXBIA 333 MG CAPSULE	3	
DAYPRO 600 MG CAPLET	3	
DAYSEE 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
DAYTRANA 10 MG/9 HR PATCH	3	Max. 60 Days Supply
DAYTRANA 15 MG/9 HR PATCH	3	Max. 60 Days Supply
DAYTRANA 20 MG/9 HOUR PATCH	3	Max. 60 Days Supply
DAYTRANA 30 MG/9 HOUR PATCH	3	Max. 60 Days Supply
DDAVP 0.01% NASAL SPRAY	3	
DDAVP 0.1 MG TABLET	3	
DDAVP 0.2 MG TABLET	3	
DDAVP 10 MCG/0.1 ML SOLUTION	3	
DDAVP 4 MCG/ML AMPUL	3	
DDAVP 4 MCG/ML VIAL	3	
DEBLITANE 0.35 MG TABLET	0	ACA*
DELTA D3 400 UNIT TABLET	0	Not covered for members 64 and younger ACA*
DELTASONE 20 MG TABLET	1	
DELYLA-28 TABLET	0	ACA*
DELZICOL DR 400 MG CAPSULE	2	
DEMADEX 10 MG TABLET	3	HSA*
DEMADEX 100 MG TABLET	3	HSA*
DEMADEX 20 MG TABLET	3	HSA*
DEMADEX 5 MG TABLET	3	HSA*
DEMECLOCYCLINE 150 MG TABLET	1	
DEMECLOCYCLINE 300 MG TABLET	1	
DEMEROL 100 MG TABLET	3	
DEMEROL 50 MG TABLET	3	
DEMSER 250 MG CAPSULE	3	HSA*
DEMULEN 1-50-21 TABLET	3	
DENAVIR 1% CREAM	3	Max. 5 GM(s) in 30 days
DENTA 5000 PLUS CREAM	1	
DENTAGEL 1.1% GEL	1	
DEPAKENE 250 MG CAPSULE	3	
DEPAKENE 250 MG/5 ML SOLUTION	3	
DEPAKOTE DR 125 MG SPRINKLE CP	3	
DEPAKOTE DR 125 MG TABLET	3	
DEPAKOTE DR 250 MG TABLET	3	
DEPAKOTE DR 500 MG TABLET	3	
DEPAKOTE ER 250 MG TABLET	3	
DEPAKOTE ER 500 MG TABLET	3	
DEPEN 250 MG TITRATAB	2	Prior Authorization required
DEPO-PROVERA 150 MG/ML SYRINGE	0	Max. 90 Days Supply;Max. 1 ML(s) in 90 days ACA*
DEPO-PROVERA 150 MG/ML VIAL	0	Max. 90 Days Supply;Max. 1 ML(s) in 90 days ACA*
DEPO-PROVERA 400 MG/ML VIAL	MD	
DEPO-SUBQ PROVERA 104 SYRINGE	0	Max. 1 ML(s) in 60 days ACA*
DEPO-TESTOSTERONE 100 MG/ML VL	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 ML(s) in 30 days
DEPO-TESTOSTERONE 200 MG/ML	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 4 ML(s) in 30 days
DEPRIZINE ORAL SUSPENSION	3	
DERMA-SMOOTHE-FS SCALP OIL	3	
DERMASORB HC 2% COMPLETE KIT	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DERMASORB TA 0.1% COMPLETE KIT	3	
DERMATOP 0.1% OINTMENT	3	
DERMATOP EMOLLIENT 0.1% CREAM	3	
DERMAZENE CREAM	1	
DERMOTIC OIL 0.01% EAR DROPS	3	
DESCOVY 200-25 MG TABLET	3	
DESIPRAMINE 10 MG TABLET	1	
DESIPRAMINE 100 MG TABLET	1	
DESIPRAMINE 150 MG TABLET	1	
DESIPRAMINE 25 MG TABLET	1	
DESIPRAMINE 50 MG TABLET	1	
DESIPRAMINE 75 MG TABLET	1	
DESLORATADINE 2.5 MG ODT	1	
DESLORATADINE 5 MG ODT	1	
DESLORATADINE 5 MG TABLET	1	
DESMOPRESSIN 0.1 MG/ML SOL	1	
DESMOPRESSIN 10 MCG/0.1 ML SPR	1	
DESMOPRESSIN AC 4 MCG/ML VIAL	1	
DESMOPRESSIN ACETATE 0.1 MG TB	1	
DESMOPRESSIN ACETATE 0.2 MG TB	1	
DESOGEN 28 DAY TABLET	3	
DESOGEST-ETH ESTRA 0.15-0.03MG	0	ACA*
DESOGESTR-ETH ESTRAD ETH ESTRA	0	ACA*
DESONATE 0.05% GEL	3	
DESONIDE 0.05% CREAM	1	
DESONIDE 0.05% LOTION	1	
DESONIDE 0.05% OINTMENT	1	
DESOWEN 0.05% CREAM	3	
DESOWEN 0.05% LOTION	3	
DESOXIMETASONE 0.05% CREAM	1	
DESOXIMETASONE 0.05% GEL	1	
DESOXIMETASONE 0.05% OINTMENT	1	
DESOXIMETASONE 0.25% CREAM	1	
DESOXIMETASONE 0.25% OINTMENT	1	
DESOXYN 5 MG TABLET	3	Max. 60 Days Supply
DESVENLAFAXINE ER 100 MG TAB	2	
DESVENLAFAXINE ER 100 MG TAB	1	(generic)
DESVENLAFAXINE ER 50 MG TAB	2	
DESVENLAFAXINE ER 50 MG TABLET	1	(generic)
DESVENLAFAXINE FUM ER 100 MG	3	Step Therapy required STA*: 18 and older
DESVENLAFAXINE FUM ER 50 MG	3	Step Therapy required STA*: 18 and older
DESVENLAFAXINE SUC ER 100 MG	2	
DESVENLAFAXINE SUC ER 25 MG TB	2	
DESVENLAFAXINE SUC ER 50 MG TB	2	
DETROL 1 MG TABLET	3	
DETROL 2 MG TABLET	3	
DETROL LA 2 MG CAPSULE	3	
DETROL LA 4 MG CAPSULE	3	
DEXAMETHASONE 0.1% EYE DROP	1	
DEXAMETHASONE 0.5 MG TABLET	1	
DEXAMETHASONE 0.5 MG/5 ML ELX	1	
DEXAMETHASONE 0.75 MG TABLET	1	
DEXAMETHASONE 1 MG TABLET	1	
DEXAMETHASONE 1.5 MG TABLET	1	
DEXAMETHASONE 10 MG/ML VIAL	MD	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DEXAMETHASONE 2 MG TABLET	1	
DEXAMETHASONE 4 MG TABLET	1	
DEXAMETHASONE 4 MG/ML VIAL	MD	
DEXAMETHASONE 6 MG TABLET	1	
DEXAMETHASONE INTENSOL 1MG/1ML	2	
DEXEDRINE 10 MG TABLET	3	Max. 60 Days Supply
DEXEDRINE 5 MG TABLET	3	Max. 60 Days Supply
DEXEDRINE SPANSULE 10 MG	3	Max. 60 Days Supply
DEXEDRINE SPANSULE 15 MG	3	Max. 60 Days Supply
DEXEDRINE SPANSULE 5 MG	3	Max. 60 Days Supply
DEXILANT DR 30 MG CAPSULE	3	
DEXILANT DR 60 MG CAPSULE	3	
DEXMETHYLPHENIDATE 10 MG TAB	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE 2.5 MG TAB	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE 5 MG TAB	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 10 MG CP	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 15 MG CP	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 20 MG CP	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 25 MG CP	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 30 MG CP	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 35 MG CP	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 40 MG CP	1	Max. 60 Days Supply
DEXMETHYLPHENIDATE ER 5 MG CAP	1	Max. 60 Days Supply
DEXPAK 10 DAY 1.5 MG TABLET	3	
DEXPAK 13 DAY 1.5 MG TABLET	2	
DEXPAK 6 DAY 1.5 MG TABLET	3	
DEXTROAMP-AMPHET ER 10 MG CAP	1	Max. 60 Days Supply
DEXTROAMP-AMPHET ER 15 MG CAP	1	Max. 60 Days Supply
DEXTROAMP-AMPHET ER 20 MG CAP	1	Max. 60 Days Supply
DEXTROAMP-AMPHET ER 25 MG CAP	1	Max. 60 Days Supply
DEXTROAMP-AMPHET ER 30 MG CAP	1	Max. 60 Days Supply
DEXTROAMP-AMPHET ER 5 MG CAP	1	Max. 60 Days Supply
DEXTROAMP-AMPHETAM 12.5 MG TAB	1	Max. 60 Days Supply
DEXTROAMP-AMPHETAM 7.5 MG TAB	1	Max. 60 Days Supply
DEXTROAMP-AMPHETAMIN 10 MG TAB	1	Max. 60 Days Supply
DEXTROAMP-AMPHETAMIN 15 MG TAB	1	Max. 60 Days Supply
DEXTROAMP-AMPHETAMIN 20 MG TAB	1	Max. 60 Days Supply
DEXTROAMP-AMPHETAMIN 30 MG TAB	1	Max. 60 Days Supply
DEXTROAMP-AMPHETAMINE 5 MG TAB	1	Max. 60 Days Supply
DEXTROAMPHETAMINE 10 MG TAB	1	Max. 60 Days Supply
DEXTROAMPHETAMINE 5 MG TAB	1	Max. 60 Days Supply
DEXTROAMPHETAMINE 5 MG/5 ML	1	Max. 60 Days Supply
DIABETA 1.25 MG TABLET	2	HSA*
DIABETA 2.5 MG TABLET	2	HSA*
DIABETA 5 MG TABLET	2	HSA*
DIALYVITE TABLET	1	
DIALYVITE WITH ZINC TABLET	1	
DIAMOX SEQUELS ER 500 MG CAP	3	
DIASCREEN 10 REAGENT STRIPS	2	HSA*
DIASCREEN 1B REAGENT STRIPS	2	
DIASCREEN 1G REAGENT STRIPS	2	HSA*
DIASCREEN 1K REAGENT STRIPS	2	
DIASCREEN 2GK REAGENT STRIPS	2	HSA*
DIASCREEN 2GP STRIPS	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DIASCREEN 3 REAGENT STRIPS	2	HSA*
DIASCREEN 4NL REAGENT STRIPS	2	
DIASCREEN 4OBL REAGENT STRIPS	2	HSA*
DIASCREEN 4PH REAGENT STRIPS	2	
DIASCREEN 5 REAGENT STRIPS	2	HSA*
DIASCREEN 7 REAGENT STRIPS	2	HSA*
DIASCREEN 8 REAGENT STRIPS	2	HSA*
DIASCREEN 9 REAGENT STRIPS	2	HSA*
DIASTAT 2.5 MG PEDI SYSTEM	3	
DIASTAT ACUDIAL 12.5-15-20 MG	3	
DIASTAT ACUDIAL 5-7.5-10 MG KT	3	
DIASTIX REAGENT STRIPS	2	HSA*
DIATRUE PLUS TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
DIAZEPAM 10 MG RECTAL GEL SYST	1	
DIAZEPAM 10 MG TABLET	1	
DIAZEPAM 2 MG TABLET	1	
DIAZEPAM 2.5 MG RECTAL GEL SYS	1	
DIAZEPAM 20 MG RECTAL GEL SYST	1	
DIAZEPAM 5 MG TABLET	1	
DIAZEPAM 5 MG/5 ML SOLUTION	1	
DIAZEPAM 5 MG/ML ORAL CONC	1	
DIAZEPAM 5 MG/ML VIAL	1	
DIBENZYLINE 10 MG CAPSULE	3	HSA*
DICLEGIS DR 10-10 MG TABLET	3	
DICLOFENAC 0.1% EYE DROPS	1	
DICLOFENAC 1.5% TOPICAL SOLN	1	
DICLOFENAC POT 50 MG TABLET	1	
DICLOFENAC SOD EC 25 MG TAB	1	
DICLOFENAC SOD EC 50 MG TAB	1	
DICLOFENAC SOD EC 75 MG TAB	1	
DICLOFENAC SOD ER 100 MG TAB	1	
DICLOFENAC SODIUM 1% GEL	1	
DICLOFENAC SODIUM 3% GEL	1	
DICLOFENAC-MISOPROST 50-200 TB	1	
DICLOFENAC-MISOPROST 75-200 TB	1	
DICLOTRAL PAK	3	
DICLOXACILLIN 250 MG CAPSULE	1	
DICLOXACILLIN 500 MG CAPSULE	1	
DICOPANOL ORAL SUSPENSION	3	
DICYCLOMINE 10 MG CAPSULE	1	
DICYCLOMINE 10 MG/5 ML SOLN	1	
DICYCLOMINE 20 MG TABLET	1	
DIDANOSINE DR 125 MG CAPSULE	1	
DIDANOSINE DR 200 MG CAPSULE	1	
DIDANOSINE DR 250 MG CAPSULE	1	
DIDANOSINE DR 400 MG CAPSULE	1	
DIFFERIN 0.1% CREAM	3	Prior Authorization required for members 30 and older
DIFFERIN 0.1% GEL	3	Prior Authorization required for members 30 and older
DIFFERIN 0.1% LOTION	3	Prior Authorization required for members 30 and older
DIFFERIN 0.3% GEL PUMP	3	Prior Authorization required for members 30 and older
DIFICID 200 MG TABLET	2	Limit fills to 1 in 30 days;Max. 20 per 10 days
DIFLORASONE 0.05% CREAM	1	
DIFLORASONE 0.05% OINTMENT	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DIFLUCAN 10 MG/ML SUSPENSION	3	
DIFLUCAN 100 MG TABLET	3	
DIFLUCAN 150 MG TABLET	3	
DIFLUCAN 200 MG TABLET	3	
DIFLUCAN 40 MG/ML SUSPENSION	3	
DIFLUCAN 50 MG TABLET	3	
DIFLUNISAL 500 MG TABLET	1	
DIGITEK 125 MCG TABLET	1	HSA*
DIGITEK 250 MCG TABLET	1	HSA*
DIGOX 125 MCG TABLET	1	HSA*
DIGOX 250 MCG TABLET	1	HSA*
DIGOXIN 0.05 MG/ML SOLUTION	2	HSA*
DIGOXIN 125 MCG TABLET	1	HSA*
DIGOXIN 250 MCG TABLET	1	HSA*
DIHYDROERGOTAMINE 1 MG/ML AM	1	
DIHYDROERGOTAMINE 4 MG/ML SPRY	1	
DILACOR XR 240 MG CAPSULE	3	HSA*
DILANTIN 100 MG CAPSULE	3	
DILANTIN 125 MG/5 ML SUSP	3	
DILANTIN 30 MG CAPSULE	2	
DILANTIN 50 MG INFATAB	3	
DILATRATE-SR 40 MG CAPSULE	2	
DILAUDID 2 MG TABLET	3	
DILAUDID 4 MG TABLET	3	
DILAUDID 8 MG TABLET	3	
DILT XR 120 MG CAPSULE	1	HSA*
DILT XR 180 MG CAPSULE	1	HSA*
DILT XR 240 MG CAPSULE	1	HSA*
DILT-CD 120 MG CAPSULE	1	HSA*
DILT-CD ER 300 MG CAPSULE	1	HSA*
DILTIAZEM 120 MG TABLET	1	HSA*
DILTIAZEM 12HR ER 120 MG CAP	1	HSA*
DILTIAZEM 12HR ER 60 MG CAP	1	HSA*
DILTIAZEM 12HR ER 90 MG CAP	1	HSA*
DILTIAZEM 24HR ER 120 MG CAP	1	HSA*
DILTIAZEM 24HR ER 180 MG CAP	1	HSA*
DILTIAZEM 24HR ER 180 MG TAB	1	HSA*
DILTIAZEM 24HR ER 240 MG CAP	1	HSA*
DILTIAZEM 24HR ER 240 MG TAB	1	HSA*
DILTIAZEM 24HR ER 300 MG CAP	1	HSA*
DILTIAZEM 24HR ER 300 MG TAB	1	HSA*
DILTIAZEM 24HR ER 360 MG CAP	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DILTIAZEM 24HR ER 360 MG TAB	1	HSA*
DILTIAZEM 24HR ER 420 MG CAP	1	HSA*
DILTIAZEM 24HR ER 420 MG TAB	1	HSA*
DILTIAZEM 30 MG TABLET	1	HSA*
DILTIAZEM 60 MG TABLET	1	HSA*
DILTIAZEM 90 MG TABLET	1	HSA*
DILTZAC ER 120 MG CAPSULE	1	HSA*
DILTZAC ER 180 MG CAPSULE	1	HSA*
DILTZAC ER 240 MG CAPSULE	1	HSA*
DILTZAC ER 300 MG CAPSULE	1	HSA*
DILTZAC ER 360 MG CAPSULE	1	HSA*
DIOVAN 160 MG TABLET	3	HSA*
DIOVAN 320 MG TABLET	3	HSA*
DIOVAN 40 MG TABLET	3	HSA*
DIOVAN 80 MG TABLET	3	HSA*
DIOVAN HCT 160-12.5 MG TAB	3	HSA*
DIOVAN HCT 160-25 MG TABLET	3	HSA*
DIOVAN HCT 320-12.5 MG TAB	3	HSA*
DIOVAN HCT 320-25 MG TABLET	3	HSA*
DIOVAN HCT 80-12.5 MG TABLET	3	HSA*
DIPENTUM 250 MG CAPSULE	3	
DIPHENOXYLAT-ATROP 2.5-0.025/5	1	
DIPHENOXYLATE-ATROP 2.5-0.025	1	
DIPROLENE 0.05% LOTION	3	
DIPROLENE 0.05% OINTMENT	3	
DIPROLENE AF 0.05% CREAM	3	
DIPYRIDAMOLE 25 MG TABLET	1	HSA*
DIPYRIDAMOLE 50 MG TABLET	1	HSA*
DIPYRIDAMOLE 75 MG TABLET	1	HSA*
DISALCID 500 MG TABLET	3	
DISALCID 750 MG TABLET	3	
DISKETS 40 MG TABLET DISPR	1	
DISOPYRAMIDE 100 MG CAPSULE	1	
DISOPYRAMIDE 150 MG CAPSULE	1	
DISULFIRAM 250 MG TABLET	1	
DISULFIRAM 500 MG TABLET	1	
DITROPAN XL 10 MG TABLET	3	
DITROPAN XL 15 MG TABLET	3	
DITROPAN XL 5 MG TABLET	3	
DIURIL 250 MG/5 ML ORAL SUSP	3	HSA*
DIVALPROEX DR 125 MG CAP SPRNK	1	
DIVALPROEX SOD DR 125 MG TAB	1	
DIVALPROEX SOD DR 250 MG TAB	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DIVALPROEX SOD DR 500 MG TAB	1	
DIVALPROEX SOD ER 250 MG TAB	1	
DIVALPROEX SOD ER 500 MG TAB	1	
DIVIGEL 1 MG GEL PACKET	2	
DOFETILIDE 125 MCG CAPSULE	2	
DOFETILIDE 250 MCG CAPSULE	2	
DOFETILIDE 500 MCG CAPSULE	2	
DOLOPHINE HCL 10 MG TABLET	3	
DOLOPHINE HCL 5 MG TABLET	3	
DONEPEZIL HCL 10 MG TABLET	1	
DONEPEZIL HCL 23 MG TABLET	1	
DONEPEZIL HCL 5 MG TABLET	1	
DONEPEZIL HCL ODT 10 MG TABLET	1	
DONEPEZIL HCL ODT 5 MG TABLET	1	
DORAL 15 MG TABLET	3	
DORYX DR 150 MG TABLET	3	
DORYX DR 200 MG TABLET	3	
DORYX DR 50 MG TABLET	3	
DORYX MPC DR 120 MG TABLET	1	
DORZOLAMIDE HCL 2% EYE DROPS	1	
DORZOLAMIDE-TIMOLOL EYE DROPS	1	
DOVER BULB SYRINGE 60 ML	3	
DOVONEX 0.005% CREAM	3	
DOXAZOSIN MESYLATE 1 MG TAB	1	HSA*
DOXAZOSIN MESYLATE 2 MG TAB	1	HSA*
DOXAZOSIN MESYLATE 4 MG TAB	1	HSA*
DOXAZOSIN MESYLATE 8 MG TAB	1	HSA*
DOXEPIN 10 MG CAPSULE	1	
DOXEPIN 10 MG/ML ORAL CONC	1	
DOXEPIN 100 MG CAPSULE	1	
DOXEPIN 150 MG CAPSULE	1	
DOXEPIN 25 MG CAPSULE	1	
DOXEPIN 5% CREAM	1	
DOXEPIN 50 MG CAPSULE	1	
DOXEPIN 75 MG CAPSULE	1	
DOXERCALCIFEROL 0.5 MCG CAP	1	
DOXERCALCIFEROL 1 MCG CAPSULE	1	
DOXERCALCIFEROL 2.5 MCG CAP	1	
DOXYCYCLINE 25 MG/5 ML SUSP	1	
DOXYCYCLINE HYC DR 100 MG TAB	1	
DOXYCYCLINE HYC DR 150 MG TAB	1	
DOXYCYCLINE HYC DR 200 MG TAB	3	
DOXYCYCLINE HYC DR 50 MG TAB	3	
DOXYCYCLINE HYC DR 75 MG TAB	1	
DOXYCYCLINE HYCLATE 100 MG CAP	1	
DOXYCYCLINE HYCLATE 100 MG TAB	1	
DOXYCYCLINE HYCLATE 150 MG TAB	2	
DOXYCYCLINE HYCLATE 20 MG TAB	1	
DOXYCYCLINE HYCLATE 50 MG CAP	1	
DOXYCYCLINE HYCLATE 75 MG TAB	2	
DOXYCYCLINE IR-DR 40 MG CAP	1	
DOXYCYCLINE MONO 100 MG CAP	1	
DOXYCYCLINE MONO 100 MG TABLET	1	
DOXYCYCLINE MONO 150 MG CAP	1	
DOXYCYCLINE MONO 150 MG TABLET	1	
DOXYCYCLINE MONO 50 MG CAP	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DOXYCYCLINE MONO 50 MG TABLET	1	
DOXYCYCLINE MONO 75 MG CAPSULE	1	
DOXYCYCLINE MONO 75 MG TABLET	1	
DRISDOL 50,000 UNITS CAPSULE	3	HSA*
DRITHOCREME HP 1% CREAM	2	
DRONABINOL 10 MG CAPSULE	1	
DRONABINOL 2.5 MG CAPSULE	1	
DRONABINOL 5 MG CAPSULE	1	
DROPLET 30G LANCETS	2	HSA*
DROSP-EE-LEVOMEF 3-0.02-0.451	0	ACA*
DROSPIRENONE-EE 3-0.02 MG TAB	0	ACA*
DROSPIRENONE-EE 3-0.03 MG TAB	0	ACA*
DROXIA 200 MG CAPSULE	3	
DROXIA 300 MG CAPSULE	3	
DROXIA 400 MG CAPSULE	3	
DRYSOL DAB-O-MATIC SOLUTION	2	
DUAC 1.2-5% GEL	2	
DUAVEE 0.45-20 MG TABLET	3	HSA*
DUETACT 30-2 MG TABLET	3	HSA*
DUETACT 30-4 MG TABLET	3	HSA*
DUEXIS 800-26.6 MG TABLET	3	Prior Authorization required;Max. 3 per day
DULERA 100 MCG/5 MCG INHALER	2	Max. 13 GM(s) in 30 days HSA*
DULERA 200 MCG/5 MCG INHALER	2	Max. 13 GM(s) in 30 days HSA*
DULOXETINE HCL DR 20 MG CAP	1	
DULOXETINE HCL DR 30 MG CAP	1	
DULOXETINE HCL DR 40 MG CAP	1	
DULOXETINE HCL DR 60 MG CAP	1	
DUONEB 0.5 MG-3 MG/3 ML SOLN	3	HSA*
DUOPA 4.63 MG-20 MG/ML SUSPENS	3	Max. 2800 ML(s) per 28 days LDD*: Accredo (866) 815-4717
DUPIXENT 300 MG/2 ML SAFE SYRG	3	Prior Authorization required;Max. 4 ML(s) per 28 days SPP*: Must use CVS Specialty
DURAGESIC 100 MCG/HR PATCH	3	Max. 15 per 30 days
DURAGESIC 12 MCG/HR PATCH	3	Max. 15 per 30 days
DURAGESIC 25 MCG/HR PATCH	3	Max. 15 per 30 days
DURAGESIC 50 MCG/HR PATCH	3	Max. 15 per 30 days
DURAGESIC 75 MCG/HR PATCH	3	Max. 15 per 30 days
DUREZOL 0.05% EYE DROPS	3	
DURLAZA ER 162.5 MG CAPSULE	3	Prior Authorization required HSA*
DUTASTERIDE 0.5 MG CAPSULE	1	
DUTASTERIDE-TAMSULOSIN 0.5-0.4	1	
DUTOPROL 100-12.5 MG TABLET	3	HSA*
DUTOPROL 25-12.5 MG TABLET	3	HSA*
DUTOPROL 50-12.5 MG TABLET	3	HSA*
DUZALLO 200-200 MG TABLET	3	Prior Authorization required;Max. 1 per day PA NTM*
DUZALLO 200-300 MG TABLET	3	Prior Authorization required;Max. 1 per day PA NTM*
DYANAVEL XR 2.5 MG/ML SUSP	3	Max. 60 Days Supply
DYAZIDE 37.5-25 CAPSULE	3	HSA*

DYMISTA NASAL SPRAY	2	
DYRENIUM 100 MG CAPSULE	3	HSA*
DYRENIUM 50 MG CAPSULE	3	HSA*
DYSPORT 300 UNIT VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
DYSPORT 500 UNITS VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty

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E-Z JECT LANCETS	2	HSA*
E-Z SPACER	MD	
E-ZJECT COLOR 32G LANCETS	2	HSA*
E-ZJECT COLOR 33G LANCETS	2	HSA*
E-ZJECT SUPER THIN 30G LANCETS	2	HSA*
E-ZJECT THIN LANCETS	2	HSA*
E.E.S. 200 MG/5 ML GRANULES	1	
E.E.S. 400 FILMTAB	1	
EASIVENT HOLDING CHAMBER	MD	
EASIVENT MASK-LARGE	MD	
EASIVENT MASK-MEDIUM	MD	
EASIVENT MASK-SMALL	MD	
EASY COMFORT 30G LANCETS	2	HSA*
EASY GLIDE CATH TIP 60 ML SYRN	3	
EASY GLIDE DENTAL IRR 10ML SYR	3	
EASY GLIDE LUER LOCK 1 ML SYR	3	
EASY GLIDE LUER LOCK 10 ML SYR	3	
EASY GLIDE LUER LOCK 3 ML SYR	3	
EASY GLIDE LUER LOCK 60 ML SYR	3	
EASY GLIDE LUER SLIP TB 1 ML	3	
EASY GLUCO G2 TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY PLUS GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY PLUS II TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY STEP GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY TALK GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY TOUCH 28G LANCETS	2	HSA*
EASY TOUCH FLIPLK 10ML 18GX1.5	3	
EASY TOUCH FLIPLK 10ML 20GX1.5	3	
EASY TOUCH FLIPLK 10ML 21GX1.5	3	
EASY TOUCH FLIPLK 10ML 22GX1.5	3	
EASY TOUCH FLIPLK 5 ML 20GX1.5	3	
EASY TOUCH FLIPLK 5 ML 21GX1.5	3	
EASY TOUCH FLIPLK 5 ML 22GX1.5	3	
EASY TOUCH FLIPLK 5 ML 25GX5/8	3	
EASY TOUCH FLIPLOCK 1 ML 25GX1	3	
EASY TOUCH FLIPLOCK 10ML 21GX1	3	
EASY TOUCH FLIPLOCK 3 ML 18GX1	3	
EASY TOUCH FLIPLOCK 3 ML 19GX1	3	
EASY TOUCH FLIPLOCK 3 ML 20GX1	3	
EASY TOUCH FLIPLOCK 3 ML 21GX1	3	
EASY TOUCH FLIPLOCK 3 ML 22GX1	3	
EASY TOUCH FLIPLOCK 3 ML 23GX1	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EASY TOUCH FLIPLOCK 3 ML 25GX1	3	
EASY TOUCH FLIPLOCK 5 ML 18GX1	3	
EASY TOUCH FLIPLOCK 5 ML 20GX1	3	
EASY TOUCH FLIPLOCK 5 ML 21GX1	3	
EASY TOUCH FLIPLOCK 5 ML 25GX1	3	
EASY TOUCH FLIPLOK 10 ML 18GX1	3	
EASY TOUCH FLIPLOK 10 ML 20GX1	3	
EASY TOUCH FLIPLOK 10 ML 25GX1	3	
EASY TOUCH FLIPLOK 1ML 26GX3/8	3	
EASY TOUCH FLIPLOK 3ML 18GX1.5	3	
EASY TOUCH FLIPLOK 3ML 19GX1.5	3	
EASY TOUCH FLIPLOK 3ML 20GX1.5	3	
EASY TOUCH FLIPLOK 3ML 21GX1.5	3	
EASY TOUCH FLIPLOK 3ML 22GX1.5	3	
EASY TOUCH FLIPLOK 3ML 23GX1.5	3	
EASY TOUCH FLIPLOK 3ML 25GX5/8	3	
EASY TOUCH FLURING 1ML 25GX5/8	3	
EASY TOUCH FLURING 1ML 25GX5/8	3	
EASY TOUCH FLURINGE 1 ML 25GX1	3	
EASY TOUCH FLURINGE 1 ML 25GX1	3	
EASY TOUCH FLURINGE 1 ML 25GX1	3	
EASY TOUCH FLURINGE 25GX5/8"	3	
EASY TOUCH GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY TOUCH HYPODERMIC 16GX1"	3	
EASY TOUCH HYPODERMIC 16GX1.5"	3	
EASY TOUCH HYPODERMIC 18GX1"	3	
EASY TOUCH HYPODERMIC 18GX1.5"	3	
EASY TOUCH HYPODERMIC 19GX1"	3	
EASY TOUCH HYPODERMIC 19GX1.5"	3	
EASY TOUCH HYPODERMIC 20GX1"	3	
EASY TOUCH HYPODERMIC 20GX1.5"	3	
EASY TOUCH HYPODERMIC 21GX1"	3	
EASY TOUCH HYPODERMIC 21GX1.5"	3	
EASY TOUCH HYPODERMIC 22GX1"	3	
EASY TOUCH HYPODERMIC 22GX1.5"	3	
EASY TOUCH HYPODERMIC 23GX1"	3	
EASY TOUCH HYPODERMIC 23GX1.25	3	
EASY TOUCH HYPODERMIC 23GX1.5"	3	
EASY TOUCH HYPODERMIC 23GX3/4"	3	
EASY TOUCH HYPODERMIC 24GX1"	3	
EASY TOUCH HYPODERMIC 25GX1"	3	
EASY TOUCH HYPODERMIC 25GX1.5"	3	
EASY TOUCH HYPODERMIC 25GX5/8"	3	
EASY TOUCH HYPODERMIC 26GX1/2"	3	
EASY TOUCH HYPODERMIC 26GX3/8"	3	
EASY TOUCH HYPODERMIC 26GX5/8"	3	
EASY TOUCH HYPODERMIC 27GX1.25	3	
EASY TOUCH HYPODERMIC 27GX1.5"	3	
EASY TOUCH HYPODERMIC 27GX1/2"	3	
EASY TOUCH HYPODERMIC 30GX1"	3	
EASY TOUCH HYPODERMIC 30GX1/2"	3	
EASY TOUCH LUER LOCK 1 ML SYR	3	
EASY TOUCH LUER LOCK 10 ML SYR	3	
EASY TOUCH LUER LOCK 3 ML SYR	3	
EASY TOUCH LUER LOCK 5 ML SYR	3	
EASY TOUCH SAFETY 21G LANCETS	2	HSA*
EASY TOUCH SAFETY 23G LANCETS	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EASY TOUCH SAFETY 26G LANCETS	2	HSA*
EASY TOUCH SHEATH 10 ML 25GX1"	3	
EASY TOUCH SHEATH 10ML 21GX1.5	2	
EASY TOUCH SHEATH 10ML 22GX1.5	3	
EASY TOUCH SHEATH 3 ML 21GX1"	3	
EASY TOUCH SHEATH 3 ML 21GX1.5	3	
EASY TOUCH SHEATH 3 ML 22GX1"	3	
EASY TOUCH SHEATH 3 ML 22GX1.5	3	
EASY TOUCH SHEATH 3 ML 23GX1"	3	
EASY TOUCH SHEATH 3 ML 25GX1"	3	
EASY TOUCH SHEATH 3 ML 25GX5/8	3	
EASY TOUCH SHEATH 5 ML 21GX1.5	3	
EASY TOUCH SHEATH 5 ML 22GX1.5	3	
EASY TOUCH SHEATH 5 ML 25GX1"	3	
EASY TOUCH SHEATHLOCK 10ML SYR	3	
EASY TOUCH SHEATHLOCK 3 ML SYR	3	
EASY TOUCH SHEATHLOCK 5 ML SYR	3	
EASY TOUCH SYR 1 ML 25GX5/8"	3	
EASY TOUCH SYR 3 ML 22GX1-1/2"	3	
EASY TOUCH SYR 3 ML 25GX5/8"	3	
EASY TOUCH SYRINGE 1 ML 25GX1"	3	
EASY TOUCH SYRINGE 3 ML 20GX1"	3	
EASY TOUCH SYRINGE 3 ML 21GX1"	3	
EASY TOUCH SYRINGE 3 ML 22GX1"	3	
EASY TOUCH SYRINGE 3 ML 23GX1"	3	
EASY TOUCH SYRINGE 3 ML 25GX1"	3	
EASY TOUCH TB FLP 1 ML 26GX5/8	3	
EASY TOUCH TB FLP 1 ML 27GX1/2	3	
EASY TOUCH TB FLP 1 ML 28GX1/2	3	
EASY TOUCH TB SHLK 1ML 25GX5/8	3	
EASY TOUCH TB SHLK 1ML 26GX5/8	3	
EASY TOUCH TB SHLK 1ML 27GX1/2	3	
EASY TOUCH TB SHLK 1ML 28GX1/2	3	
EASY TOUCH TWIST 28G LANCETS	2	HSA*
EASY TOUCH TWIST 30G LANCETS	2	HSA*
EASY TOUCH TWIST 32G LANCETS	2	HSA*
EASY TOUCH TWIST 33G LANCETS	2	HSA*
EASY TOUCH UNI-SLIP 10 ML SYR	3	
EASY TOUCH UNI-SLIP 3 ML SYR	3	
EASY TOUCH UNI-SLIP 5 ML SYR	3	
EASY TRAK GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY TWIST & CAP 28G LANCETS	2	HSA*
EASYGLUCO PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASYGLUCO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASYMAX 15 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASYMAX GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EC-NAPROSYN EC 375 MG TABLET	3	
EC-NAPROSYN EC 500 MG TABLET	3	
ECONAZOLE NITRATE 1% CREAM	1	
ECONTRA EZ 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ECOTRIN EC 325 MG TABLET	0	ACA*
ECOZA 1% FOAM	3	
ECPIRIN EC 325 MG TABLET	0	ACA*
EDARBI 40 MG TABLET	3	HSA*
EDARBI 80 MG TABLET	3	HSA*
EDARBYCLOR 40-12.5 MG TABLET	3	HSA*
EDARBYCLOR 40-25 MG TABLET	3	HSA*
EDECRIN 25 MG TABLET	3	HSA*
EDEX 10 MCG CARTRIDGE 2-PK KIT	2	Covered for males only;Not covered for members 17 and younger; Max. 3 in 30 days
EDEX 20 MCG CARTRIDGE 2-PK KIT	2	Covered for males only;Not covered for members 17 and younger; Max. 3 in 30 days
EDEX 40 MCG CARTRIDGE 2-PK KIT	2	Covered for males only;Not covered for members 17 and younger; Max. 3 in 30 days
EDLUAR 10 MG SL TABLET	3	Step Therapy required STA*: 18 and older
EDLUAR 5 MG SL TABLET	3	Step Therapy required STA*: 18 and older
EDURANT 25 MG TABLET	3	
EFFER-K 10 MEQ TABLET EFF	3	
EFFER-K 20 MEQ TABLET EFF	3	
EFFER-K 25 MEQ TABLET EFF	1	
EFFEXOR XR 150 MG CAPSULE	3	Step Therapy required STA*: 18 and older
EFFEXOR XR 37.5 MG CAPSULE	3	Step Therapy required STA*: 18 and older
EFFEXOR XR 75 MG CAPSULE	3	Step Therapy required STA*: 18 and older
EFFIENT 10 MG TABLET	3	HSA*
EFFIENT 5 MG TABLET	3	HSA*
EFUDEX 5% CREAM	3	
EGRIFTA 1 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty 1-844-EGRIFTA (1-844-347-4382)
EGRIFTA 2 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty 1-844-EGRIFTA (1-844-347-4382)
ELDEPRYL 5 MG CAPSULE	3	
ELDERCAPS CAPSULE	3	
ELEMENT COMPACT TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ELEMENT TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ELESTAT 0.05% EYE DROPS	3	
ELESTRIN 0.06% GEL	3	
ELETONE CREAM	3	
ELETONE CREAM TWIN PACK	3	
ELETRIPTAN HBR 20 MG TABLET	2	Max. quantity of 12 per fill MQC*: 12 tabs per copay
ELETRIPTAN HBR 40 MG TABLET	2	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ELIDEL 1% CREAM	2	Prior Authorization required
ELIMITE 5% CREAM	3	
ELINEST-28 TABLET	0	ACA*
ELIPHOS 667 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ELIQUIS 2.5 MG TABLET	2	HSA*
ELIQUIS 5 MG TABLET	2	HSA*
ELIXOPHYLLIN 80 MG/15 ML ELIX	1	HSA*
ELLA 30 MG TABLET	0	Max. quantity of 1 per fill ACA*
ELMIRON 100 MG CAPSULE	3	
ELOCON 0.1% CREAM	3	
ELOCON 0.1% LOTION	3	
ELOCON 0.1% OINTMENT	3	
ELOCTATE 3,000 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
EMADINE 0.05% EYE DROPS	3	
EMBEDA ER 100-4 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 20-0.8 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 30-1.2 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 50-2 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 60-2.4 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 80-3.2 MG CAPSULE	2	Max. 3 per day
EMBRACE 30G LANCETS	2	HSA*
EMBRACE EVO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EMBRACE PRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EMBRACE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EMCYT 140 MG CAPSULE	2	CH*
EMEND 125 MG CAPSULE	3	Max. 30 Days Supply;Max. quantity of 1 per fill MQC*: 1 cap/copay
EMEND 125 MG POWDER PACKET	3	Max. 30 Days Supply;Max. quantity of 1 per fill MQC*: 1 packet/copay
EMEND 40 MG CAPSULE	3	Max. 30 Days Supply;Max. quantity of 4 per fill MQC*: 4 caps/copay
EMEND 80 MG CAPSULE	3	Max. 30 Days Supply;Max. quantity of 2 per fill MQC*: 2 caps/copay
EMEND TRIPACK	3	Max. 30 Days Supply;Max. quantity of 3 per fill MQC*: 1 pack/copay
EMFLAZA 18 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 22.75 MG/ML ORAL SUSP	3	Prior Authorization required;Max. 1 ML(s) per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 30 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 36 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 6 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMLA CREAM	3	
EMOQUETTE 28 DAY TABLET	0	ACA*
EMSAM 12 MG/24 HOURS PATCH	3	
EMSAM 6 MG/24 HOURS PATCH	3	
EMSAM 9 MG/24 HOURS PATCH	3	
EMTRIVA 10 MG/ML SOLUTION	3	
EMTRIVA 200 MG CAPSULE	3	
EMULSION SB TOPICAL EMULSION	1	
EMVERM 100 MG TABLET CHEW	3	Max. quantity of 6 per fill;Max. 6 in 21 days MQC*: 6 tabs/copay. Max 6 tabs/21- day supply
ENABLEX 15 MG TABLET	3	
ENABLEX 7.5 MG TABLET	3	
ENALAPRIL MALEATE 10 MG TAB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ENALAPRIL MALEATE 2.5 MG TAB	1	HSA*
ENALAPRIL MALEATE 20 MG TAB	1	HSA*
ENALAPRIL MALEATE 5 MG TABLET	1	HSA*
ENALAPRIL-HCTZ 10-25 MG TABLET	1	HSA*
ENALAPRIL-HCTZ 5-12.5 MG TAB	1	HSA*
ENBREL 25 MG KIT	2	Prior Authorization required SPP*: Must use CVS Specialty
ENBREL 25 MG/0.5 ML SYRINGE	2	Prior Authorization required SPP*: Must use CVS Specialty
ENBREL 50 MG/ML MINI CARTRIDGE	2	Prior Authorization required SPP*: Must use CVS Specialty
ENBREL 50 MG/ML SURECLICK SYR	2	Prior Authorization required SPP*: Must use CVS Specialty
ENBREL 50 MG/ML SYRINGE	2	Prior Authorization required SPP*: Must use CVS Specialty
ENDOCET 10-325 MG TABLET	1	
ENDOCET 10-650 MG TABLET	1	
ENDOCET 2.5-325 MG TABLET	1	
ENDOCET 5-325 TABLET	1	
ENDOCET 7.5-325 MG TABLET	1	
ENDOCET 7.5-500 MG TABLET	1	
ENDODAN 4.8355-325 MG TABLET	1	
ENDOMETRIN 100 MG SUPPOSITORY	2	Max. 30 Days Supply IVF*
ENGERIX-B 10 MCG/0.5 ML PED VL	MD	Not covered for members 17 and younger
ENGERIX-B 20 MCG/ML SYRN	MD	Not covered for members 17 and younger
ENGERIX-B 20 MCG/ML VIAL	MD	Not covered for members 17 and younger
ENGERIX-B PEDI 10 MCG/0.5 SYRN	MD	Not covered for members 17 and younger
ENJUVIA 0.3 MG TABLET	2	
ENJUVIA 0.45 MG TABLET	2	
ENJUVIA 0.625 MG TABLET	2	
ENJUVIA 0.9 MG TABLET	2	
ENJUVIA 1.25 MG TABLET	2	
ENOXAPARIN 100 MG/ML SYRINGE	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 120 MG/0.8 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 150 MG/ML SYRINGE	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 30 MG/0.3 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 300 MG/3 ML VIAL	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 40 MG/0.4 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 60 MG/0.6 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 80 MG/0.8 ML SYR	1	HSA*; SPP*: CVS Specialty
ENPRESSE-28 TABLET	0	ACA*
ENSKYCE 28 TABLET	0	ACA*
ENSTILAR 0.005%-0.064% FOAM	3	Max. 2 GM(s) per day Max 60g/28 days supply
ENTACAPONE 200 MG TABLET	1	
ENTECAVIR 0.5 MG TABLET	1	
ENTECAVIR 1 MG TABLET	1	
ENTEREG 12 MG CAPSULE	3	
ENTOCORT EC 3 MG CAPSULE	3	
ENTRESTO 24 MG-26 MG TABLET	2	Prior Authorization required;Max. 2 per day HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ENTRESTO 49 MG-51 MG TABLET	2	Prior Authorization required;Max. 2 per day HSA*
ENTRESTO 97 MG-103 MG TABLET	2	Prior Authorization required;Max. 2 per day HSA*
ENULOSE 10 GM/15 ML SOLUTION	1	
ENVARSUS XR 0.75 MG TABLET	3	
ENVARSUS XR 1 MG TABLET	3	
ENVARSUS XR 4 MG TABLET	3	
EPANED 1 MG/ML ORAL SOLUTION	3	HSA*
EPCLUSA 400 MG-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
EPICERAM SKIN BARRIER EMULSION	3	
EPIDUO 0.1-2.5% GEL PUMP	3	Prior Authorization required for members 30 and older
EPIDUO FORTE 0.3-2.5% GEL PUMP	3	Prior Authorization required for members 30 and older
EPIFOAM FOAM	3	
EPINASTINE HCL 0.05% EYE DROPS	1	
EPINEPHRINE 0.15 MG AUTO-INJCT	1	Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
EPINEPHRINE 0.3 MG AUTO-INJECT	1	Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
EPIPEN 0.3 MG AUTO-INJECTOR	3	Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
EPIPEN 2-PAK 0.3 MG AUTO-INJCT	3	Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
EPIPEN JR 2-PAK 0.15 MG INJCTR	3	Max. quantity of 2 per fill HSA*; MQC*: 2 units/copay
EPISIL LIQUID	2	
EPITOL 200 MG TABLET	1	
EPIVIR 10 MG/ML ORAL SOLN	3	
EPIVIR 150 MG TABLET	3	
EPIVIR 300 MG TABLET	3	
EPIVIR HBV 100 MG TABLET	3	
EPIVIR HBV 25 MG/5 ML SOLN	2	
EPLERENONE 25 MG TABLET	1	HSA*
EPLERENONE 50 MG TABLET	1	HSA*
EPOGEN 10,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPOGEN 2,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPOGEN 20,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
EPOGEN 3,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPOGEN 4,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPROSARTAN MESYLATE 600 MG TAB	1	HSA*
EPZICOM TABLET	3	
EQ BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EQUETRO 100 MG CAPSULE	3	
EQUETRO 200 MG CAPSULE	3	
EQUETRO 300 MG CAPSULE	3	
ERGOLOID MESYLATES 1 MG TAB	1	
ERGOMAR 2 MG TABLET SL	2	
ERGOTAMINE-CAFFEINE 1-100MG TB	1	
ERIVEDGE 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ERRIN 0.35 MG TABLET	0	ACA*
ERTACZO 2% CREAM	3	
ERY 2% PADS	1	
ERY-TAB EC 250 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ERY-TAB EC 333 MG TABLET	3	
ERY-TAB EC 500 MG TABLET	1	
ERYGEL 2% GEL	3	
ERYPED 200 MG/5 ML SUSPENSION	3	
ERYPED 400 MG/5 ML SUSPENSION	2	
ERYTHROCIN 250 MG FILMTAB	1	
ERYTHROMYCIN 0.5% EYE OINTMENT	1	
ERYTHROMYCIN 2% GEL	1	
ERYTHROMYCIN 2% PLEDGETS	1	
ERYTHROMYCIN 2% SOLUTION	1	
ERYTHROMYCIN 200 MG/5 ML GRAN	1	
ERYTHROMYCIN 250 MG FILMTAB	1	
ERYTHROMYCIN 500 MG FILMTAB	1	
ERYTHROMYCIN DR 250 MG CAP	1	
ERYTHROMYCIN ES 400 MG TAB	1	
ERYTHROMYCIN-BENZOYL GEL	1	
ERYTHROMYCIN-SULFISOX SUSP	1	
ESBRIET 267 MG CAPSULE	2	Max. 9 per day SPP*: Must use CVS Specialty
ESBRIET 267 MG TABLET	2	Max. 9 per day SPP*: Must use CVS Specialty
ESBRIET 801 MG TABLET	2	Max. 3 per day SPP*: Must use CVS Specialty
ESCITALOPRAM 10 MG TABLET	1	
ESCITALOPRAM 20 MG TABLET	1	
ESCITALOPRAM 5 MG TABLET	1	
ESCITALOPRAM OXALATE 5 MG/5 ML	1	
ESGIC 50-325-40 MG TABLET	3	
ESGIC CAPSULE	3	
ESGIC PLUS CAPSULE	2	
ESGIC-PLUS 50-500-40 MG TABLET	3	
ESOMEPRAZOLE DR 24.65 MG CAP	3	
ESOMEPRAZOLE DR 49.3 MG CAP	3	
ESOMEPRAZOLE MAG DR 20 MG CAP	2	Prior Authorization required
ESOMEPRAZOLE MAG DR 20 MG CAP	1	OTC Version
ESOMEPRAZOLE MAG DR 40 MG CAP	2	Prior Authorization required
ESTARYLLA 0.25-0.035 MG TABLET	0	ACA*
ESTAZOLAM 1 MG TABLET	1	
ESTAZOLAM 2 MG TABLET	1	
ESTRACE 0.01% CREAM	2	
ESTRACE 0.5 MG TABLET	3	
ESTRACE 1 MG TABLET	3	
ESTRACE 2 MG TABLET	3	
ESTRADIOL 0.025 MG PATCH	1	
ESTRADIOL 0.0375 MG PATCH	1	
ESTRADIOL 0.0375 MG/DAY PATCH	1	
ESTRADIOL 0.05 MG PATCH	1	
ESTRADIOL 0.06 MG/DAY PATCH	1	
ESTRADIOL 0.075 MG PATCH	1	
ESTRADIOL 0.075 MG/DAY PATCH	1	
ESTRADIOL 0.1 MG PATCH	1	
ESTRADIOL 0.5 MG TABLET	1	
ESTRADIOL 1 MG TABLET	1	
ESTRADIOL 10 MCG VAGINAL INSRT	2	
ESTRADIOL 2 MG TABLET	1	
ESTRADIOL TDS 0.025 MG/DAY	1	
ESTRADIOL TDS 0.05 MG/DAY	1	
ESTRADIOL TDS 0.1 MG/DAY	1	
ESTRADIOL-NORETH 0.5-0.1 MG TB	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ESTRADIOL-NORETH 1-0.5 MG TAB	1	
ESTRASORB PACKET	2	
ESTRING 2 MG VAGINAL RING	2	Max. 90 Days Supply;Max. 1 in 90 days
ESTROGEL 0.06% GEL	3	
ESTROGEN-METHYLTESTOS F.S. TAB	1	Max. 30 Days Supply
ESTROGEN-METHYLTESTOS H.S. TAB	1	Max. 30 Days Supply
ESTROPIPATE 0.625(0.75 MG) TAB	1	
ESTROPIPATE 1.25(1.5 MG) TAB	1	
ESTROPIPATE 2.5(3 MG) TAB	1	
ESTROSTEP FE-28 TABLET	3	
ESZOPICLONE 1 MG TABLET	1	
ESZOPICLONE 2 MG TABLET	1	
ESZOPICLONE 3 MG TABLET	1	
ETHACRYNIC ACID 25 MG TABLET	2	HSA*
ETHAMBUTOL HCL 100 MG TABLET	1	
ETHAMBUTOL HCL 400 MG TABLET	1	
ETHOSUXIMIDE 250 MG CAPSULE	1	
ETHOSUXIMIDE 250 MG/5 ML SOLN	1	
ETHYL ACETATE LIQUID	3	
ETHYL CHLORIDE SPRAY	1	
ETHYNODIOL-ETH ESTRA 1MG-50MCG	0	ACA*
ETIDRONATE DISODIUM 200 MG TAB	1	HSA*
ETIDRONATE DISODIUM 400 MG TAB	1	HSA*
ETODOLAC 200 MG CAPSULE	1	
ETODOLAC 300 MG CAPSULE	1	
ETODOLAC 400 MG TABLET	1	
ETODOLAC 500 MG TABLET	1	
ETODOLAC ER 400 MG TABLET	1	
ETODOLAC ER 500 MG TABLET	1	
ETODOLAC ER 600 MG TABLET	1	
ETOPOSIDE 50 MG CAPSULE	1	CH*
EUCRISA 2% OINTMENT	3	Prior Authorization required
EURAX 10% CREAM	3	
EURAX 10% LOTION	3	
EVAMIST 1.53 MG/SPRAY	3	Max. quantity of 1 per fill MQC*: 1 bottle/copay
EVEKEO 10 MG TABLET	3	Max. 60 Days Supply
EVEKEO 5 MG TABLET	3	Max. 60 Days Supply
EVENCARE G2 TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVENCARE G3 TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVENCARE GLUCOSE TST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVENCARE MINI GLUCOSE TEST STR	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVISTA 60 MG TABLET	3	HSA*
EVOCLIN 1% FOAM	3	
EVOLUTION TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVOTAZ 300 MG-150 MG TABLET	3	
EVOXAC 30 MG CAPSULE	3	
EVZIO 0.4 MG AUTO-INJECTOR	3	Prior Authorization required;Max. 1.6 ML(s) per 30 days MQC*: 2 units per copay
EVZIO 2 MG AUTO-INJECTOR	3	Prior Authorization required;Max. 1.6 ML(s) per 30 days MQC*: 2 units per copay
EXALGO ER 12 MG TABLET	3	Max. 2 per day
EXALGO ER 16 MG TABLET	3	Max. 2 per day

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EXALGO ER 32 MG TABLET	3	Max. 2 per day
EXALGO ER 8 MG TABLET	3	Max. 2 per day
EXEL 3 ML SYRN 27G X 1 1/4"	3	
EXEL ALLERGY SYRINGE 27G-1 ML	3	
EXEL HYPO NEEDLE 16GX0.05"	3	
EXEL HYPO NEEDLE 16GX1"	3	
EXEL HYPO NEEDLE 18GX0.5"	3	
EXEL HYPO NEEDLE 18GX1"	3	
EXEL HYPO NEEDLE 19GX1"	3	
EXEL HYPO NEEDLE 19GX1.5"	3	
EXEL HYPO NEEDLE 20GX0.5"	3	
EXEL HYPO NEEDLE 20GX0.75"	3	
EXEL HYPO NEEDLE 20GX1"	3	
EXEL HYPO NEEDLE 21GX0.5"	3	
EXEL HYPO NEEDLE 21GX1"	3	
EXEL HYPO NEEDLE 21GX2"	3	
EXEL HYPO NEEDLE 22GX0.5"	3	
EXEL HYPO NEEDLE 22GX0.75"	3	
EXEL HYPO NEEDLE 22GX1"	3	
EXEL HYPO NEEDLE 23GX0.75"	3	
EXEL HYPO NEEDLE 23GX1"	3	
EXEL HYPO NEEDLE 23GX1.5"	3	
EXEL HYPO NEEDLE 25GX0.5"	3	
EXEL HYPO NEEDLE 25GX0.625"	3	
EXEL HYPO NEEDLE 25GX0.75"	3	
EXEL HYPO NEEDLE 25GX1"	3	
EXEL HYPO NEEDLE 26GX0.375"	3	
EXEL HYPO NEEDLE 26GX0.5"	3	
EXEL HYPO NEEDLE 26GX0.625"	3	
EXEL HYPO NEEDLE 26GX1.5"	3	
EXEL HYPO NEEDLE 27GX0.5"	3	
EXEL HYPO NEEDLE 30GX1.5"	3	
EXEL SYRINGE 10 ML	3	
EXEL SYRINGE 20 ML	3	
EXEL SYRINGE 20GX1" 3 ML	3	
EXEL SYRINGE 20GX1-1/2" 3 ML	3	
EXEL SYRINGE 21GX1" 3 ML	3	
EXEL SYRINGE 21GX1-1/2" 3 ML	3	
EXEL SYRINGE 22GX1" 3 ML	3	
EXEL SYRINGE 22GX1-1/2" 3 ML	3	
EXEL SYRINGE 22GX3/4" 3 ML	3	
EXEL SYRINGE 23GX1" 3 ML	3	
EXEL SYRINGE 23GX1-1/2" 3 ML	3	
EXEL SYRINGE 25GX1" 3 ML	3	
EXEL SYRINGE 25GX5/8" 3 ML	3	
EXEL SYRINGE 3 ML	3	
EXEL SYRINGE 30 ML	3	
EXEL SYRINGE 5 ML	3	
EXEL SYRINGE 50 ML	3	
EXEL TB WITH NEEDLE 25GX5/8"	3	
EXEL TB WITH NEEDLE 26GX3/8"	3	
EXEL TB WITH NEEDLE 26GX5/8"	3	
EXEL TB WITH NEEDLE 27GX1/2"	3	
EXEL TUBERCULIN SYRINGE 1 ML	3	
EXELDERM 1% CREAM	3	
EXELDERM 1% SOLUTION	3	
EXELON 1.5 MG CAPSULE	3	
EXELON 13.3 MG/24HR PATCH	3	
EXELON 2 MG/ML ORAL SOLUTION	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EXELON 3 MG CAPSULE	3	
EXELON 4.5 MG CAPSULE	3	
EXELON 4.6 MG/24HR PATCH	3	
EXELON 6 MG CAPSULE	3	
EXELON 9.5 MG/24HR PATCH	3	
EXEMESTANE 25 MG TABLET	1	CH*; HSA*
EXFORGE 10-160 MG TABLET	3	HSA*
EXFORGE 10-320 MG TABLET	3	HSA*
EXFORGE 5-160 MG TABLET	3	HSA*
EXFORGE 5-320 MG TABLET	3	HSA*
EXFORGE HCT 10-160-12.5 MG TAB	3	HSA*
EXFORGE HCT 10-160-25 MG TAB	3	HSA*
EXFORGE HCT 10-320-25 MG TAB	3	HSA*
EXFORGE HCT 5-160-12.5 MG TAB	3	HSA*
EXFORGE HCT 5-160-25 MG TAB	3	HSA*
EXJADE 125 MG TABLET	3	SPP*: Must use CVS Specialty
EXJADE 250 MG TABLET	3	SPP*: Must use CVS Specialty
EXJADE 500 MG TABLET	3	SPP*: Must use CVS Specialty
EXODERM LOTION	1	
EXOTIC-HC EAR DROP	1	
EXTAVIA 0.3 MG KIT	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
EXTINA 2% FOAM	3	
EYLEA 2 MG/0.05 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
EZ SMART 28G LANCETS	2	HSA*
EZ SMART PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EZ SMART TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EZETIMIBE 10 MG TABLET	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-10 MG	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-20 MG	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-40 MG	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-80 MG	2	Max. 1 per day HSA*

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FABIOR 0.1% FOAM	3	Prior Authorization required for members 30 and older
FACTIVE 320 MG TABLET	3	
FALLBACK SOLO 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
FALMINA-28 TABLET	0	ACA*
FAMCICLOVIR 125 MG TABLET	1	
FAMCICLOVIR 250 MG TABLET	1	
FAMCICLOVIR 500 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FAMOTIDINE 20 MG TABLET	1	
FAMOTIDINE 40 MG TABLET	1	
FAMOTIDINE 40 MG/5 ML SUSP	1	
FAMVIR 125 MG TABLET	3	
FAMVIR 250 MG TABLET	3	
FAMVIR 500 MG TABLET	3	
FANAPT 1 MG TABLET	3	
FANAPT 10 MG TABLET	3	
FANAPT 12 MG TABLET	3	
FANAPT 2 MG TABLET	3	
FANAPT 4 MG TABLET	3	
FANAPT 6 MG TABLET	3	
FANAPT 8 MG TABLET	3	
FANAPT TITRATION PACK	3	
FANATREX ORAL SUSPENSION	3	
FARESTON 60 MG TABLET	2	CH*; HSA*
FARXIGA 10 MG TABLET	3	HSA*
FARXIGA 5 MG TABLET	3	HSA*
FARYDAK 10 MG CAPSULE	3	CH*; SPP*: CVS Specialty
FARYDAK 15 MG CAPSULE	3	CH*; SPP*: CVS Specialty
FARYDAK 20 MG CAPSULE	3	CH*; SPP*: CVS Specialty
FAYOSIM TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
FAZACLO 100 MG ODT	3	Max. 28 Days Supply
FAZACLO 12.5 MG ODT	3	Max. 28 Days Supply
FAZACLO 150 MG ODT	3	Max. 28 Days Supply
FAZACLO 200 MG ODT	3	Max. 28 Days Supply
FAZACLO 25 MG ODT	3	Max. 28 Days Supply
FC2 FEMALE CONDOM	0	ACA*
FEIBA NF 2,500 UNIT (NOMINAL)	MD	SPP*: Must use CVS Specialty
FELBAMATE 400 MG TABLET	1	
FELBAMATE 600 MG TABLET	1	
FELBAMATE 600 MG/5 ML SUSP	1	
FELBATOL 400 MG TABLET	3	
FELBATOL 600 MG TABLET	3	
FELBATOL 600 MG/5 ML SUSP	3	
FELDENE 10 MG CAPSULE	3	
FELDENE 20 MG CAPSULE	3	
FELODIPINE ER 10 MG TABLET	1	HSA*
FELODIPINE ER 2.5 MG TABLET	1	HSA*
FELODIPINE ER 5 MG TABLET	1	HSA*
FEM PH VAGINAL JELLY	3	
FEMARA 2.5 MG TABLET	3	CH*; HSA*
FEMCAP 22 MM CERVICAL CAP	0	ACA*
FEMCAP 26 MM CERVICAL CAP	0	ACA*
FEMCAP 30 MM CERVICAL CAP	0	ACA*
FEMCON FE CHEWABLE TABLET	3	
FEMHRT 0.5 MG-2.5 MCG TABLET	3	
FEMRING 0.05 MG VAGINAL RING	3	Max. 90 Days Supply;Max. 1 in 90 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FEMRING 0.10 MG VAGINAL RING	3	Max. 90 Days Supply;Max. 1 in 90 days
FEMYNOR 28 TABLET	0	ACA*
FENOFIBRATE 120 MG TABLET	1	HSA*
FENOFIBRATE 130 MG CAPSULE	1	HSA*
FENOFIBRATE 134 MG CAPSULE	1	HSA*
FENOFIBRATE 145 MG TABLET	1	HSA*
FENOFIBRATE 150 MG CAPSULE	1	HSA*
FENOFIBRATE 160 MG TABLET	1	HSA*
FENOFIBRATE 200 MG CAPSULE	1	HSA*
FENOFIBRATE 40 MG TABLET	1	HSA*
FENOFIBRATE 43 MG CAPSULE	1	HSA*
FENOFIBRATE 48 MG TABLET	1	HSA*
FENOFIBRATE 50 MG CAPSULE	1	HSA*
FENOFIBRATE 54 MG TABLET	1	HSA*
FENOFIBRATE 67 MG CAPSULE	1	HSA*
FENOFIBRIC ACID 105 MG TABLET	1	HSA*
FENOFIBRIC ACID 35 MG TABLET	1	HSA*
FENOFIBRIC ACID DR 135 MG CAP	1	HSA*
FENOFIBRIC ACID DR 45 MG CAP	1	HSA*
FENOGLIDE 120 MG TABLET	3	HSA*
FENOGLIDE 40 MG TABLET	3	HSA*
FENOPROFEN 200 MG CAPSULE	1	
FENOPROFEN 400 MG CAPSULE	1	
FENOPROFEN 600 MG TABLET	1	
FENORTHO 200 MG CAPSULE	3	
FENORTHO 400 MG CAPSULE	3	
FENTANYL 100 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 12 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 25 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 37.5 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 50 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 62.5 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 75 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 87.5 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL CIT OTFC 1,200 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CIT OTFC 1,600 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 200 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 400 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 600 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 800 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL-ROPIV-NS 2 MCG-0.1%	1	
FENTORA 100 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 200 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 400 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 600 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 800 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FEROCON CAPSULE	1	
FERREX 150 FORTE CAPSULE	1	
FERREX 150 FORTE PLUS CAPSULE	1	
FERRIPROX 100 MG/ML SOLUTION	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
FERRIPROX 500 MG TABLET	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
FERROCITE PLUS TABLET	1	
FERROGELS FORTE SOFTGEL	1	
FETZIMA 20-40 MG TITRATION PAK	3	Step Therapy required STA*: 18 and older
FETZIMA ER 120 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FETZIMA ER 20 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FETZIMA ER 40 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FETZIMA ER 80 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FEXMID 7.5 MG TABLET	3	
FEXOFENADINE-PSE ER 180-240 TB	1	
FIASP 100 UNIT/ML FLEXTOUCH	3	Prior Authorization required HSA*; PA NTM*
FIASP 100 UNIT/ML VIAL	3	Prior Authorization required HSA*; PA NTM*
FIBRICOR 105 MG TABLET	3	HSA*
FIBRICOR 35 MG TABLET	3	HSA*
FIFTY50 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FIFTY50 SAFETY SEAL 30G LANCET	2	HSA*
FIFTY50 SAFETY SEAL 32G LANCET	2	HSA*
FINACEA 15% FOAM	2	
FINACEA 15% GEL	2	
FINASTERIDE 5 MG TABLET	1	
FINE 30 UNIVERSAL 30G LANCETS	2	HSA*
FINGERSTIX LANCETS	2	HSA*
FIORICET 50-300-40 MG CAPSULE	3	
FIORICET-COD 50-300-40-30 CAP	3	
FIORINAL 50-325-40 MG CAPSULE	3	
FIORINAL-COD 30-50-325-40 CAP	3	
FIRAZYR 30 MG/3 ML SYRINGE	3	SPP*: Must use CVS Specialty
FIRST 2% TESTOSTERONE OINT	3	Max. 30 Days Supply
FIRST HYDROCORT 10% GEL	3	
FIRST-DUKE'S MOUTHWASH	3	
FIRST-LANSOPRAZOLE 3 MG/ML	3	
FIRST-MARY'S MOUTHWASH	3	
FIRST-MOUTHWASH BLM SUSPENSION	3	
FIRST-OMEPRAZOLE 2 MG/ML SUSP	3	
FIRST-PROGESTERONE VGS 100 SUP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 200 SUP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 25 SUPP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 400 SUP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 50 SUPP	3	Max. 30 Days Supply
FIRST-TESTOSTERONE MC 2% CR	3	Max. 30 Days Supply
FLAGYL 250 MG TABLET	3	
FLAGYL 375 CAPSULE	3	
FLAGYL 500 MG TABLET	3	
FLAGYL ER 750 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FLAREX 0.1% EYE DROPS	3	
FLAVOXATE HCL 100 MG TABLET	1	
FLECAINIDE ACETATE 100 MG TAB	1	
FLECAINIDE ACETATE 150 MG TAB	1	
FLECAINIDE ACETATE 50 MG TAB	1	
FLECTOR 1.3% PATCH	2	
FLEXICHAMBER	MD	
FLEXICHAMBER-LG CHILD MASK	MD	
FLEXICHAMBER-SM ADULT MASK	MD	
FLEXICHAMBER-SM CHILD MASK	MD	
FLO-PRED 16.7(15) MG/5 ML SUSP	3	
FLOLIPID 20 MG/5 ML ORAL SUSP	3	Prior Authorization required HSA*; PA NTM*
FLOLIPID 40 MG/5 ML ORAL SUSP	3	Prior Authorization required HSA*; PA NTM*
FLOMAX 0.4 MG CAPSULE	3	
FLONASE 0.05% NASAL SPRAY	3	
FLOVENT 100 MCG DISKUS	2	HSA*
FLOVENT 250 MCG DISKUS	2	HSA*
FLOVENT 50 MCG DISKUS	2	HSA*
FLOVENT HFA 110 MCG INHALER	2	HSA*
FLOVENT HFA 220 MCG INHALER	2	HSA*
FLOVENT HFA 44 MCG INHALER	2	HSA*
FLOW-EZE VENTED NEEDLE	3	
FLOWTUSS 2.5-200 MG/5 ML SOLN	3	
FLOXIN 0.3% EAR DROPS	3	
FLUAD 2017-2018 SYRINGE	0	Not covered for members 64 and younger ACA*
FLUARIX QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
FLUBLOK 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUBLOK QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
FLUCAINE EYE DROPS	1	
FLUCELVAX QUAD 2017-2018 SYR	0	Not covered for members 18 and younger ACA*
FLUCELVAX QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUCONAZOLE 10 MG/ML SUSP	1	
FLUCONAZOLE 100 MG TABLET	1	
FLUCONAZOLE 150 MG TABLET	1	
FLUCONAZOLE 200 MG TABLET	1	
FLUCONAZOLE 40 MG/ML SUSP	1	
FLUCONAZOLE 50 MG TABLET	1	
FLUCYTOSINE 250 MG CAPSULE	1	
FLUCYTOSINE 500 MG CAPSULE	1	
FLUDROCORTISONE 0.1 MG TABLET	1	
FLULAVAL QUAD 2017-2018 SYR	0	Not covered for members 18 and younger ACA*
FLULAVAL QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUMADINE 100 MG TABLET	3	
FLUNISOLIDE 0.025% SPRAY	1	
FLUOCINOLONE 0.01% BODY OIL	1	
FLUOCINOLONE 0.01% CREAM	1	
FLUOCINOLONE 0.01% SOLUTION	1	
FLUOCINOLONE 0.025% CREAM	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FLUOCINOLONE 0.025% OINTMENT	1	
FLUOCINOLONE OIL 0.01% EAR DRP	1	
FLUOCINONIDE 0.05% CREAM	1	
FLUOCINONIDE 0.05% GEL	1	
FLUOCINONIDE 0.05% OINTMENT	1	
FLUOCINONIDE 0.05% SOLUTION	1	
FLUOCINONIDE 0.1% CREAM	1	
FLUOCINONIDE-E 0.05% CREAM	1	
FLURESCEIN-BENOXINATE EYE DRP	3	
FLURIDEX DAILY DEFENSE	3	
FLURIDEX SENSITIVITY RLF GEL	1	
FLUOROMETHOLONE 0.1% DROPS	1	
FLUOROPLEX 1% CREAM	3	
FLUOROURACIL 0.5% CREAM	1	
FLUOROURACIL 2% TOPICAL SOLN	1	
FLUOROURACIL 5% CREAM	1	
FLUOROURACIL 5% TOPICAL SOLN	1	
FLUOXETINE 20 MG/5 ML SOLUTION	1	
FLUOXETINE DR 90 MG CAPSULE	1	
FLUOXETINE HCL 10 MG CAPSULE	1	
FLUOXETINE HCL 10 MG TABLET	1	
FLUOXETINE HCL 20 MG CAPSULE	1	
FLUOXETINE HCL 20 MG TABLET	1	
FLUOXETINE HCL 40 MG CAPSULE	1	
FLUOXETINE HCL 60 MG TABLET	3	Step Therapy required
FLUPHENAZINE 1 MG TABLET	1	
FLUPHENAZINE 10 MG TABLET	1	
FLUPHENAZINE 2.5 MG TABLET	1	
FLUPHENAZINE 2.5 MG/5 ML ELIX	1	
FLUPHENAZINE 5 MG TABLET	1	
FLUPHENAZINE 5 MG/ML CONC	1	
FLURANDRENOLIDE 0.05% CREAM	1	
FLURANDRENOLIDE 0.05% LOTION	1	
FLURANDRENOLIDE 0.05% OINTMENT	2	
FLURAZEPAM 15 MG CAPSULE	1	
FLURAZEPAM 30 MG CAPSULE	1	
FLURBIPROFEN 0.03% EYE DROP	1	
FLURBIPROFEN 100 MG TABLET	1	
FLURBIPROFEN 50 MG TABLET	1	
FLURESS EYE DROPS	3	
FLUROX EYE DROPS	3	
FLUTAMIDE 125 MG CAPSULE	1	CH*
FLUTICASONE PROP 0.005% OINT	1	
FLUTICASONE PROP 0.05% CREAM	1	
FLUTICASONE PROP 0.05% LOTION	1	
FLUTICASONE PROP 50 MCG SPRAY	1	
FLUTICASONE-SALMETEROL 113-14	1	Max. 60 in 30 days HSA*
FLUTICASONE-SALMETEROL 232-14	1	Max. 60 in 30 days HSA*
FLUTICASONE-SALMETEROL 55-14	1	Max. 60 in 30 days HSA*
FLUVASTATIN ER 80 MG TABLET	1	HSA*
FLUVASTATIN SODIUM 20 MG CAP	1	HSA*
FLUVASTATIN SODIUM 40 MG CAP	1	HSA*
FLUVIRIN 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FLUVIRIN 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUVOXAMINE ER 100 MG CAPSULE	1	
FLUVOXAMINE ER 150 MG CAPSULE	1	
FLUVOXAMINE MALEATE 100 MG TAB	1	
FLUVOXAMINE MALEATE 25 MG TAB	1	
FLUVOXAMINE MALEATE 50 MG TAB	1	
FLUZONE HIGH-DOSE 2017-18 SYR	0	Not covered for members 64 and younger ACA*
FLUZONE INTRADERM QUAD 2017-18	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD PEDI 2017-18 SYR	0	Not covered for members 18 and younger ACA*
FML FORTE 0.25% EYE DROPS	2	
FML LIQUIFILM 0.1% EYE DROP	3	
FML S.O.P. 0.1% OINTMENT	2	
FOCALIN 10 MG TABLET	3	Max. 60 Days Supply
FOCALIN 2.5 MG TABLET	3	Max. 60 Days Supply
FOCALIN 5 MG TABLET	3	Max. 60 Days Supply
FOCALIN XR 10 MG CAPSULE	3	Max. 60 Days Supply
FOCALIN XR 15 MG CAPSULE	3	Max. 60 Days Supply
FOCALIN XR 20 MG CAPSULE	3	Max. 60 Days Supply
FOCALIN XR 25 MG CAPSULE	3	Max. 60 Days Supply
FOCALIN XR 30 MG CAPSULE	3	Max. 60 Days Supply
FOCALIN XR 35 MG CAPSULE	3	Max. 60 Days Supply
FOCALIN XR 40 MG CAPSULE	3	Max. 60 Days Supply
FOCALIN XR 5 MG CAPSULE	3	Max. 60 Days Supply
FOLBEE PLUS TABLET	1	
FOLGARD OS TABLET	3	
FOLGARD RX TABLET	3	
FOLIC ACID 1 MG TABLET	1	ACA*: Females 12-50 years of age
FOLIC ACID-VIT B6-VIT B12 TAB	1	
FOLLISTIM AQ 150 UNIT VIAL	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLLISTIM AQ 300 UNIT CARTRIDG	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLLISTIM AQ 600 UNIT CARTRIDG	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLLISTIM AQ 75 UNIT VIAL	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLLISTIM AQ 900 UNIT CARTRIDG	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLPLEX 2.2 TABLET	1	
FOLTRATE TABLET	3	
FONDAPARINUX 10 MG/0.8 ML SYR	1	HSA*; SPP*: CVS Specialty
FONDAPARINUX 2.5 MG/0.5 ML SYR	1	HSA*; SPP*: CVS Specialty
FONDAPARINUX 5 MG/0.4 ML SYR	1	HSA*; SPP*: CVS Specialty
FONDAPARINUX 7.5 MG/0.6 ML SYR	1	HSA*; SPP*: CVS Specialty
FORA 30G LANCETS	2	HSA*
FORA BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D15C GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FORA D15G GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D15Z GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D20 GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D40-G31 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G20 GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G30A GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G71A GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G90 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA GD50 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA TEST N'GO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA TN'G VOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V10 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V10-V12-D10-D20 STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V12 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V20 GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V22 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V30A GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORACARE 30G LANCETS	2	HSA*
FORACARE GD20 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORACARE GD40 GLUCOSE STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORADIL AEROLIZER 12 MCG CAP	2	Max. 2 per day HSA*
FORFIVO XL 450 MG TABLET	2	
FORMA-RAY 20% SOLUTION	2	
FORMADON 10% SOLUTION	1	
FORMALDEHYDE 10% SOLUTION	1	
FORTAMET ER 1,000 MG TABLET	3	HSA*
FORTAMET ER 500 MG TABLET	3	HSA*
FORTAVIT SOFTGEL	3	
FORTEO 600 MCG/2.4 ML PEN INJ	2	Prior Authorization required;Max. 2.4 ML(s) per 28 days HSA*; Max 1 syringe/28 days supply; SPP: Must use CVS Specialty
FORTESTA 10 MG GEL PUMP	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 120 GM(s) in 30 days
FORTICAL 200 UNITS NASAL SPRAY	2	HSA*
FORTISCARE GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FOSAMAX 70 MG TABLET	3	Max. 4 per 28 days HSA*
FOSAMAX PLUS D 70 MG-2,800 IU	3	Max. 28 Days Supply;Max. 4 per 28 days HSA*
FOSAMAX PLUS D 70 MG-5,600 IU	3	Max. 4 per 28 days HSA*
FOSAMPRENAVIR 700 MG TABLET	2	
FOSINOPRIL SODIUM 10 MG TAB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FOSINOPRIL SODIUM 20 MG TAB	1	HSA*
FOSINOPRIL SODIUM 40 MG TAB	1	HSA*
FOSINOPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
FOSINOPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
FOSRENOL 1,000 MG POWDER PACK	3	
FOSRENOL 1,000 MG TABLET CHEW	3	
FOSRENOL 500 MG TABLET CHEW	3	
FOSRENOL 750 MG POWDER PACKET	3	
FOSRENOL 750 MG TABLET CHEW	3	
FRAGMIN 10,000 UNITS/ML SYRING	2	HSA*; SPP*: CVS Specialty
FRAGMIN 12,500 UNITS/0.5 ML	2	HSA*; SPP*: CVS Specialty
FRAGMIN 15,000 UNITS/0.6 ML	2	HSA*; SPP*: CVS Specialty
FRAGMIN 18,000 UNITS/0.72 ML	2	HSA*; SPP*: CVS Specialty
FRAGMIN 2,500 UNITS/0.2 ML SYR	2	HSA*; SPP*: CVS Specialty
FRAGMIN 5,000 UNITS/0.2 ML SYR	2	HSA*; SPP*: CVS Specialty
FRAGMIN 7,500 UNITS/0.3 ML SYR	2	HSA*; SPP*: CVS Specialty
FRAGMIN 95,000 UNITS/3.8 ML VL	2	HSA*; SPP*: CVS Specialty
FREESTYLE 28G LANCETS	2	HSA*
FREESTYLE FREEDOM LITE METER	MD	Max. 1 in 365 days HSA*
FREESTYLE INSULINX GLUCOSE SYS	MD	Max. 1 in 365 days HSA*
FREESTYLE INSULINX TEST STRIP	2	Max. 204 per 30 days HSA*
FREESTYLE INSULINX TEST STRIPS	2	Max. 204 per 30 days HSA*
FREESTYLE LITE METER	MD	Max. 1 in 365 days HSA*
FREESTYLE LITE TEST STRIP	2	Max. 204 per 30 days HSA*
FREESTYLE LITE TEST STRIPS	2	Max. 204 per 30 days HSA*
FREESTYLE PREC NEO TEST STRIPS	2	Max. 204 per 30 days HSA*
FREESTYLE PRECISION NEO METER	MD	Max. 1 in 365 days HSA*
FREESTYLE TEST STRIPS	2	Max. 204 per 30 days HSA*
FREESTYLE UNISTIK 2 LANCETS	2	HSA*
FROVA 2.5 MG TABLET	3	Max. quantity of 9 per fill;Step Therapy required MQC*: 9 tabs/copay
FROVATRIPTAN SUCC 2.5 MG TAB	1	Max. quantity of 9 per fill;Step Therapy required MQC*: 9 tabs/copay
FULYZAQ 125 MG DR TABLET	3	Step Therapy required
FURADANTIN 25 MG/5 ML SUSP	3	
FUROSEMIDE 10 MG/ML SOLUTION	1	HSA*
FUROSEMIDE 20 MG TABLET	1	HSA*
FUROSEMIDE 40 MG TABLET	1	HSA*
FUROSEMIDE 40 MG/5 ML SOLN	1	HSA*
FUROSEMIDE 80 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FUSION SPRINKLES POWDER PACKET	3	
FUZEON 90 MG VIAL	2	SPP*: Must use CVS Specialty
FYAVOLV 0.5 MG-2.5 MCG TABLET	1	
FYAVOLV 1 MG-5 MCG TABLET	1	
FYCOMPA 0.5 MG/ML ORAL SUSP	3	
FYCOMPA 10 MG TABLET	3	
FYCOMPA 12 MG TABLET	3	
FYCOMPA 2 MG TABLET	3	
FYCOMPA 4 MG TABLET	3	
FYCOMPA 6 MG TABLET	3	
FYCOMPA 8 MG TABLET	3	

G

G TUSSIN AC LIQUID	1	
G-4 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
GABAPENTIN 100 MG CAPSULE	1	
GABAPENTIN 250 MG/5 ML SOLN	1	
GABAPENTIN 300 MG CAPSULE	1	
GABAPENTIN 400 MG CAPSULE	1	
GABAPENTIN 600 MG TABLET	1	
GABAPENTIN 800 MG TABLET	1	
GABITRIL 12 MG TABLET	2	
GABITRIL 16 MG TABLET	2	
GABITRIL 2 MG TABLET	3	
GABITRIL 4 MG TABLET	3	
GALANTAMINE 4 MG/ML ORAL SOLN	1	
GALANTAMINE ER 16 MG CAPSULE	1	
GALANTAMINE ER 24 MG CAPSULE	1	
GALANTAMINE ER 8 MG CAPSULE	1	
GALANTAMINE HBR 12 MG TABLET	1	
GALANTAMINE HBR 4 MG TABLET	1	
GALANTAMINE HBR 8 MG TABLET	1	
GALZIN 25 MG CAPSULE	3	
GALZIN 50 MG CAPSULE	3	
GANIRELIX ACET 250 MCG/0.5 ML	2	Max. 30 Days Supply IVF*
GARAMYCIN 0.3% EYE DROPS	3	
GARAMYCIN 3 MG/GM EYE OINTMENT	3	
GARDASIL 9 SYRINGE	0	Not covered for members 27 and older ACA*
GARDASIL 9 VIAL	0	Not covered for members 27 and older ACA*
GARDASIL SYRINGE	0	Not covered for members 27 and older ACA*
GARDASIL VIAL	0	Not covered for members 27 and older ACA*
GASTROCROM 100 MG/5 ML CONC	3	
GATIFLOXACIN 0.5% EYE DROPS	1	
GATTEX 5 MG 30-VIAL KIT	3	Prior Authorization required SPP*: Must use CVS Specialty
GAVILYTE-C SOLUTION	0	ACA*
GAVILYTE-G SOLUTION	0	ACA*
GAVILYTE-H AND BISACODYL KIT	0	ACA*
GAVILYTE-N SOLUTION	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GE100 BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GELCLAIR ORAL GEL PACKET	2	
GELFILM OPHTHALMIC 25X50MM	3	
GELFOAM POWDER	3	
GELNIQUE 10% GEL SACHETS	3	Max. 1 GM(s) per day Max 30 packets or 1 pump/30 days supply
GELNIQUE 3% GEL	3	Max. 92 GM(s) in 30 days Max 1 pump/30 days supply
GELX ORAL GEL	3	
GEMFIBROZIL 600 MG TABLET	1	HSA*
GENERESS FE CHEWABLE TABLET	3	
GENERLAC 10 GM/15 ML SOLUTION	1	
GENGRAF 100 MG CAPSULE	1	
GENGRAF 100 MG/ML SOLUTION	1	
GENGRAF 25 MG CAPSULE	1	
GENGRAF 50 MG CAPSULE	1	
GENOTROPIN 12 MG CARTRIDGE	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN 5 MG CARTRIDGE	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 0.2 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 0.4 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 0.6 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 0.8 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 1 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 1.2 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 1.4 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 1.6 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 1.8 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENOTROPIN MINIQUICK 2 MG	3	Prior Authorization required SPP*: Must use CVS Specialty
GENSTRIP GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GENTAK 0.3 % EYE OINTMENT	1	
GENTAMICIN 0.1% CREAM	1	
GENTAMICIN 0.1% OINTMENT	1	
GENTAMICIN 3 MG/GM EYE OINT	1	
GENTAMICIN 3 MG/ML EYE DROPS	1	
GENULTIMATE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GENVOYA TABLET	3	
GEODON 20 MG CAPSULE	3	
GEODON 40 MG CAPSULE	3	
GEODON 60 MG CAPSULE	3	
GEODON 80 MG CAPSULE	3	
GIANVI 3 MG-0.02 MG TABLET	0	ACA*
GIAZO 1.1 GM TABLET	3	
GILDAGIA 0.4 MG-0.035 MG TAB	0	ACA*
GILDESS 1 MG-20 MCG TABLET	0	ACA*
GILDESS 1.5 MG-30 MCG TABLET	0	ACA*
GILDESS 24 FE 1-0.02 MG TABLET	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GILDESS FE 1-20 TABLET	0	ACA*
GILDESS FE 1.5-30 TABLET	0	ACA*
GILENYA 0.5 MG CAPSULE	2	Max. 1 per day SPP*: Must use CVS Specialty
GILOTRIF 20 MG TABLET	3	CH*; LDD*: Accredo (866) 815-4717
GILOTRIF 30 MG TABLET	3	CH*; LDD*: Accredo (866) 815-4717
GILOTRIF 40 MG TABLET	3	CH*; LDD*: Accredo (866) 815-4717
GLATIRAMER 20 MG/ML SYRINGE	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
GLATIRAMER 40 MG/ML SYRINGE	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
GLATOPA 20 MG/ML SYRINGE	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
GLEEVEC 100 MG TABLET	3	Max. 30 Days Supply CH*; SPP*: CVS Specialty
GLEEVEC 400 MG TABLET	3	Max. 30 Days Supply CH*; SPP*: CVS Specialty
GLEOSTINE 10 MG CAPSULE	3	CH*
GLEOSTINE 100 MG CAPSULE	2	CH*
GLEOSTINE 40 MG CAPSULE	3	CH*
GLEOSTINE 5 MG CAPSULE	3	CH*
GLIMEPIRIDE 1 MG TABLET	1	HSA*
GLIMEPIRIDE 2 MG TABLET	1	HSA*
GLIMEPIRIDE 4 MG TABLET	1	HSA*
GLIPIZIDE 10 MG TABLET	1	HSA*
GLIPIZIDE 5 MG TABLET	1	HSA*
GLIPIZIDE ER 2.5 MG TABLET	1	HSA*
GLIPIZIDE XL 10 MG TABLET	1	HSA*
GLIPIZIDE XL 5 MG TABLET	1	HSA*
GLIPIZIDE-METFORMIN 2.5-250 MG	1	HSA*
GLIPIZIDE-METFORMIN 2.5-500 MG	1	HSA*
GLIPIZIDE-METFORMIN 5-500 MG	1	HSA*
GLUCAGEN 1 MG HYPOKIT	2	
GLUCAGON 1 MG EMERGENCY KIT	2	HSA*
GLUCO NAVII GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOCARD 01 SENSOR PLUS STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOCARD EXPRESSION TEST STRP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOCARD SHINE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOCARD VITAL SENSOR STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOCARD VITAL TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOCOM 28G LANCETS	2	HSA*
GLUCOCOM 30G LANCETS	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GLUCOCOM 33G LANCETS	2	HSA*
GLUCOCOM GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOPHAGE 1,000 MG TABLET	3	HSA*
GLUCOPHAGE 500 MG TABLET	3	HSA*
GLUCOPHAGE 850 MG TABLET	3	HSA*
GLUCOPHAGE XR 500 MG TAB	3	HSA*
GLUCOPHAGE XR 750 MG TAB	3	HSA*
GLUCOSOURCE LANCETS	2	HSA*
GLUCOTROL 10 MG TABLET	3	HSA*
GLUCOTROL 5 MG TABLET	3	HSA*
GLUCOTROL XL 10 MG TABLET	3	HSA*
GLUCOTROL XL 2.5 MG TABLET	3	HSA*
GLUCOTROL XL 5 MG TABLET	3	HSA*
GLUCOVANCE 2.5-500 MG TABLET	3	HSA*
GLUCOVANCE 5-500 MG TABLET	3	HSA*
GLUMETZA ER 1,000 MG TABLET	3	Prior Authorization required HSA*
GLUMETZA ER 500 MG TABLET	3	Prior Authorization required HSA*
GLYBURID-METFORMIN 1.25-250 MG	1	HSA*
GLYBURIDE 1.25 MG TABLET	1	HSA*
GLYBURIDE 2.5 MG TABLET	1	HSA*
GLYBURIDE 5 MG TABLET	1	HSA*
GLYBURIDE MICRO 1.5 MG TAB	1	HSA*
GLYBURIDE MICRO 3 MG TABLET	1	HSA*
GLYBURIDE MICRO 6 MG TABLET	1	HSA*
GLYBURIDE-METFORMIN 2.5-500 MG	1	HSA*
GLYBURIDE-METFORMIN 5-500 MG	1	HSA*
GLYCATE 1.5 MG TABLET	3	
GLYCINE 1.5% IRRIGATION	1	
GLYCOPYRROLATE 1 MG TABLET	1	
GLYCOPYRROLATE 1.5 MG TABLET	2	
GLYCOPYRROLATE 2 MG TABLET	1	
GLYDO 2% JELLY SYRINGE	1	
GLYNASE 1.5 MG PRESTAB	3	HSA*
GLYNASE 3 MG PRESTAB	3	HSA*
GLYNASE 6 MG PRESTAB	3	HSA*
GLYSET 100 MG TABLET	3	HSA*
GLYSET 25 MG TABLET	3	HSA*
GLYSET 50 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GLYXAMBI 10 MG-5 MG TABLET	3	HSA*
GLYXAMBI 25 MG-5 MG TABLET	3	HSA*
GMATE 30G LANCETS	2	HSA*
GMATE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
GNP UNIVERSAL 1 STANDARD 21G	2	HSA*
GNP UNIVERSAL 1 SUPER THIN 30G	2	HSA*
GOCOVRI ER 137 MG CAPSULE	3	Prior Authorization required PA NTM*; LDD*: Walgreens Specialty (800) 424-9002
GOCOVRI ER 68.5 MG CAPSULE	3	Prior Authorization required PA NTM*; LDD*: Walgreens Specialty (800) 424-9002
GOLYTELY PACKET	3	
GOLYTELY SOLUTION	3	
GONAL-F 450 UNITS VIAL	2	Max. 30 Days Supply IVF*
GONAL-F RFF 300 UNITS PEN	2	Max. 30 Days Supply
GONAL-F RFF 450 UNITS PEN	2	Max. 30 Days Supply
GONAL-F RFF 75 UNITS VIAL	2	Max. 30 Days Supply
GONAL-F RFF REDI-JECT 300 UNIT	2	Max. 30 Days Supply
GONAL-F RFF REDI-JECT 450 UNIT	2	Max. 30 Days Supply
GONAL-F RFF REDI-JECT 900 UNIT	2	Max. 30 Days Supply
GONITRO 0.4 MG SUBLINGUAL PWD	3	HSA*
GORDO-UREA 22% OINTMENT	3	
GORDO-UREA 40% OINTMENT	3	
GRALISE 30-DAY STARTER PACK	3	
GRALISE ER 300 MG TABLET	3	
GRALISE ER 600 MG TABLET	3	
GRANISETRON HCL 1 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
GRANISOL 2 MG/10 ML SOLUTION	1	Max. quantity of 30 per fill MQC*: 30mL/copay
GRANIX 300 MCG/0.5 ML SAFE SYR	3	Prior Authorization required SPP*: CVS Specialty
GRANIX 480 MCG/0.8 ML SAFE SYR	3	Prior Authorization required SPP*: CVS Specialty
GRANULEX SPRAY	1	
GRASTEK 2,800 BAU SL TABLET	3	Max. 1 per day
GRIFULVIN V 500 MG TABLET	3	
GRIS-PEG 125 MG TABLET	3	
GRIS-PEG 250 MG TABLET	3	
GRISEOFULVIN 125 MG/5 ML SUSP	1	
GRISEOFULVIN MICRO 500 MG TAB	1	
GRISEOFULVIN ULTRA 125 MG TAB	1	
GRISEOFULVIN ULTRA 250 MG TAB	1	
GUAIACOL LIQUID PURIFIED	3	
GUAIATUSSIN AC LIQUID	1	
GUAIFEN-CODEINE 100-10 MG/5 ML	1	
GUAIFENESIN AC COUGH SYRUP	1	
GUAIFENESIN DAC ORAL SOLUTION	1	
GUAIFENESIN-CODEINE SYRUP	1	
GUANFACINE 1 MG TABLET	1	HSA*
GUANFACINE 2 MG TABLET	1	HSA*
GUANFACINE HCL ER 1 MG TABLET	1	
GUANFACINE HCL ER 2 MG TABLET	1	
GUANFACINE HCL ER 3 MG TABLET	1	
GUANFACINE HCL ER 4 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GUANIDINE HCL 125 MG TABLET	1	
GYNAZOLE 1 2% CREAM	3	
GYNOL II 3% GEL	0	ACA*

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HAEGARDA 2,000 UNIT VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
HAEGARDA 3,000 UNIT VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
HALCION 0.25 MG TABLET	3	
HALOBETASOL PROP 0.05% CREAM	1	
HALOBETASOL PROP 0.05% OINTMNT	1	
HALOG 0.1% CREAM	3	
HALOG 0.1% OINTMENT	3	
HALONATE COMBO PACK	3	
HALONATE PAC COMBO PACK	3	
HALOPERIDOL 0.5 MG TABLET	1	
HALOPERIDOL 1 MG TABLET	1	
HALOPERIDOL 10 MG TABLET	1	
HALOPERIDOL 2 MG TABLET	1	
HALOPERIDOL 20 MG TABLET	1	
HALOPERIDOL 5 MG TABLET	1	
HALOPERIDOL LAC 2 MG/ML CONC	1	
HARVONI 90-400 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
HAVRIX 1,440 UNITS/ML SYRINGE	MD	Not covered for members 17 and younger
HAVRIX 1,440 UNITS/ML VIAL	MD	Not covered for members 17 and younger
HAVRIX 720 UNIT/0.5 ML SYRINGE	MD	Not covered for members 17 and younger
HAVRIX 720 UNITS/0.5 ML VIAL	MD	Not covered for members 17 and younger
HEALTHPRO GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
HEALTHY ACCENTS UNILET 30G	2	HSA*
HEATHER TABLET	0	ACA*
HECORIA 0.5 MG CAPSULE	2	
HECORIA 1 MG CAPSULE	2	
HECORIA 5 MG CAPSULE	2	
HECTOROL 0.5 MCG CAPSULE	3	
HECTOROL 1 MCG CAPSULE	3	
HECTOROL 2.5 MCG CAPSULE	3	
HELIDAC THERAPY	3	
HELIXATE FS 2,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty; Kogenate Preferred
HEMA-COMBISTIX REAGENT STRIPS	2	
HEMANGEOL 4.28 MG/ML ORAL SOLN	3	HSA*
HEMATINIC-FOLIC ACID TABLET	1	
HEMATINIC-VITAMIN-MINERAL TAB	1	
HEMATOGEN FA SOFTGEL	1	
HEMATOGEN FORTE SOFTGEL	1	
HEMATRON LIQUID	3	
HEMMOREX-HC 25 MG SUPPOSITORY	3	
HEMMOREX-HC 30 MG SUPPOSITORY	3	
HEMOCYTE PLUS CAPSULE	3	
HEMOCYTE-F TABLET	3	
HEMOFIL M 1,700 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
HEMRIL-30 30 MG SUPPOSITORY	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
HEPARIN SOD 10,000 UNIT/ML VL	1	
HEPARIN SOD 20,000 UNIT/ML VL	1	
HEPARIN SOD 5,000 UNIT/ML VIAL	1	
HEPSERA 10 MG TABLET	3	
HETLIOZ 20 MG CAPSULE	3	Prior Authorization required;Max. 1 per day LDD*: Diplomat Pharmacy (877) 977-9118
HEXALEN 50 MG CAPSULE	2	CH*
HIPREX 1 GM TABLET	3	
HOMATROPAIRE 5% EYE DROPS	1	
HOMATROPINE 5% EYE DROPS	1	
HORIZANT ER 300 MG TABLET	3	
HORIZANT ER 600 MG TABLET	3	
HP ACTHAR GEL 80 UNIT/ML VIAL	MD	Prior Authorization required SPP*: CVS Specialty
HPR EMOLLIENT FOAM	3	
HPR PLUS CREAM	3	
HPR PLUS EMOLLIENT FOAM	3	
HPR PLUS HYDROGEL KIT	1	
HPR PLUS-MB HYDROGEL KIT	1	
HUMALOG 100 UNITS/ML CARTRIDGE	2	HSA*
HUMALOG 100 UNITS/ML KWIKPEN	2	HSA*
HUMALOG 100 UNITS/ML VIAL	2	HSA*
HUMALOG 200 UNITS/ML KWIKPEN	2	HSA*
HUMALOG JR 100 UNIT/ML KWIKPEN	2	HSA*
HUMALOG MIX 50-50 KWIKPEN	2	HSA*
HUMALOG MIX 50-50 VIAL	2	HSA*
HUMALOG MIX 75-25 KWIKPEN	2	HSA*
HUMALOG MIX 75-25 VIAL	2	HSA*
HUMATE-P 2,400 UNIT VWF:RCO	MD	SPP*: Must use CVS Specialty
HUMATROPE 12 MG CARTRIDGE	3	Prior Authorization required SPP*: Must use CVS Specialty
HUMATROPE 24 MG CARTRIDGE	3	Prior Authorization required SPP*: Must use CVS Specialty
HUMATROPE 5 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
HUMATROPE 6 MG CARTRIDGE	3	Prior Authorization required SPP*: Must use CVS Specialty
HUMIRA 10 MG/0.2 ML SYRINGE	2	Prior Authorization required SPP*: Must use CVS Specialty
HUMIRA 20 MG/0.4 ML SYRINGE	2	Prior Authorization required SPP*: Must use CVS Specialty
HUMIRA 40 MG/0.8 ML PEN	2	Prior Authorization required SPP*: Must use CVS Specialty
HUMIRA 40 MG/0.8 ML SYRINGE	2	Prior Authorization required SPP*: Must use CVS Specialty
HUMIRA PEDIATRIC CROHN'S START	2	Prior Authorization required SPP*: Must use CVS Specialty
HUMIRA PEN CROHN-UC-HS STARTER	2	Prior Authorization required SPP*: Must use CVS Specialty
HUMIRA PEN PSORIASIS-UVEITIS	2	Prior Authorization required SPP*: Must use CVS Specialty
HUMULIN 70-30 PEN	2	HSA*
HUMULIN 70-30 VIAL	2	HSA*
HUMULIN 70/30 KWIKPEN	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
HUMULIN N 100 UNITS/ML KWIKPEN	2	HSA*
HUMULIN N 100 UNITS/ML VIAL	2	HSA*
HUMULIN R 100 UNITS/ML VIAL	2	HSA*
HUMULIN R 500 UNITS/ML KWIKPEN	2	HSA*
HUMULIN R 500 UNITS/ML VIAL	2	HSA*
HYCAMTIN 0.25 MG CAPSULE	3	CH*; SPP*: CVS Specialty
HYCAMTIN 1 MG CAPSULE	3	CH*; SPP*: CVS Specialty
HYCET 7.5 MG-325 MG/15 ML SOLN	3	
HYCOFENIX 2.5-30-200 MG/5 ML	3	
HYDRALAZINE 10 MG TABLET	1	HSA*
HYDRALAZINE 100 MG TABLET	1	HSA*
HYDRALAZINE 25 MG TABLET	1	HSA*
HYDRALAZINE 50 MG TABLET	1	HSA*
HYDREA 500 MG CAPSULE	3	CH*
HYDROCHLOROTHIAZIDE 12.5 MG CP	1	HSA*
HYDROCHLOROTHIAZIDE 12.5 MG TB	1	HSA*
HYDROCHLOROTHIAZIDE 25 MG TAB	1	HSA*
HYDROCHLOROTHIAZIDE 50 MG TAB	1	HSA*
HYDROCOD-CPM-PSEUDOEP 5-4-60/5	1	
HYDROCODON-ACETAMINOPH 2.5-500	1	
HYDROCODON-ACETAMINOPH 7.5-500	1	
HYDROCODON-ACETAMINOPH 7.5-650	1	
HYDROCODON-ACETAMINOPH 7.5-750	1	
HYDROCODON-ACETAMINOPHEN 5-500	1	
HYDROCODON-ACETAMINOPHN 10-500	1	
HYDROCODON-ACETAMINOPHN 10-650	1	
HYDROCODON-ACETAMINOPHN 10-660	1	
HYDROCODON-ACETAMINOPHN 10-750	1	
HYDROCODONE-ACETAMIN 10-300 MG	1	
HYDROCODONE-ACETAMIN 10-325 MG	1	
HYDROCODONE-ACETAMIN 2.5-167/5	1	
HYDROCODONE-ACETAMIN 2.5-325	1	
HYDROCODONE-ACETAMIN 5-163/7.5	1	
HYDROCODONE-ACETAMIN 5-300 MG	1	
HYDROCODONE-ACETAMIN 5-325 MG	1	
HYDROCODONE-ACETAMIN 7.5-300	1	
HYDROCODONE-ACETAMIN 7.5-325	1	
HYDROCODONE-ACETAMN 7.5-325/15	1	
HYDROCODONE-CHLORPHEN ER SUSP	1	
HYDROCODONE-HOMATROPINE 5-1.5	1	
HYDROCODONE-HOMATROPINE SYRUP	1	
HYDROCODONE-IBUPROFEN 10-200	1	
HYDROCODONE-IBUPROFEN 2.5-200	1	
HYDROCODONE-IBUPROFEN 5-200 MG	1	
HYDROCODONE-IBUPROFEN 7.5-200	1	
HYDROCORT-PRAMOXINE 1%-1% CRM	1	
HYDROCORT-PRAMOXINE 2.5-1% CRM	1	
HYDROCORTISON-ACETIC ACID SOLN	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
HYDROCORTISONE 1% CREAM	1	
HYDROCORTISONE 1% OINTMENT	1	
HYDROCORTISONE 10 MG TABLET	1	
HYDROCORTISONE 100 MG/60 ML	1	
HYDROCORTISONE 2.5% CREAM	1	
HYDROCORTISONE 2.5% LOTION	1	
HYDROCORTISONE 2.5% OINTMENT	1	
HYDROCORTISONE 20 MG TABLET	1	
HYDROCORTISONE 5 MG TABLET	1	
HYDROCORTISONE AC 25 MG SUPP	1	
HYDROCORTISONE AC 30 MG SUPP	1	
HYDROCORTISONE ACETATE 2% GEL	1	
HYDROCORTISONE BUTY 0.1% CREAM	1	
HYDROCORTISONE BUTYR 0.1% OINT	1	
HYDROCORTISONE BUTYR 0.1% SOLN	1	
HYDROCORTISONE VAL 0.2% CREAM	1	
HYDROCORTISONE VAL 0.2% OINTMT	1	
HYDROCORTISONE-IODOQUINOL CRM	1	
HYDROCORTISONE-PRAMOXINE CREAM	1	
HYDROMET SYRUP	1	
HYDROMORPHONE 2 MG TABLET	1	
HYDROMORPHONE 3 MG SUPPOS	1	
HYDROMORPHONE 4 MG TABLET	1	
HYDROMORPHONE 5 MG/5 ML SOLN	1	
HYDROMORPHONE 8 MG TABLET	1	
HYDROMORPHONE HCL ER 12 MG TAB	1	Max. 2 per day
HYDROMORPHONE HCL ER 16 MG TAB	1	Max. 2 per day
HYDROMORPHONE HCL ER 32 MG TAB	1	Max. 2 per day
HYDROMORPHONE HCL ER 8 MG TAB	1	Max. 2 per day
HYDROXOCOBALAMIN 1,000 MCG/ML	1	
HYDROXYCHLOROQUINE 200 MG TAB	1	
HYDROXYUREA 500 MG CAPSULE	1	CH*
HYDROXYZINE 10 MG/5 ML SOLN	1	
HYDROXYZINE HCL 10 MG TABLET	1	
HYDROXYZINE HCL 25 MG TABLET	1	
HYDROXYZINE HCL 50 MG TABLET	1	
HYDROXYZINE PAM 100 MG CAP	1	
HYDROXYZINE PAM 25 MG CAP	1	
HYDROXYZINE PAM 50 MG CAP	1	
HYGEL 2.5% GEL	3	
HYLATOPIC EMOLLIENT FOAM	3	
HYLATOPICPLUS CREAM	3	
HYLATOPICPLUS EMOLLIENT FOAM	3	
HYLATOPICPLUS LOTION	3	
HYPER-SAL 3.5% VIAL	3	
HYPER-SAL 7% VIAL	3	
HYPERCARE 20% SOLUTION	1	
HYPERRAB S-D 150 UNITS/ML VIAL	MD	
HYPO NEEDLE,POLYPROPYL HUB	3	
HYPODERMIC NEEDLE,ALUM HUB	3	
HYSINGLA ER 100 MG TABLET	2	Max. 30 Days Supply;Max. 1 per day
HYSINGLA ER 120 MG TABLET	2	Max. 30 Days Supply;Max. 1 per day
HYSINGLA ER 20 MG TABLET	2	Max. 30 Days Supply;Max. 2 per day
HYSINGLA ER 30 MG TABLET	2	Max. 30 Days Supply;Max. 2 per day
HYSINGLA ER 40 MG TABLET	2	Max. 30 Days Supply;Max. 1 per day
HYSINGLA ER 60 MG TABLET	2	Max. 30 Days Supply;Max. 1 per day
HYSINGLA ER 80 MG TABLET	2	Max. 30 Days Supply;Max. 1 per day
HYZAAR 100-12.5 TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
HYZAAR 100-25 TABLET	3	HSA*
HYZAAR 50-12.5 TABLET	3	HSA*

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IBANDRONATE 3 MG/3 ML SYRINGE	MD	SPP*: Must use CVS Specialty
IBANDRONATE SODIUM 150 MG TAB	1	Max. 1 per 30 days HSA*
IBRANCE 100 MG CAPSULE	3	CH*; SPP*: CVS Specialty
IBRANCE 125 MG CAPSULE	3	CH*; SPP*: CVS Specialty
IBRANCE 75 MG CAPSULE	3	CH*; SPP*: CVS Specialty
IBUDONE 10-200 MG TABLET	3	
IBUDONE 5-200 MG TABLET	3	
IBUPROFEN 100 MG/5 ML SUSP	1	
IBUPROFEN 400 MG TABLET	1	
IBUPROFEN 600 MG TABLET	1	
IBUPROFEN 800 MG TABLET	1	
ICLUSIG 15 MG TABLET	3	CH*
ICLUSIG 45 MG TABLET	3	CH*
IDELVION 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
IDHIFA 100 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
IDHIFA 50 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
IFEREX 150 FORTE CAPSULE	1	
ILARIS 150 MG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ILARIS 180 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ILEVRO 0.3% OPHTH DROPS	3	
ILOTYCIN 0.5% EYE OINTMENT	3	
IMATINIB MESYLATE 100 MG TAB	2	Max. 30 Days Supply CH*; SPP*: CVS Specialty
IMATINIB MESYLATE 400 MG TAB	2	Max. 30 Days Supply CH*; SPP*: CVS Specialty
IMBRUVICA 140 MG CAPSULE	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
IMDUR ER 120 MG TABLET	3	
IMDUR ER 30 MG TABLET	3	
IMDUR ER 60 MG TABLET	3	
IMIPRAMINE HCL 10 MG TABLET	1	
IMIPRAMINE HCL 25 MG TABLET	1	
IMIPRAMINE HCL 50 MG TABLET	1	
IMIPRAMINE PAMOATE 100 MG CAP	1	
IMIPRAMINE PAMOATE 125 MG CAP	1	
IMIPRAMINE PAMOATE 150 MG CAP	1	
IMIPRAMINE PAMOATE 75 MG CAP	1	
IMIQUIMOD 5% CREAM PACKET	1	
IMITREX 100 MG TABLET	3	Max. quantity of 6 per fill;Step Therapy required MQC*: 6 tabs/copay
IMITREX 20 MG NASAL SPRAY	3	Max. quantity of 6 per fill MQC*: 6 sprays/copay
IMITREX 25 MG TABLET	3	Max. quantity of 24 per fill;Step Therapy required MQC*: 24 tabs/copay

DRUG NAME	TIER	LIMITATIONS/ * NOTES
IMITREX 4 MG/0.5 ML PEN INJECT	3	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
IMITREX 5 MG NASAL SPRAY	3	Max. quantity of 6 per fill MQC*: 6 sprays/copay
IMITREX 50 MG TABLET	3	Max. quantity of 12 per fill;Step Therapy required MQC*: 12 tabs/copay
IMITREX 6 MG/0.5 ML PEN INJECT	3	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
IMITREX 6 MG/0.5 ML VIAL	3	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
IMOGAM RABIES-HT 150 UNIT/ML	MD	
IMOVAX RABIES VACCINE+DILUENT	MD	
IMPAVIDO 50 MG CAPSULE	3	
IMURAN 50 MG TABLET	3	
IN-CHECK DIAL TRAINING DEVICE	MD	
IN-CHECK NASAL WITH MASK	MD	
IN-CHECK ORAL FLOW METER	MD	
INCONTROL SUPER THIN 30G LANCT	2	HSA*
INCONTROL ULTRA THIN 28G LANCT	2	HSA*
INCRELEX 40 MG/4 ML VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
INCRUSE ELLIPTA 62.5 MCG INH	2	Max. quantity of 30 per fill;Max. 30 in 30 days HSA*
INDAPAMIDE 1.25 MG TABLET	1	HSA*
INDAPAMIDE 2.5 MG TABLET	1	HSA*
INDERAL LA 160 MG CAPSULE	3	HSA*
INDERAL LA 60 MG CAPSULE	3	HSA*
INDERAL LA 80 MG CAPSULE	3	HSA*
INDERAL XL 120 MG CAPSULE	3	HSA*
INDOCIN 25 MG/5 ML SUSPENSION	3	
INDOCIN 50 MG SUPPOSITORY	2	
INDOMETHACIN 25 MG CAPSULE	1	
INDOMETHACIN 50 MG CAPSULE	1	
INDOMETHACIN ER 75 MG CAPSULE	1	
INFASURF 35 MG/ML VIAL	3	
INFERGEN 15 MCG/0.5 ML VIAL	2	LDD*: Accredo (866) 815-4717
INFERGEN 9 MCG/0.3 ML VIAL	2	LDD*: Accredo (866) 815-4717
INFINITY TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
INGREZZA 40 MG CAPSULE	3	Prior Authorization required;Max. 2 per day LDD*: Pantherx Specialty Pharmacy 1-855-726-8479; PA NTM*
INGREZZA 80 MG CAPSULE	3	Prior Authorization required;Max. 1 per day LDD*: Pantherx Specialty Pharmacy 1-855-726-8479; PA NTM*
INJECT EASE 28G LANCETS	2	HSA*
INJECT EASE 30G LANCETS	2	HSA*
INLYTA 1 MG TABLET	3	CH*; SPP*: CVS Specialty
INLYTA 5 MG TABLET	3	CH*; SPP*: CVS Specialty
INNOPRAN XL 120 MG CAPSULE	2	HSA*
INNOPRAN XL 80 MG CAPSULE	2	HSA*
INOVA 4% EASY PAD	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
INOVA 4-1 EASY PAD	3	
INOVA 8% EASY PAD	3	
INOVA 8-2 EASY PAD	3	
INSPIRACHAMBER	MD	
INSPIRACHAMBER WITH MASK-MED	MD	
INSPRA 25 MG TABLET	3	HSA*
INSPRA 50 MG TABLET	3	HSA*
INTELENCE 100 MG TABLET	3	
INTELENCE 200 MG TABLET	3	
INTELENCE 25 MG TABLET	3	
INTERMEZZO 1.75 MG TAB SUBLING	3	Step Therapy required STA*: 18 and older
INTERMEZZO 3.5 MG TAB SUBLING	3	Step Therapy required STA*: 18 and older
INTRAROSA 6.5 MG VAG INSERT	3	Prior Authorization required;Max. 28 per 28 days PA NTM*
INTRON A 10 MILLION UNITS VIAL	2	SPP*: Must use CVS Specialty
INTRON A 18 MILLION UNIT/3 ML	2	SPP*: Must use CVS Specialty
INTRON A 18 MILLION UNITS VIAL	2	SPP*: Must use CVS Specialty
INTRON A 25 MILLION UNIT/2.5ML	2	SPP*: Must use CVS Specialty
INTRON A 50 MILLION UNITS VIAL	2	SPP*: Must use CVS Specialty
INTROVALE 0.15-0.03 MG TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
INTUNIV ER 1 MG TABLET	3	
INTUNIV ER 2 MG TABLET	3	
INTUNIV ER 3 MG TABLET	3	
INTUNIV ER 4 MG TABLET	3	
INVACARE 30G LANCETS	2	HSA*
INVEGA ER 1.5 MG TABLET	3	
INVEGA ER 3 MG TABLET	3	
INVEGA ER 6 MG TABLET	3	
INVEGA ER 9 MG TABLET	3	
INVEGA SUSTENNA 117 MG/0.75 ML	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 156 MG/ML SYRG	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 234 MG/1.5 ML	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 39 MG/0.25 ML	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 78 MG/0.5 ML	MD	SPP*: Must use CVS Specialty
INVIRASE 200 MG CAPSULE	2	
INVIRASE 500 MG TABLET	2	
INVOKAMET 150-1,000 MG TABLET	2	HSA*
INVOKAMET 150-500 MG TABLET	2	HSA*
INVOKAMET 50-1,000 MG TABLET	2	HSA*
INVOKAMET 50-500 MG TABLET	2	HSA*
INVOKAMET XR 150-1,000 MG TAB	2	HSA*
INVOKAMET XR 150-500 MG TABLET	2	HSA*
INVOKAMET XR 50-1,000 MG TAB	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
INVOKAMET XR 50-500 MG TABLET	2	HSA*
INVOKANA 100 MG TABLET	2	HSA*
INVOKANA 300 MG TABLET	2	HSA*
IODOFLEX PAD	3	
IODOSORB GEL	3	
IOPHEN-C NR LIQUID	1	
IOPIDINE 0.5% EYE DROPS	3	
IOPIDINE 1% EYE DROPS	3	
IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	1	HSA*
IPRATROPIUM 0.03% SPRAY	1	
IPRATROPIUM 0.06% SPRAY	1	
IPRATROPIUM BR 0.02% SOLN	1	HSA*
IPRIVASK 15 MG VIAL	3	HSA*; SPP*: CVS Specialty
IRBESARTAN 150 MG TABLET	1	HSA*
IRBESARTAN 300 MG TABLET	1	HSA*
IRBESARTAN 75 MG TABLET	1	HSA*
IRBESARTAN-HCTZ 150-12.5 MG TB	1	HSA*
IRBESARTAN-HCTZ 300-12.5 MG TB	1	HSA*
IRENKA DR 40 MG CAPSULE	1	Step Therapy required STA*: 18 and older
IRESSA 250 MG TABLET	3	CH*; SPP*: CVS Specialty
IRON AG-PS-ASC-B12-FA-THRE-SUC	1	
IRRIGATION SYRINGE	3	
ISENTRESS 100 MG POWDER PACKET	2	
ISENTRESS 100 MG TABLET CHEW	2	
ISENTRESS 25 MG TABLET CHEW	2	
ISENTRESS 400 MG TABLET	2	
ISENTRESS HD 600 MG TABLET	2	
ISIBLOOM 28 DAY TABLET	0	ACA*
ISOCHRON 40 MG TABLET SA	3	
ISOMETHEPT-DICHLORALP-ACETAMIN	1	
ISONIAZID 100 MG TABLET	1	
ISONIAZID 300 MG TABLET	1	
ISONIAZID 50 MG/5 ML SOLUTION	1	
ISOPTO ATROPINE 1% EYE DROPS	3	
ISOPTO CARBACHOL 3% DROPS	3	
ISOPTO CARPINE 1% EYE DROPS	3	
ISOPTO CARPINE 2% EYE DROPS	3	
ISOPTO CARPINE 4% EYE DROPS	3	
ISOPTO HOMATROPINE 5% DROPS	3	
ISOPTO HYOSCINE 0.25% DROPS	3	
ISORDIL 40 MG TABLET	2	
ISORDIL TITRADOSE 5 MG TAB	3	
ISOSORBIDE DN 10 MG TABLET	1	
ISOSORBIDE DN 2.5 MG TAB SL	1	
ISOSORBIDE DN 20 MG TABLET	1	
ISOSORBIDE DN 30 MG TABLET	1	
ISOSORBIDE DN 5 MG TABLET	1	
ISOSORBIDE DN 5 MG TABLET SL	1	
ISOSORBIDE DN ER 40 MG TABLET	1	
ISOSORBIDE MN 10 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ISOSORBIDE MN 20 MG TABLET	1	
ISOSORBIDE MN ER 120 MG TAB	1	
ISOSORBIDE MN ER 30 MG TABLET	1	
ISOSORBIDE MN ER 60 MG TABLET	1	
ISOXSUPRINE 10 MG TABLET	1	
ISOXSUPRINE 20 MG TABLET	1	
ISRADIPINE 2.5 MG CAPSULE	1	HSA*
ISRADIPINE 5 MG CAPSULE	1	HSA*
ISTALOL 0.5% EYE DROPS	3	
ITRACONAZOLE 100 MG CAPSULE	1	Max. 84 Days Supply;Prior Authorization required;Max. 168 in 365 days
IV INFUSION CPI KIT	3	
IVERMECTIN 3 MG TABLET	1	
IXINITY 500 UNIT RANGE	MD	SPP*: Must use CVS Specialty

J

J-COF DHC LIQUID	1	
J-MAX DHC LIQUID	1	
JADENU 180 MG TABLET	3	SPP*: Must use CVS Specialty
JADENU 360 MG TABLET	3	SPP*: Must use CVS Specialty
JADENU 90 MG TABLET	3	SPP*: Must use CVS Specialty
JADENU SPRINKLE 180 MG GRANULE	3	SPP*: Must use CVS Specialty
JADENU SPRINKLE 360 MG GRANULE	3	SPP*: Must use CVS Specialty
JADENU SPRINKLE 90 MG GRANULE	3	SPP*: Must use CVS Specialty
JAKAFI 10 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 15 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 20 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 25 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 5 MG TABLET	3	CH*; SPP*: CVS Specialty
JALYN 0.5-0.4 MG CAPSULE	3	
JANTOVEN 1 MG TABLET	1	HSA*
JANTOVEN 10 MG TABLET	1	HSA*
JANTOVEN 2 MG TABLET	1	HSA*
JANTOVEN 2.5 MG TABLET	1	HSA*
JANTOVEN 3 MG TABLET	1	HSA*
JANTOVEN 4 MG TABLET	1	HSA*
JANTOVEN 5 MG TABLET	1	HSA*
JANTOVEN 6 MG TABLET	1	HSA*
JANTOVEN 7.5 MG TABLET	1	HSA*
JANUMET 50-1,000 MG TABLET	2	HSA*
JANUMET 50-500 MG TABLET	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
JANUMET XR 100-1,000 MG TABLET	2	HSA*
JANUMET XR 50-1,000 MG TABLET	2	HSA*
JANUMET XR 50-500 MG TABLET	2	HSA*
JANUVIA 100 MG TABLET	2	HSA*
JANUVIA 25 MG TABLET	2	HSA*
JANUVIA 50 MG TABLET	2	HSA*
JARDIANCE 10 MG TABLET	2	HSA*
JARDIANCE 25 MG TABLET	2	HSA*
JENCYCLA 0.35 MG TABLET	0	ACA*
JENTADUETO 2.5 MG-1000 MG TAB	2	HSA*
JENTADUETO 2.5 MG-500 MG TAB	2	HSA*
JENTADUETO 2.5 MG-850 MG TAB	2	HSA*
JENTADUETO XR 2.5 MG-1,000 MG	2	HSA*
JENTADUETO XR 5 MG-1,000 MG TB	2	HSA*
JEVANTIQUE LO 0.5 MG-2.5 MCG	3	
JINTELI 1 MG-5 MCG TABLET	1	
JOLESSA 0.15 MG-0.03 MG TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
JOLIVETTE TABLET	0	ACA*
JUBLIA 10% TOPICAL SOLUTION	3	Prior Authorization required;Max. 2 ML(s) per 15 days
JULEBER 28 DAY TABLET	0	ACA*
JUNEL 1 MG-20 MCG TABLET	0	ACA*
JUNEL 1.5 MG-30 MCG TABLET	0	ACA*
JUNEL FE 1 MG-20 MCG TABLET	0	ACA*
JUNEL FE 1.5 MG-30 MCG TABLET	0	ACA*
JUNEL FE 24 TABLET	0	ACA*
JUXTAPID 10 MG CAPSULE	3	HSA*; LDD*: Accredo (866) 815-4717
JUXTAPID 20 MG CAPSULE	3	HSA*; LDD*: Accredo (866) 815-4717
JUXTAPID 30 MG CAPSULE	3	HSA*; LDD*: Accredo (866) 815-4717
JUXTAPID 40 MG CAPSULE	3	HSA*; LDD*: Accredo (866) 815-4717
JUXTAPID 5 MG CAPSULE	3	HSA*; LDD*: Accredo (866) 815-4717
JUXTAPID 60 MG CAPSULE	3	HSA*; LDD*: Accredo (866) 815-4717

K

K EFFERVESCENT 25 MEQ TABLET	1	
K-PHOS #2 TABLET	3	
K-PHOS NEUTRAL TABLET	3	
K-PHOS ORIGINAL TABLET	3	
K-SOL 20% (40 MEQ/15 ML) LIQ	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
K-TAB ER 10 MEQ TABLET	3	
K-TAB ER 20 MEQ TABLET	3	
K-TAB ER 8 MEQ TABLET	3	
KADIAN ER 10 MG CAPSULE	3	Max. 2 per day
KADIAN ER 100 MG CAPSULE	3	Max. 2 per day
KADIAN ER 130 MG CAPSULE	2	Max. 2 per day
KADIAN ER 150 MG CAPSULE	2	Max. 2 per day
KADIAN ER 20 MG CAPSULE	3	Max. 2 per day
KADIAN ER 200 MG CAPSULE	2	Max. 2 per day
KADIAN ER 30 MG CAPSULE	3	Max. 2 per day
KADIAN ER 40 MG CAPSULE	2	Max. 2 per day
KADIAN ER 50 MG CAPSULE	3	Max. 2 per day
KADIAN ER 60 MG CAPSULE	3	Max. 2 per day
KADIAN ER 70 MG CAPSULE	2	Max. 2 per day
KADIAN ER 80 MG CAPSULE	3	Max. 2 per day
KAITLIB FE CHEWABLE TABLET	0	ACA*
KALETRA 100-25 MG TABLET	2	
KALETRA 200-50 MG TABLET	2	
KALETRA 80 MG-20 MG/ML SOLN	3	
KALYDECO 150 MG TABLET	2	Prior Authorization required LDD*: Diplomat Pharmacy (877) 977-9118
KALYDECO 50 MG GRANULES PACKET	2	Prior Authorization required LDD*: Diplomat Pharmacy (877) 977-9118
KALYDECO 75 MG GRANULES PACKET	2	Prior Authorization required LDD*: Diplomat Pharmacy (877) 977-9118
KAOCHLOR-EFF 20 MEQ TABLET	3	
KAPVAY ER 0.1 MG TABLET	3	
KARBINAL ER 4 MG/ 5 ML SUSP	3	
KARIVA 28 DAY TABLET	0	ACA*
KAYEXALATE POWDER	3	
KAZANO 12.5-1,000 MG TABLET	3	HSA*
KAZANO 12.5-500 MG TABLET	3	HSA*
KEFLEX 250 MG CAPSULE	3	
KEFLEX 500 MG CAPSULE	3	
KEFLEX 750 MG CAPSULE	3	
KELNOR 1-35 28 TABLET	0	ACA*
KENALOG 0.147 MG/GRAM SPRAY	3	
KEPPRA 1,000 MG TABLET	3	
KEPPRA 100 MG/ML ORAL SOLN	3	
KEPPRA 250 MG TABLET	3	
KEPPRA 500 MG TABLET	3	
KEPPRA 750 MG TABLET	3	
KEPPRA XR 500 MG TABLET	3	
KEPPRA XR 750 MG TABLET	3	
KERAFOAM 30% FOAM	3	
KERALYT 6% GEL	3	
KERALYT SCALP COMPLETE KIT	3	
KERYDIN 5% TOPICAL SOLUTION	3	Prior Authorization required
KETALAR 200 MG/20 ML VIAL	3	
KETALAR 500 MG/10 ML VIAL	3	
KETALAR 500 MG/5 ML VIAL	3	
KETAMINE 100 MG/ML VIAL	1	
KETAMINE 200 MG/20 ML VIAL	1	
KETAMINE 500 MG/10 ML VIAL	1	
KETEK 300 MG TABLET	3	
KETEK 400 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
KETO-DIASTIX REAGENT STRIPS	2	HSA*
KETOCONAZOLE 2% CREAM	1	
KETOCONAZOLE 2% FOAM	1	
KETOCONAZOLE 2% SHAMPOO	1	
KETOCONAZOLE 200 MG TABLET	1	
KETODAN 2% FOAM	1	
KETODAN 2% FOAM KIT	3	
KETONE TEST STRIPS	2	
KETOPROFEN 50 MG CAPSULE	1	
KETOPROFEN 75 MG CAPSULE	1	
KETOPROFEN ER 200 MG CAPSULE	1	
KETOROLAC 0.4% OPHTH SOLUTION	1	
KETOROLAC 0.5% OPHTH SOLUTION	1	
KETOROLAC 10 MG TABLET	1	Max. 5 Days Supply;Max. quantity of 20 per fill
KETOSTIX REAGENT STRIPS	2	
KEVEYIS 50 MG TABLET	3	Prior Authorization required LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
KEVZARA 150 MG/1.14 ML SYRINGE	3	Prior Authorization required;Max. 2.28 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
KEVZARA 200 MG/1.14 ML SYRINGE	3	Prior Authorization required;Max. 2.28 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
KHEDEZLA ER 100 MG TABLET	3	Step Therapy required STA*: 18 and older
KHEDEZLA ER 50 MG TABLET	3	Step Therapy required STA*: 18 and older
KIDS VITAMIN D3 TAB CHEW	3	
KIMIDESS 28 DAY TABLET	0	ACA*
KINERET 100 MG/0.67 ML SYRINGE	3	Prior Authorization required LDD*: Omnicare/RX Crossroads. 866-547-0644.
KINNEY BRAND 23G LANCETS	2	HSA*
KIONEX 15 GM/60 ML SUSPENSION	1	
KISQALI 200 MG DAILY DOSE	3	Prior Authorization required;Max. 63 per 28 days CH*; SPP*: CVS Specialty
KISQALI 400 MG DAILY DOSE	3	Prior Authorization required;Max. 63 per 28 days CH*; SPP*: CVS Specialty
KISQALI 600 MG DAILY DOSE	3	Prior Authorization required;Max. 63 per 28 days CH*; SPP*: CVS Specialty
KISQALI FEMARA 200 MG CO-PACK	3	Prior Authorization required CH*; SPP*: CVS Specialty
KISQALI FEMARA 400 MG CO-PACK	3	Prior Authorization required CH*; SPP*: CVS Specialty
KISQALI FEMARA 600 MG CO-PACK	3	Prior Authorization required CH*; SPP*: CVS Specialty
KITABIS PAK 300 MG/5 ML	2	SPP*: Must use CVS Specialty
KLARON 10% LOTION	3	
KLONOPIN 0.5 MG TABLET	3	
KLONOPIN 1 MG TABLET	3	
KLONOPIN 2 MG TABLET	3	
KLOR-CON 10 MEQ TABLET	3	
KLOR-CON 20 MEQ PACKET	3	
KLOR-CON 25 MEQ PACKET	3	
KLOR-CON 8 MEQ TABLET	3	
KLOR-CON M10 TABLET	3	
KLOR-CON M15 TABLET	1	
KLOR-CON M20 TABLET	1	
KLOR-CON SPRINKLE ER 10 MEQ CP	1	
KLOR-CON SPRINKLE ER 8 MEQ CAP	1	
KLOR-CON-EF 25 MEQ TAB EFF	3	
KOATE 250 UNIT VIAL	MD	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
KOGENATE FS 500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
KOMBIGLYZE XR 2.5-1,000 MG TAB	3	HSA*
KOMBIGLYZE XR 5-1,000 MG TAB	3	HSA*
KOMBIGLYZE XR 5-500 MG TABLET	3	HSA*
KORLYM 300 MG TABLET	3	HSA*; LDD; SPP*: Must use Dohmen Life Sciences. 1-800-305-7881.
KOVALTRY 3,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
KRISTALOSE 10 GM PACKET	2	
KRISTALOSE 20 GM PACKET	2	
KRO PREMIUM BLOOD GLUCOSE TEST	3	Prior Authorization required;Max. 204 per 30 days HSA*
KRO UNIVERSAL 1 THIN 26G LANCT	2	HSA*
KROGER SUPER THIN LANCETS	2	HSA*
KRYSTEXXA 8 MG/ML VIAL	MD	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
KURVELO TABLET	0	ACA*
KUVAN 100 MG POWDER PACKET	2	SPP*: Must use CVS Specialty
KUVAN 100 MG TABLET	2	SPP*: Must use CVS Specialty
KUVAN 500 MG POWDER PACKET	2	SPP*: Must use CVS Specialty
KYNAMRO 200 MG/ML SYRINGE	3	SPP*: Must use CVS Specialty

L

LABETALOL HCL 100 MG TABLET	1	HSA*
LABETALOL HCL 200 MG TABLET	1	HSA*
LABETALOL HCL 300 MG TABLET	1	HSA*
LABSTIX REAGENT STRIPS	2	
LAC-HYDRIN 12% CREAM	3	
LAC-HYDRIN 12% LOTION	3	
LACRISERT 5 MG EYE INSERT	2	
LACTIC ACID 10% E CREAM	1	
LACTIC ACID 10% LOTION	1	
LACTULOSE 10 GM/15 ML SOLUTION	1	
LAMICTAL 100 MG TABLET	3	
LAMICTAL 150 MG TABLET	3	
LAMICTAL 2 MG DISPER TABLET	2	
LAMICTAL 200 MG TABLET	3	
LAMICTAL 25 MG DISPER TABLET	3	
LAMICTAL 25 MG TABLET	3	
LAMICTAL 5 MG DISPER TABLET	3	
LAMICTAL ODT 100 MG TABLET	3	
LAMICTAL ODT 200 MG TABLET	3	
LAMICTAL ODT 25 MG TABLET	3	
LAMICTAL ODT 50 MG TABLET	3	
LAMICTAL ODT START KIT (BLUE)	3	
LAMICTAL ODT START KIT (GREEN)	3	
LAMICTAL ODT START KT (ORANGE)	3	
LAMICTAL TAB START KIT (BLUE)	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LAMICTAL TAB START KIT (GREEN)	3	
LAMICTAL TB START KIT (ORANGE)	3	
LAMICTAL XR 100 MG TABLET	3	
LAMICTAL XR 200 MG TABLET	3	
LAMICTAL XR 25 MG TABLET	3	
LAMICTAL XR 250 MG TABLET	3	
LAMICTAL XR 300 MG TABLET	3	
LAMICTAL XR 50 MG TABLET	3	
LAMICTAL XR START KIT (BLUE)	2	
LAMICTAL XR START KIT (GREEN)	2	
LAMICTAL XR START KIT (ORANGE)	2	
LAMISIL 125 MG GRANULES PACKET	3	Max. 1 per day
LAMISIL 187.5 MG GRANULES PACK	3	Max. 1 per day
LAMISIL 250 MG TABLET	3	Max. quantity of 28 per fill;Max. 84 in 365 days
LAMIVUDINE 10 MG/ML ORAL SOLN	1	
LAMIVUDINE 150 MG TABLET	1	
LAMIVUDINE 300 MG TABLET	1	
LAMIVUDINE HBV 100 MG TABLET	1	
LAMIVUDINE-ZIDOVUDINE TABLET	1	
LAMOTRIGINE 100 MG TABLET	1	
LAMOTRIGINE 150 MG TABLET	1	
LAMOTRIGINE 200 MG TABLET	1	
LAMOTRIGINE 25 MG DISPER TAB	1	
LAMOTRIGINE 25 MG TABLET	1	
LAMOTRIGINE 5 MG DISPER TABLET	1	
LAMOTRIGINE ER 100 MG TABLET	1	
LAMOTRIGINE ER 200 MG TABLET	1	
LAMOTRIGINE ER 25 MG TABLET	1	
LAMOTRIGINE ER 250 MG TABLET	1	
LAMOTRIGINE ER 300 MG TABLET	1	
LAMOTRIGINE ER 50 MG TABLET	1	
LAMOTRIGINE ODT 100 MG TABLET	1	
LAMOTRIGINE ODT 200 MG TABLET	1	
LAMOTRIGINE ODT 25 MG TABLET	1	
LAMOTRIGINE ODT 50 MG TABLET	1	
LAMOTRIGINE ODT KIT (BLUE)	1	
LAMOTRIGINE ODT KIT (GREEN)	1	
LAMOTRIGINE ODT KIT (ORANGE)	1	
LAMOTRIGINE TAB START KIT-BLUE	1	
LAMOTRIGINE TAB START KT-GREEN	2	
LAMOTRIGINE TAB START KT-ORANG	2	
LANCETS 33G	2	HSA*
LANCETS THIN 23G	2	HSA*
LANCETS ULTRA THIN 26G	2	HSA*
LANOXIN 125 MCG TABLET	3	HSA*
LANOXIN 187.5 MCG TABLET	3	HSA*
LANOXIN 250 MCG TABLET	3	HSA*
LANOXIN 62.5 MCG TABLET	3	HSA*
LANSOPRAZOL-AMOXICIL-CLARITHRO	1	
LANSOPRAZOLE DR 15 MG CAPSULE	2	
LANSOPRAZOLE DR 30 MG CAPSULE	2	
LANTHANUM CARB 1,000 MG TB CHW	2	
LANTHANUM CARB 500 MG TAB CHEW	2	
LANTHANUM CARB 750 MG TAB CHEW	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LANTUS 100 UNIT/ML VIAL	2	HSA*
LANTUS SOLOSTAR 100 UNIT/ML	2	HSA*
LARIN 1.5 MG-30 MCG TABLET	0	ACA*
LARIN 21 1-20 TABLET	0	ACA*
LARIN 24 FE 1 MG-20 MCG TABLET	0	ACA*
LARIN FE 1-20 TABLET	0	ACA*
LARIN FE 1.5-30 TABLET	0	ACA*
LARISSIA-28 TABLET	0	ACA*
LASIX 20 MG TABLET	3	HSA*
LASIX 40 MG TABLET	3	HSA*
LASIX 80 MG TABLET	3	HSA*
LASTACAFT 0.25% EYE DROPS	3	
LATANOPROST 0.005% EYE DROPS	1	
LATRIX 50% TOPICAL SUSPENSION	1	
LATUDA 120 MG TABLET	2	
LATUDA 20 MG TABLET	2	
LATUDA 40 MG TABLET	2	
LATUDA 60 MG TABLET	2	
LATUDA 80 MG TABLET	2	
LAYOLIS FE CHEWABLE TABLET	0	ACA*
LAZANDA 100 MCG NASAL SPRAY	3	Prior Authorization required;Max. 1 per 2 days
LAZANDA 300 MCG NASAL SPRAY	3	Prior Authorization required;Max. 1 per 2 days
LAZANDA 400 MCG NASAL SPRAY	3	Prior Authorization required;Max. 1 per 2 days
LEENA 28 TABLET	0	ACA*
LEFLUNOMIDE 10 MG TABLET	1	
LEFLUNOMIDE 20 MG TABLET	1	
LENVIMA 10 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 14 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 18 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 20 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 24 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 8 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LESCOL 20 MG CAPSULE	3	HSA*
LESCOL 40 MG CAPSULE	3	HSA*
LESCOL XL 80 MG TABLET	3	HSA*
LESSINA-28 TABLET	0	ACA*
LETAIRIS 10 MG TABLET	2	SPP*: Must Use CVS Specialty
LETAIRIS 5 MG TABLET	2	SPP*: Must Use CVS Specialty
LETROZOLE 2.5 MG TABLET	1	CH*; HSA*
LEUCOVORIN CALCIUM 10 MG TAB	1	
LEUCOVORIN CALCIUM 15 MG TAB	1	
LEUCOVORIN CALCIUM 25 MG TAB	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LEUCOVORIN CALCIUM 5 MG TAB	1	
LEUKERAN 2 MG TABLET	2	CH*
LEUPROLIDE 2WK 14 MG/2.8 ML KT	1	Max. 30 Days Supply IVF*
LEVALBUTEROL 0.31 MG/3 ML SOL	1	HSA*
LEVALBUTEROL 0.63 MG/3 ML SOL	1	HSA*
LEVALBUTEROL 1.25 MG/3 ML SOL	1	HSA*
LEVALBUTEROL CONC 1.25 MG/0.5	1	HSA*
LEVALBUTEROL TAR HFA 45MCG INH	2	HSA*
LEVAQUIN 25 MG/ML SOLUTION	3	
LEVAQUIN 250 MG TABLET	3	
LEVAQUIN 500 MG TABLET	3	
LEVAQUIN 750 MG TABLET	3	
LEVATOL 20 MG TABLET	3	HSA*
LEVEMIR 100 UNITS/ML VIAL	2	HSA*
LEVEMIR FLEXTOUCH 100 UNITS/ML	2	HSA*
LEVETIRACETAM 1,000 MG TABLET	1	
LEVETIRACETAM 100 MG/ML SOLN	1	
LEVETIRACETAM 250 MG TABLET	1	
LEVETIRACETAM 500 MG TABLET	1	
LEVETIRACETAM 750 MG TABLET	1	
LEVETIRACETAM ER 500 MG TABLET	1	
LEVETIRACETAM ER 750 MG TABLET	1	
LEVITRA 10 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVITRA 2.5 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVITRA 20 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVITRA 5 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVO-T 100 MCG TABLET	3	
LEVO-T 112 MCG TABLET	3	
LEVO-T 125 MCG TABLET	3	
LEVO-T 137 MCG TABLET	3	
LEVO-T 150 MCG TABLET	3	
LEVO-T 175 MCG TABLET	3	
LEVO-T 200 MCG TABLET	3	
LEVO-T 25 MCG TABLET	3	
LEVO-T 300 MCG TABLET	3	
LEVO-T 50 MCG TABLET	3	
LEVO-T 75 MCG TABLET	3	
LEVO-T 88 MCG TABLET	3	
LEVOBUNOLOL 0.25% EYE DROPS	1	
LEVOBUNOLOL 0.5% EYE DROPS	1	
LEVOCARNITINE 1 G/10 ML SOLN	1	
LEVOCARNITINE 330 MG TABLET	1	
LEVOCETIRIZINE 2.5 MG/5 ML SOL	1	
LEVOCETIRIZINE 5 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LEVOFLOXACIN 0.5% EYE DROPS	1	
LEVOFLOXACIN 25 MG/ML SOLUTION	1	
LEVOFLOXACIN 250 MG TABLET	1	
LEVOFLOXACIN 500 MG TABLET	1	
LEVOFLOXACIN 750 MG TABLET	1	
LEVONEST-28 TABLET	0	ACA*
LEVONO-E ESTRAD 0.10-0.02-0.01	0	Max. 91 Days Supply;Max. 1 per day ACA*
LEVONO-E ESTRAD 0.15-0.03-0.01	0	Max. 91 Days Supply;Max. 1 per day ACA*
LEVONOR-ETH ESTRA 0.09-0.02 MG	0	ACA*
LEVONOR-ETH ESTRAD 0.1-0.02 MG	0	ACA*
LEVONOR-ETH ESTRAD 0.15-0.03	0	ACA*
LEVONOR-ETH ESTRAD TRIPHASIC	0	Max. 91 Days Supply ACA*
LEVONORGESTREL 0.75 MG TABLET	0	Max. quantity of 1 per fill ACA*
LEVONORGESTREL 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
LEVORA-28 TABLET	0	ACA*
LEVORPHANOL 2 MG TABLET	1	
LEVOTHYROXINE 100 MCG TABLET	1	
LEVOTHYROXINE 112 MCG TABLET	1	
LEVOTHYROXINE 125 MCG TABLET	1	
LEVOTHYROXINE 137 MCG TABLET	1	
LEVOTHYROXINE 150 MCG TABLET	1	
LEVOTHYROXINE 175 MCG TABLET	1	
LEVOTHYROXINE 200 MCG TABLET	1	
LEVOTHYROXINE 25 MCG TABLET	1	
LEVOTHYROXINE 300 MCG TABLET	1	
LEVOTHYROXINE 50 MCG TABLET	1	
LEVOTHYROXINE 75 MCG TABLET	1	
LEVOTHYROXINE 88 MCG TABLET	1	
LEVOXYL 100 MCG TABLET	1	
LEVOXYL 112 MCG TABLET	1	
LEVOXYL 125 MCG TABLET	1	
LEVOXYL 137 MCG TABLET	1	
LEVOXYL 150 MCG TABLET	1	
LEVOXYL 175 MCG TABLET	1	
LEVOXYL 200 MCG TABLET	1	
LEVOXYL 25 MCG TABLET	1	
LEVOXYL 50 MCG TABLET	1	
LEVOXYL 75 MCG TABLET	1	
LEVOXYL 88 MCG TABLET	1	
LEVULAN KERASTICK	3	
LEXAPRO 10 MG TABLET	3	Step Therapy required STA*: 18 and older
LEXAPRO 20 MG TABLET	3	Step Therapy required STA*: 18 and older
LEXAPRO 5 MG TABLET	3	Step Therapy required STA*: 18 and older
LEXAPRO 5 MG/5 ML SOLUTION	3	Step Therapy required STA*: 18 and older
LEXIVA 50 MG/ML SUSPENSION	2	
LEXIVA 700 MG TABLET	3	
LIALDA DR 1.2 GM TABLET	3	
LIBERTY TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
LIBRAX CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LIDO BDK KIT	1	
LIDOCAINE 2% VISCOUS SOLN	1	
LIDOCAINE 3% CREAM	1	
LIDOCAINE 5% OINTMENT	1	
LIDOCAINE 5% PATCH	1	
LIDOCAINE HCL 2% JELLY	1	
LIDOCAINE HCL 4% SOLUTION	1	
LIDOCAINE-HC 3-0.5% CREAM	1	
LIDOCAINE-HC 3-1% CREAM KIT	1	
LIDOCAINE-HC 3-2.5% GEL KIT	1	
LIDOCAINE-PRILOCAINE CREAM	1	
LIDODERM 5% PATCH	3	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LILLOW-28 TABLET	0	ACA*
LINDANE 1% LOTION	1	
LINDANE 1% SHAMPOO	1	
LINEZOLID 100 MG/5 ML SUSP	1	
LINEZOLID 600 MG TABLET	1	
LINZESS 145 MCG CAPSULE	2	
LINZESS 290 MCG CAPSULE	2	
LINZESS 72 MCG CAPSULE	2	
LIOTHYRONINE SOD 25 MCG TAB	1	
LIOTHYRONINE SOD 5 MCG TAB	1	
LIOTHYRONINE SOD 50 MCG TAB	1	
LIPITOR 10 MG TABLET	3	Prior Authorization required HSA*
LIPITOR 20 MG TABLET	3	Prior Authorization required HSA*
LIPITOR 40 MG TABLET	3	Prior Authorization required HSA*
LIPITOR 80 MG TABLET	3	Prior Authorization required HSA*
LIPOFEN 150 MG CAPSULE	3	HSA*
LIPOFEN 50 MG CAPSULE	3	HSA*
LIPTRUZET 10-20 MG TABLET	3	Max. 1 per day HSA*
LIPTRUZET 10-40 MG TABLET	3	Max. 1 per day HSA*
LIPTRUZET 10-80 MG TABLET	3	Max. 1 per day HSA*
LISINOPRIL 10 MG TABLET	1	HSA*
LISINOPRIL 2.5 MG TABLET	1	HSA*
LISINOPRIL 20 MG TABLET	1	HSA*
LISINOPRIL 30 MG TABLET	1	HSA*
LISINOPRIL 40 MG TABLET	1	HSA*
LISINOPRIL 5 MG TABLET	1	HSA*
LISINOPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
LISINOPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
LISINOPRIL-HCTZ 20-25 MG TAB	1	HSA*
LITE TOUCH 30G LANCETS	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LITE TOUCH 33G LANCETS	2	HSA*
LITEAIRE MDI CHAMBER	MD	
LITETOUCH MEDIUM MASK	MD	
LITHIUM 8 MEQ/5 ML SOLUTION	1	
LITHIUM CARBONATE 150 MG CAP	1	
LITHIUM CARBONATE 300 MG CAP	1	
LITHIUM CARBONATE 300 MG TAB	1	
LITHIUM CARBONATE 600 MG CAP	1	
LITHIUM CARBONATE ER 300 MG TB	1	
LITHIUM CARBONATE ER 450 MG TB	1	
LITHOBID ER 300 MG TABLET	3	
LITHOSTAT 250 MG TABLET	3	
LIVALO 1 MG TABLET	3	HSA*
LIVALO 2 MG TABLET	3	HSA*
LIVALO 4 MG TABLET	3	HSA*
LO LOESTRIN FE 1-10 TABLET	0	ACA*
LOCOID 0.1% CREAM	3	
LOCOID 0.1% LOTION	3	
LOCOID 0.1% OINTMENT	3	
LOCOID 0.1% SOLUTION	3	
LOCORT 11 DAY 1.5 MG TABLET	3	
LOCORT 7 DAY 1.5 MG TABLET	3	
LODINE 400 MG TABLET	3	
LODOSYN 25 MG TABLET	3	
LOESTRIN 21 1-20 TABLET	3	
LOESTRIN 21 1.5-30 TABLET	3	
LOESTRIN FE 1-20 TABLET	3	
LOESTRIN FE 1.5-30 TABLET	3	
LOFIBRA 134 MG CAPSULE	3	HSA*
LOFIBRA 160 MG TABLET	3	HSA*
LOFIBRA 200 MG CAPSULE	3	HSA*
LOFIBRA 54 MG TABLET	3	HSA*
LOFIBRA 67 MG CAPSULE	3	HSA*
LOMEDIA 24 FE 1 MG-20 MCG TAB	0	ACA*
LOMOTIL 2.5-0.025 MG TABLET	3	
LOMUSTINE 10 MG CAPSULE	1	CH*
LOMUSTINE 100 MG CAPSULE	1	CH*
LOMUSTINE 40 MG CAPSULE	1	CH*
LONGS THIN LANCETS 26G	2	HSA*
LONSURF 15 MG-6.14 MG TABLET	3	CH*; SPP*: CVS Specialty
LONSURF 20 MG-8.19 MG TABLET	3	CH*; SPP*: CVS Specialty
LOPERAMIDE 2 MG CAPSULE	1	
LOPID 600 MG TABLET	3	HSA*
LOPINAVIR-RITONAVIR 80-20MG/ML	2	
LOPREEZA 0.5 MG-0.1 MG TABLET	1	
LOPREEZA 1 MG-0.5 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LOPRESSOR 100 MG TABLET	3	HSA*
LOPRESSOR 50 MG TABLET	3	HSA*
LOPRESSOR HCT 50-25 TABLET	3	HSA*
LOPROX 0.77% CREAM	3	
LOPROX 0.77% GEL	3	
LOPROX 0.77% TOPICAL SUSP	3	
LOPROX 1% SHAMPOO	3	
LORAZEPAM 0.5 MG TABLET	1	
LORAZEPAM 1 MG TABLET	1	
LORAZEPAM 2 MG TABLET	1	
LORAZEPAM 2 MG/ML ORAL CONCENT	1	
LORCET 10-650 TABLET	3	
LORCET 5-325 MG TABLET	1	
LORCET HD 10-325 MG TABLET	1	
LORCET PLUS 7.5-325 MG TABLET	1	
LORCET PLUS TABLET	3	
LORENZA 4%-1% PATCH	3	
LORTAB 10 MG-300 MG/15 ML ELXR	3	
LORTAB 10-325 MG TABLET	3	
LORTAB 10-500 TABLET	3	
LORTAB 5-325 MG TABLET	3	
LORTAB 5-500 TABLET	3	
LORTAB 7.5-325 MG TABLET	3	
LORTAB 7.5-500 TABLET	3	
LORTUSS EX LIQUID	1	
LORYNA 3 MG-0.02 MG TABLET	0	ACA*
LORZONE 375 MG TABLET	3	
LORZONE 750 MG TABLET	3	
LOSARTAN POTASSIUM 100 MG TAB	1	HSA*
LOSARTAN POTASSIUM 25 MG TAB	1	HSA*
LOSARTAN POTASSIUM 50 MG TAB	1	HSA*
LOSARTAN-HCTZ 100-12.5 MG TAB	1	HSA*
LOSARTAN-HCTZ 100-25 MG TAB	1	HSA*
LOSARTAN-HCTZ 50-12.5 MG TAB	1	HSA*
LOSEASONIQUE TABLET	3	Max. 91 Days Supply;Max. 1 per day
LOTEMAX 0.5% EYE DROPS	2	
LOTEMAX 0.5% EYE OINTMENT	2	
LOTEMAX 0.5% OPHTHALMIC GEL	2	
LOTENSIN 20 MG TABLET	3	HSA*
LOTENSIN 40 MG TABLET	3	HSA*
LOTENSIN HCT 10-12.5 MG TABLET	3	HSA*
LOTENSIN HCT 20-12.5 MG TABLET	3	HSA*
LOTENSIN HCT 20-25 MG TABLET	3	HSA*
LOTREL 10-20 MG CAPSULE	3	HSA*
LOTREL 10-40 MG CAPSULE	3	HSA*
LOTREL 2.5-10 MG CAPSULE	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LOTREL 5-10 MG CAPSULE	3	HSA*
LOTREL 5-20 MG CAPSULE	3	HSA*
LOTREL 5-40 MG CAPSULE	3	HSA*
LOTRISONE CREAM	3	
LOTRONEX 0.5 MG TABLET	3	Covered for females only
LOTRONEX 1 MG TABLET	3	Covered for females only
LOVASTATIN 10 MG TABLET	0	ACA*
LOVASTATIN 20 MG TABLET	0	ACA*
LOVASTATIN 40 MG TABLET	0	ACA*
LOVAZA 1 GM CAPSULE	3	HSA*
LOVENOX 100 MG/ML SYRINGE	3	HSA*; SPP*: CVS Specialty
LOVENOX 120 MG/0.8 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
LOVENOX 150 MG/ML SYRINGE	3	HSA*; SPP*: CVS Specialty
LOVENOX 30 MG/0.3 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
LOVENOX 300 MG/3 ML VIAL	3	HSA*; SPP*: CVS Specialty
LOVENOX 40 MG/0.4 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
LOVENOX 60 MG/0.6 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
LOVENOX 80 MG/0.8 ML SYRINGE	3	HSA*; SPP*: CVS Specialty
LOW-OGESTREL-28 TABLET	0	ACA*
LOXAPINE 10 MG CAPSULE	1	
LOXAPINE 25 MG CAPSULE	1	
LOXAPINE 5 MG CAPSULE	1	
LOXAPINE 50 MG CAPSULE	1	
LOXITANE 5 MG CAPSULE	3	
LUER LOCK SYRINGE 30 ML	3	
LUER SLIP TIP SYR TRAY 1 ML	3	
LUER-LOCK SYRINGE 60 ML	3	
LUFYLLIN 200 MG TABLET	2	HSA*
LUFYLLIN-400 TABLET	3	HSA*
LUGOL'S STRONG IODINE SOLUTION	1	
LUMIGAN 0.01% EYE DROPS	2	
LUNESTA 1 MG TABLET	3	Step Therapy required STA*: 18 and older
LUNESTA 2 MG TABLET	3	Step Therapy required STA*: 18 and older
LUNESTA 3 MG TABLET	3	Step Therapy required STA*: 18 and older
LUPANETA PK 11.25-5 MG 3MO KIT	3	Max. 1 in 90 days
LUPANETA PK 3.75-5 MG 1MO KIT	3	Max. 1 in 30 days
LUPRON DEPOT 11.25 MG 3MO KIT	MD	Prior Authorization required;Max. 1 in 90 days SPP*: CVS Specialty
LUPRON DEPOT 22.5 MG 3MO KIT	MD	Prior Authorization required;Max. 1 in 84 days SPP*: CVS Specialty
LUPRON DEPOT 3.75 MG KIT	MD	Prior Authorization required;Max. 1 per 30 days SPP*: CVS Specialty
LUPRON DEPOT 45 MG 6MO KIT	MD	Prior Authorization required;Max. 1 in 168 days SPP*: CVS Specialty
LUPRON DEPOT 7.5 MG KIT	MD	Prior Authorization required;Max. 1 per 28 days SPP*: CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LUPRON DEPOT-4 MONTH KIT	MD	Prior Authorization required;Max. 1 in 112 days SPP*: CVS Specialty
LUPRON DEPOT-PED 11.25 MG KIT	MD	Prior Authorization required;Max. 1 per 30 days SPP*: CVS Specialty
LUPRON DEPOT-PED 15 MG KIT	MD	Prior Authorization required;Max. 1 per 30 days SPP*: CVS Specialty
LUPRON DEPOT-PED 30 MG 3MO KIT	MD	Prior Authorization required;Max. 1 in 84 days SPP*: CVS Specialty
LUPRON DEPOT-PED 7.5 MG KIT	MD	Prior Authorization required;Max. 1 per 30 days SPP*: CVS Specialty
LUTERA-28 TABLET	0	ACA*
LUVOX CR 100 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LUVOX CR 150 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LUXAMEND WOUND CREAM	3	
LUXIQ 0.12% FOAM	3	
LUZU 1% CREAM	3	
LYCELLE HEAD LICE REMOVAL KIT	3	
LYNPARZA 100 MG TABLET	3	CH*
LYNPARZA 150 MG TABLET	3	CH*
LYNPARZA 50 MG CAPSULE	3	CH*
LYRICA 100 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYRICA 150 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYRICA 20 MG/ML ORAL SOLUTION	3	Step Therapy required STA*: 18 and older
LYRICA 200 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYRICA 225 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYRICA 25 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYRICA 300 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYRICA 50 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYRICA 75 MG CAPSULE	3	Step Therapy required STA*: 18 and older
LYSIPLEX PLUS TABLET	3	
LYSODREN 500 MG TABLET	2	CH*
LYSTEDA 650 MG TABLET	3	Max. 30 in 30 days
LYZA 0.35 MG TABLET	0	ACA*

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MACROBID 100 MG CAPSULE	3	
MACRODANTIN 100 MG CAPSULE	3	
MACRODANTIN 25 MG CAPSULE	3	
MACRODANTIN 50 MG CAPSULE	3	
MAFENIDE ACETATE 50 GM POWD PK	1	
MAGELLAN TUBERCULIN SYR 1 ML	3	
MAGNACET 10 MG-400 MG TABLET	3	
MAGNACET 5 MG-400 MG TABLET	3	
MAGNACET 7.5 MG-400 MG TABLET	3	
MAGNEBIND 400 RX TABLET	1	
MAKENA 250 MG/ML VIAL	MD	Prior Authorization required;Max. 4 ML(s) per 28 days IVF*
MALARONE 250-100 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MALARONE 62.5-25 MG PED TAB	3	
MALATHION 0.5% LOTION	1	
MAPROTILINE 25 MG TABLET	1	
MAPROTILINE 50 MG TABLET	1	
MAPROTILINE 75 MG TABLET	1	
MARGESIC CAPSULE	1	
MARINOL 10 MG CAPSULE	3	
MARINOL 2.5 MG CAPSULE	3	
MARINOL 5 MG CAPSULE	3	
MARLISSA-28 TABLET	0	ACA*
MARPLAN 10 MG TABLET	3	
MARTEN-TAB 325-50 TABLET	1	
MATULANE 50 MG CAPSULE	2	CH*; LDD*: Walgreens Specialty (800) 424-9002
MATZIM LA 180 MG TABLET	1	HSA*
MATZIM LA 240 MG TABLET	1	HSA*
MATZIM LA 300 MG TABLET	1	HSA*
MATZIM LA 360 MG TABLET	1	HSA*
MATZIM LA 420 MG TABLET	1	HSA*
MAVIK 1 MG TABLET	3	HSA*
MAVIK 2 MG TABLET	3	HSA*
MAVIK 4 MG TABLET	3	HSA*
MAVYRET 100-40 MG TABLET	2	Prior Authorization required;Max. 84 per 28 days SPP*: Must use CVS Specialty
MAXAIR AUTOHALER 0.2 MG AERO	2	HSA*
MAXALT 10 MG TABLET	3	Max. quantity of 9 per fill;Step Therapy required MQC*: 9 tabs/copay
MAXALT 5 MG TABLET	3	Max. quantity of 18 per fill;Step Therapy required MQC*: 18 tabs/copay
MAXALT MLT 10 MG TABLET	3	Max. quantity of 9 per fill;Step Therapy required MQC*: 9 tabs/copay
MAXALT MLT 5 MG TABLET	3	Max. quantity of 18 per fill;Step Therapy required MQC*: 18 tabs/copay
MAXIDEX 0.1% EYE DROPS	3	
MAXIDONE 10-750 MG TABLET	3	
MAXIFLU CD TABLET	3	
MAXIFLU CDX TABLET	3	
MAXIMA TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
MAXITROL EYE DROPS	3	
MAXITROL EYE OINTMENT	3	
MAXZIDE 37.5 MG-25 MG TABLET	3	HSA*
MAXZIDE 75 MG-50 MG TABLET	3	HSA*
MB HYDROGEL KIT	1	
MECLIZINE 12.5 MG TABLET	1	
MECLIZINE 25 MG TABLET	1	
MECLOFENAMATE 100 MG CAPSULE	1	
MECLOFENAMATE 50 MG CAPSULE	1	
MEDI-LANCE LANCETS	2	HSA*
MEDLANCE PLUS 21G LANCETS	2	HSA*
MEDLANCE PLUS 30G LANCETS	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MEDLANCE PLUS LITE 25G LANCETS	2	HSA*
MEDLANCE PLUS SPECIAL BLADE	2	HSA*
MEDROL 16 MG TABLET	3	
MEDROL 2 MG TABLET	3	
MEDROL 32 MG TABLET	3	
MEDROL 4 MG DOSEPAK	3	
MEDROL 4 MG TABLET	3	
MEDROL 8 MG TABLET	3	
MEDROXYPROGESTERONE 10 MG TAB	1	
MEDROXYPROGESTERONE 150 MG/ML	0	Max. 90 Days Supply;Max. 1 ML(s) in 90 days ACA*
MEDROXYPROGESTERONE 150 MG/ML	0	Max. 90 Days Supply;Max. 1 ML(s) in 60 days
MEDROXYPROGESTERONE 2.5 MG TAB	1	
MEDROXYPROGESTERONE 5 MG TAB	1	
MEFENAMIC ACID 250 MG CAPSULE	1	
MEFLOQUINE HCL 250 MG TABLET	1	
MEGACE 40 MG/ML ORAL SUSP	3	CH*
MEGACE ES 625 MG/5 ML SUSP	3	CH*
MEGESTROL 20 MG TABLET	1	CH*
MEGESTROL 40 MG TABLET	1	CH*
MEGESTROL 625 MG/5 ML SUSP	1	CH*
MEGESTROL ACET 40 MG/ML SUSP	1	CH*
MEKINIST 0.5 MG TABLET	3	CH*; SPP*: CVS Specialty
MEKINIST 2 MG TABLET	3	CH*; SPP*: CVS Specialty
MELODETTA 24 FE CHEWABLE TAB	0	ACA*
MELOXICAM 15 MG TABLET	1	
MELOXICAM 7.5 MG TABLET	1	
MELOXICAM 7.5 MG/5 ML SUSP	1	
MELPHALAN 2 MG TABLET	2	CH*
MEMANTINE 5-10 MG TITRATION PK	1	
MEMANTINE HCL 10 MG TABLET	1	
MEMANTINE HCL 2 MG/ML SOLUTION	1	
MEMANTINE HCL 5 MG TABLET	1	
MENACTRA VIAL	MD	
MENEST 0.3 MG TABLET	2	
MENEST 0.625 MG TABLET	2	
MENEST 1.25 MG TABLET	2	
MENEST 2.5 MG TABLET	2	
MENOMUNE-A-C-Y-W-135 VIAL	MD	
MENOMUNE-A-C-Y-W-135 W-DILUENT	MD	
MENOPUR 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
MENOSTAR 14 MCG/DAY PATCH	3	
MENTAX 1% CREAM	2	
MEPERIDINE 100 MG TABLET	1	
MEPERIDINE 50 MG TABLET	1	
MEPERIDINE 50 MG/5 ML SOLUTION	1	
MEPERIDINE 550 MG/55 ML-NS SYR	1	
MEPHYTON 5 MG TABLET	2	HSA*
MEPROBAMATE 200 MG TABLET	1	
MEPROBAMATE 400 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MEPRON 750 MG/5 ML SUSPENSION	3	
MERCAPTOPURINE 50 MG TABLET	1	CH*
MESALAMINE 4 GM/60 ML ENEMA	1	
MESALAMINE 800 MG DR TABLET	2	
MESALAMINE DR 1.2 GM TABLET	2	
MESNEX 400 MG TABLET	3	
MESTINON 180 MG TIMESPAN	3	
MESTINON 60 MG TABLET	3	
MESTINON 60 MG/5 ML SYRUP	2	
METADATE CD 10 MG CAPSULE	3	Max. 60 Days Supply
METADATE CD 20 MG CAPSULE	3	Max. 60 Days Supply
METADATE CD 30 MG CAPSULE	3	Max. 60 Days Supply
METADATE CD 40 MG CAPSULE	3	Max. 60 Days Supply
METADATE CD 50 MG CAPSULE	3	Max. 60 Days Supply
METADATE CD 60 MG CAPSULE	3	Max. 60 Days Supply
METADATE ER 20 MG TABLET	1	Max. 60 Days Supply
METAPROTERENOL 10 MG TABLET	1	HSA*
METAPROTERENOL 10 MG/5 ML SYR	1	HSA*
METAPROTERENOL 20 MG TABLET	1	HSA*
METAXALL 800 MG TABLET	1	
METAXALONE 400 MG TABLET	1	
METAXALONE 800 MG TABLET	1	
METFORMIN ER 1,000 MG OSM-TAB	1	HSA*; (generic Fortamet)
METFORMIN HCL 1,000 MG TABLET	1	HSA*
METFORMIN HCL 500 MG TABLET	1	HSA*
METFORMIN HCL 850 MG TABLET	1	HSA*
METFORMIN HCL ER 1,000 MG TAB	2	Prior Authorization required HSA*; (generic Glumetza)
METFORMIN HCL ER 500 MG OSM-TB	1	HSA*; (generic Fortamet)
METFORMIN HCL ER 500 MG TABLET	1	HSA*
METFORMIN HCL ER 500 MG TABLET	2	Prior Authorization required HSA*; (generic Glumetza)
METFORMIN HCL ER 750 MG TABLET	1	HSA*
METHADONE 10 MG/5 ML SOLUTION	1	
METHADONE 10 MG/ML ORAL CONC	1	
METHADONE 5 MG/5 ML SOLUTION	1	
METHADONE HCL 10 MG TABLET	1	
METHADONE HCL 10 MG/ML VIAL	1	
METHADONE HCL 5 MG TABLET	1	
METHADOSE 10 MG/ML ORAL CONC	3	
METHADOSE 40 MG TABLET DISPR	1	
METHAMPHETAMINE 5 MG TABLET	1	Max. 60 Days Supply
METHAZOLAMIDE 25 MG TABLET	1	
METHAZOLAMIDE 50 MG TABLET	1	
METHENAMINE HIPP 1 GM TABLET	1	
METHENAMINE MD 1 GM TABLET	1	
METHENAMINE MD 500 MG TABLET	1	
METHERGINE 0.2 MG TABLET	3	
METHIMAZOLE 10 MG TABLET	1	
METHIMAZOLE 5 MG TABLET	1	
METHITEST 10 MG TABLET	3	Max. 30 Days Supply;Prior Authorization required
METHOCARBAMOL 500 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
METHOCARBAMOL 750 MG TABLET	1	
METHOTREXATE 1 GM VIAL	MD	
METHOTREXATE 1 GRAM/40 ML VIAL	MD	
METHOTREXATE 100 MG/4 ML VIAL	MD	
METHOTREXATE 2.5 MG TABLET	1	
METHOTREXATE 50 MG/2 ML VIAL	MD	
METHOXSALEN 10 MG CAPSULE	1	
METHSCOPOLAMINE BROM 2.5 MG TB	1	
METHSCOPOLAMINE BROM 5 MG TAB	1	
METHYCLOTHIAZIDE 5 MG TABLET	1	HSA*
METHYLDOPA 250 MG TABLET	1	HSA*
METHYLDOPA 500 MG TABLET	1	HSA*
METHYLDOPA-HCTZ 250-15 MG TAB	1	HSA*
METHYLDOPA-HCTZ 250-25 MG TAB	1	HSA*
METHYLERGONOVINE 0.2 MG TABLET	1	
METHYLIN 10 MG CHEWABLE TABLET	3	Max. 60 Days Supply
METHYLIN 10 MG/5 ML SOLUTION	3	Max. 60 Days Supply
METHYLIN 2.5 MG CHEWABLE TAB	3	Max. 60 Days Supply
METHYLIN 5 MG CHEWABLE TABLET	3	Max. 60 Days Supply
METHYLIN 5 MG/5 ML SOLUTION	3	Max. 60 Days Supply
METHYLPHENIDATE 10 MG CHEW TAB	1	Max. 60 Days Supply
METHYLPHENIDATE 10 MG TABLET	1	Max. 60 Days Supply
METHYLPHENIDATE 10 MG/5 ML SOL	1	Max. 60 Days Supply
METHYLPHENIDATE 2.5 MG CHEW TB	1	Max. 60 Days Supply
METHYLPHENIDATE 20 MG TABLET	1	Max. 60 Days Supply
METHYLPHENIDATE 5 MG CHEW TAB	1	Max. 60 Days Supply
METHYLPHENIDATE 5 MG TABLET	1	Max. 60 Days Supply
METHYLPHENIDATE 5 MG/5 ML SOLN	1	Max. 60 Days Supply
METHYLPHENIDATE CD 10 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 20 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 40 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 50 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 60 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE ER 10 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 18 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 20 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE ER 20 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 27 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 36 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 40 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE ER 54 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE LA 30 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE LA 60 MG CAP	1	Max. 60 Days Supply
METHYLPREDNISOLONE 16 MG TAB	1	
METHYLPREDNISOLONE 32 MG TAB	1	
METHYLPREDNISOLONE 4 MG DOSEPK	1	
METHYLPREDNISOLONE 4 MG TABLET	1	
METHYLPREDNISOLONE 8 MG TAB	1	
METHYLTESTOSTERONE 10 MG CAP	1	Max. 30 Days Supply;Prior Authorization required
METIPRANOLOL 0.3% EYE DROPS	1	
METOCLOPRAMIDE 10 MG TABLET	1	
METOCLOPRAMIDE 5 MG TABLET	1	
METOCLOPRAMIDE 5 MG/5 ML SOLN	1	
METOCLOPRAMIDE HCL 10 MG ODT	1	
METOCLOPRAMIDE HCL 5 MG ODT	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
METOLAZONE 10 MG TABLET	1	HSA*
METOLAZONE 2.5 MG TABLET	1	HSA*
METOLAZONE 5 MG TABLET	1	HSA*
METOPIRONE 250 MG CAPSULE	3	
METOPROLOL ER-HCTZ 100-12.5 MG	2	HSA*
METOPROLOL ER-HCTZ 25-12.5 MG	2	HSA*
METOPROLOL ER-HCTZ 50-12.5 MG	2	HSA*
METOPROLOL SUCC ER 100 MG TAB	1	HSA*
METOPROLOL SUCC ER 200 MG TAB	1	HSA*
METOPROLOL SUCC ER 25 MG TAB	1	HSA*
METOPROLOL SUCC ER 50 MG TAB	1	HSA*
METOPROLOL TARTRATE 100 MG TAB	1	HSA*
METOPROLOL TARTRATE 25 MG TAB	1	HSA*
METOPROLOL TARTRATE 37.5 MG TB	1	HSA*
METOPROLOL TARTRATE 50 MG TAB	1	HSA*
METOPROLOL TARTRATE 75 MG TAB	1	HSA*
METOPROLOL-HCTZ 100-25 MG TAB	1	HSA*
METOPROLOL-HCTZ 100-50 MG TAB	1	HSA*
METOPROLOL-HCTZ 50-25 MG TAB	1	HSA*
METOZOLV ODT 5 MG TABLET	3	
METROCREAM 0.75% CREAM	3	
METROGEL TOPICAL 1% GEL	3	
METROGEL-VAGINAL 0.75% GEL	3	
METROLOTION TOPICAL 0.75%	3	
METRONIDAZOLE 0.75% CREAM	1	
METRONIDAZOLE 0.75% LOTION	1	
METRONIDAZOLE 250 MG TABLET	1	
METRONIDAZOLE 375 MG CAPSULE	1	
METRONIDAZOLE 500 MG TABLET	1	
METRONIDAZOLE TOPICAL 0.75% GL	1	
METRONIDAZOLE TOPICAL 1% GEL	1	
METRONIDAZOLE VAGINAL 0.75% GL	1	
MEVACOR 20 MG TABLET	3	HSA*
MEVACOR 40 MG TABLET	3	HSA*
MEXILETINE 150 MG CAPSULE	1	
MEXILETINE 200 MG CAPSULE	1	
MEXILETINE 250 MG CAPSULE	1	
MIACALCIN 200 UNIT NASAL SPRAY	3	HSA*
MIBELAS 24 FE CHEWABLE TABLET	0	ACA*
MICARDIS 20 MG TABLET	3	HSA*
MICARDIS 40 MG TABLET	3	HSA*
MICARDIS 80 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MICARDIS HCT 40-12.5 MG TABLET	3	HSA*
MICARDIS HCT 80-12.5 MG TABLET	3	HSA*
MICARDIS HCT 80-25 MG TABLET	3	HSA*
MICONAZOLE 3 200 MG VAG SUPP	1	
MICORT HC 2.5% CREAM	3	
MICRHOGAM ULTRA-FILTD PLUS SYR	MD	SPP*: Must use CVS Specialty
MICRO THIN 33G LANCETS	2	HSA*
MICROCHAMBER	MD	
MICROCRYSTAL CELLULOSE POWDER	3	
MICROCYN SKIN-WOUND CARE SPRAY	3	
MICROCYN SKIN-WOUND HYDROGEL	3	
MICRODOT TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
MICRODOT XTRA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
MICROGESTIN 21 1-20 TABLET	0	ACA*
MICROGESTIN 21 1.5-30 TAB	0	ACA*
MICROGESTIN 24 FE 1 MG-20 MCG	0	ACA*
MICROGESTIN FE 1-20 TABLET	0	ACA*
MICROGESTIN FE 1.5-30 TAB	0	ACA*
MICROLET LANCETS	2	HSA*
MICROLIFE PEAK FLOW METER	MD	
MICROSPACER FOR AEROSOL DEVICE	MD	
MICROZIDE 12.5 MG CAPSULE	3	HSA*
MIDAZOLAM HCL 2 MG/ML SYRUP	1	
MIDODRINE HCL 10 MG TABLET	1	HSA*
MIDODRINE HCL 2.5 MG TABLET	1	HSA*
MIDODRINE HCL 5 MG TABLET	1	HSA*
MIFEPREX 200 MG TABLET	3	
MIGERGOT SUPPOSITORY	3	
MIGLITOL 100 MG TABLET	1	HSA*
MIGLITOL 25 MG TABLET	1	HSA*
MIGLITOL 50 MG TABLET	1	HSA*
MIGRANAL NASAL SPRAY	3	
MILLIPRED 10 MG/5 ML SOLUTION	3	
MILLIPRED 5 MG TABLET	3	
MILLIPRED DP 5 MG 12-DAY PACK	3	
MILLIPRED DP 5 MG 6-DAY PACK	3	
MIMVEY 1-0.5 MG TABLET	1	
MIMVEY LO 0.5-0.1 MG TABLET	1	
MINASTRIN 24 FE CHEWABLE TAB	3	
MINI WRIGHT PEAK FLOW METER	MD	
MINIMED INFUSION SET	MD	
MINIMED RESERVOIR 3 ML	MD	
MINIPRESS 1 MG CAPSULE	3	HSA*
MINIPRESS 2 MG CAPSULE	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MINIPRESS 5 MG CAPSULE	3	HSA*
MINIPRIN EC 81 MG TABLET	0	ACA*
MINITRAN 0.1 MG/HR PATCH	1	HSA*
MINITRAN 0.2 MG/HR PATCH	1	HSA*
MINITRAN 0.4 MG/HR PATCH	1	HSA*
MINITRAN 0.6 MG/HR PATCH	1	HSA*
MINIVELLE 0.025 MG PATCH	3	
MINIVELLE 0.0375 MG PATCH	3	
MINIVELLE 0.05 MG PATCH	3	
MINIVELLE 0.075 MG PATCH	3	
MINIVELLE 0.1 MG PATCH	3	
MINOCIN 100 MG PELLETIZED CAP	3	
MINOCIN 50 MG PELLETIZED CAP	3	
MINOCIN 75 MG PELLETIZED CAP	3	
MINOCIN KIT 100 MG COMBO	3	
MINOCIN KIT 50 MG COMBO	3	
MINOCYCLINE 100 MG CAPSULE	1	
MINOCYCLINE 50 MG CAPSULE	1	
MINOCYCLINE 75 MG CAPSULE	1	
MINOCYCLINE ER 135 MG TABLET	1	Prior Authorization required
MINOCYCLINE ER 45 MG TABLET	1	Prior Authorization required
MINOCYCLINE ER 90 MG TABLET	1	Prior Authorization required
MINOCYCLINE HCL 100 MG TABLET	1	
MINOCYCLINE HCL 50 MG TABLET	1	
MINOCYCLINE HCL 75 MG TABLET	1	
MINOXIDIL 10 MG TABLET	1	HSA*
MINOXIDIL 2.5 MG TABLET	1	HSA*
MIRAPEX 0.125 MG TABLET	3	
MIRAPEX 0.25 MG TABLET	3	
MIRAPEX 0.5 MG TABLET	3	
MIRAPEX 0.75 MG TABLET	3	
MIRAPEX 1 MG TABLET	3	
MIRAPEX 1.5 MG TABLET	3	
MIRAPEX ER 0.375 MG TABLET	3	
MIRAPEX ER 0.75 MG TABLET	3	
MIRAPEX ER 1.5 MG TABLET	3	
MIRAPEX ER 2.25 MG TABLET	3	
MIRAPEX ER 3 MG TABLET	3	
MIRAPEX ER 3.75 MG TABLET	3	
MIRAPEX ER 4.5 MG TABLET	3	
MIRCERA 100 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 150 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 200 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 30 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 50 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 75 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCETTE 28 DAY TABLET	3	
MIRTAZAPINE 15 MG ODT	1	
MIRTAZAPINE 15 MG TABLET	1	
MIRTAZAPINE 30 MG ODT	1	
MIRTAZAPINE 30 MG TABLET	1	
MIRTAZAPINE 45 MG ODT	1	
MIRTAZAPINE 45 MG TABLET	1	
MIRTAZAPINE 7.5 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MIRVASO 0.33% GEL PUMP	3	
MISOPROSTOL 100 MCG TABLET	1	
MISOPROSTOL 200 MCG TABLET	1	
MISTASSIST IFCD	MD	
MITIGARE 0.6 MG CAPSULE	3	
MOBIC 15 MG TABLET	3	
MOBIC 7.5 MG TABLET	3	
MOBIC 7.5 MG/5 ML SUSPENSION	3	
MODAFINIL 100 MG TABLET	2	Prior Authorization required;Max. 1 per day
MODAFINIL 200 MG TABLET	2	Prior Authorization required;Max. 1 per day
MODERIBA 200 MG TABLET	3	SPP*: Must use CVS Specialty
MODERIBA 200-400 MG DOSEPACK	3	SPP*: Must use CVS Specialty
MODERIBA 400-400 MG DOSEPACK	3	SPP*: Must use CVS Specialty
MODERIBA 600-400 MG DOSEPACK	3	SPP*: Must use CVS Specialty
MODERIBA 600-600 MG DOSEPACK	3	SPP*: Must use CVS Specialty
MODICON 28 TABLET	3	
MOEXIPRIL HCL 15 MG TABLET	1	HSA*
MOEXIPRIL HCL 7.5 MG TABLET	1	HSA*
MOEXIPRIL-HCTZ 15-12.5 MG TAB	1	HSA*
MOEXIPRIL-HCTZ 15-25 MG TABLET	1	HSA*
MOEXIPRIL-HCTZ 7.5-12.5 MG TAB	1	HSA*
MOLINDONE HCL 10 MG TABLET	1	
MOLINDONE HCL 25 MG TABLET	1	
MOLINDONE HCL 5 MG TABLET	1	
MOMETASONE FUROATE 0.1% CREAM	1	
MOMETASONE FUROATE 0.1% OINT	1	
MOMETASONE FUROATE 0.1% SOLN	1	
MOMETASONE FUROATE 50 MCG SPRY	1	
MOMEXIN COMBO PACK	3	
MONAGHAN Z STAT CHAMBER-MD MSK	MD	
MONDOXYNE NL 100 MG CAPSULE	3	
MONDOXYNE NL 50 MG CAPSULE	3	
MONDOXYNE NL 75 MG CAPSULE	3	
MONO-LINYAH 28 TABLET	0	ACA*
MONOCLATE-P 1,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
MONODOX 100 MG CAPSULE	3	
MONODOX 50 MG CAPSULE	3	
MONODOX 75 MG CAPSULE	3	
MONOJECT 1 ML SYRN 28GX1/2"	2	HSA*
MONOJECT 12 ML SYRINGE 18GX1"	3	
MONOJECT 12 ML SYRN 20GX1.25	3	
MONOJECT 12 ML SYRN 21GX1"	3	
MONOJECT 12 ML SYRN 21GX1.5"	3	
MONOJECT 3 ML SYRINGE	3	
MONOJECT 3 ML SYRINGE 21GX1"	3	
MONOJECT 3 ML SYRINGE 23GX1"	3	
MONOJECT 3 ML SYRINGE 25GX1"	3	
MONOJECT 3 ML SYRN 21GX1-1/2"	3	
MONOJECT 3 ML SYRN 22GX1-1/2"	3	
MONOJECT 3 ML SYRN 25GX1"	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MONOJECT 3 ML SYRN 25GX1.25"	3	
MONOJECT 3 ML SYRN 25GX5/8"	3	
MONOJECT 3 ML SYRN 27GX1.25"	3	
MONOJECT 6 ML SYRN 20GX11/2"	3	
MONOJECT 6 ML SYRN 21GX1"	3	
MONOJECT 6 ML SYRN 21GX11/2"	3	
MONOJECT 6 ML SYRN 22GX11/2"	3	
MONOJECT 6CC SAFETY SYRINGE	3	
MONOJECT CONTROL SYRINGE 12ML	3	
MONOJECT DISP SYRINGE 20 ML	3	
MONOJECT HYPO NEEDLE 19X1	3	
MONOJECT HYPO NEEDLE 19X1-1/2	3	
MONOJECT HYPO NEEDLE 20X1	3	
MONOJECT HYPO NEEDLE 20X1-1/2	3	
MONOJECT HYPO NEEDLE 21X1	3	
MONOJECT HYPO NEEDLE 21X1-1/2	3	
MONOJECT HYPO NEEDLE 22X1	3	
MONOJECT HYPO NEEDLE 22X1.5	3	
MONOJECT HYPO NEEDLE 23X0.5	3	
MONOJECT HYPO NEEDLE 23X1	3	
MONOJECT HYPO NEEDLE 25X1	3	
MONOJECT HYPO NEEDLE 25X1.5	3	
MONOJECT HYPO NEEDLE 25X5/8	3	
MONOJECT HYPO NEEDLE 26X1.5	3	
MONOJECT HYPO NEEDLE 27X0.5	3	
MONOJECT HYPO NEEDLE 30X3/4	3	
MONOJECT LUER LOCK TB SYR 1 ML	3	
MONOJECT MAGELLAN SYRINGE	3	
MONOJECT MAGELLAN SYRINGE 1 ML	3	
MONOJECT MAGELLAN SYRINGE 3 ML	3	
MONOJECT MEGELLAN TB SYR 1 ML	3	
MONOJECT PHARMACY TRAY	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SMARTIP CANNULA 12 ML	3	
MONOJECT SMARTIP CANNULA 3 ML	3	
MONOJECT SMARTIP CANNULA 6 ML	3	
MONOJECT SYR PHARM TRAY PK	3	
MONOJECT SYR PHARM TRAY PK	3	
MONOJECT SYRINGE 1 ML	2	HSA*
MONOJECT SYRINGE 12 ML	3	
MONOJECT SYRINGE 140 ML	3	
MONOJECT SYRINGE 3 ML	3	
MONOJECT SYRINGE 3 ML 20GX1	3	
MONOJECT SYRINGE 3 ML 22GX1"	3	
MONOJECT SYRINGE 35 ML	3	
MONOJECT SYRINGE 6 ML	3	
MONOJECT SYRINGE 60 ML	3	
MONOJECT SYRN 3 ML 20GX1-1/2"	3	
MONOJECT SYRN 3 ML 20GX3/4"	3	
MONOJECT TB 1 ML SYRN 26X3/8"	3	
MONOJECT TB 1 ML SYRN 28GX1/2	3	
MONOJECT TB SAFETY SYRINGE	3	
MONOJECT TB SYRN 25GX5/8"	3	
MONOJECT TB SYRN 27GX1/2"	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MONOJECT TUBERCULIN SYR 1 ML	3	
MONOLET 21G LANCETS	2	HSA*
MONOLET THIN 28G LANCETS	2	HSA*
MONONESSA 28 TABLET	0	ACA*
MONONINE 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
MONTELUKAST SOD 10 MG TABLET	1	HSA*
MONTELUKAST SOD 4 MG GRANULES	1	HSA*
MONTELUKAST SOD 4 MG TAB CHEW	1	HSA*
MONTELUKAST SOD 5 MG TAB CHEW	1	HSA*
MONUROL 3 GM SACHET	3	
MORGIDOX 100 MG CAPSULE	3	
MORGIDOX 1X100 MG KIT	3	
MORGIDOX 50 MG CAPSULE	3	
MORPHABOND ER 100 MG TABLET	2	Max. 2 per day
MORPHABOND ER 15 MG TABLET	2	Max. 2 per day
MORPHABOND ER 30 MG TABLET	2	Max. 2 per day
MORPHABOND ER 60 MG TABLET	2	Max. 2 per day
MORPHINE 100MG/100ML-0.9% NACL	1	
MORPHINE 50 MG/50 ML-0.9% NACL	1	
MORPHINE SULF 10 MG SUPPOS	1	
MORPHINE SULF 10 MG/5 ML SOLN	1	
MORPHINE SULF 100 MG/5 ML SOLN	1	
MORPHINE SULF 20 MG SUPPOS	1	
MORPHINE SULF 20 MG/5 ML SOLN	1	
MORPHINE SULF 30 MG SUPPOS	1	
MORPHINE SULF 5 MG SUPPOS	1	
MORPHINE SULF ER 100 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 15 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 200 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 30 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 60 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULFATE ER 10 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 100 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 120 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 20 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 30 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 45 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 50 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 60 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 75 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 80 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 90 MG CAP	1	Max. 2 per day
MORPHINE SULFATE IR 15 MG TAB	2	
MORPHINE SULFATE IR 30 MG TAB	2	
MOTOFEN 1-0.025 MG TABLET	3	
MOVANTIK 12.5 MG TABLET	2	
MOVANTIK 25 MG TABLET	2	
MOVIPREP POWDER PACKET	2	
MOXATAG ER 775 MG TABLET	3	
MOXEZA 0.5% EYE DROPS	3	
MOXIFLOXACIN 0.5% EYE DROPS	2	
MOXIFLOXACIN HCL 400 MG TABLET	1	
MS CONTIN 100 MG TABLET	3	Max. 90 per 30 days
MS CONTIN 15 MG TABLET	3	Max. 90 per 30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MS CONTIN 200 MG TABLET	3	Max. 90 per 30 days
MS CONTIN 30 MG TABLET	3	Max. 90 per 30 days
MS CONTIN 60 MG TABLET	3	Max. 90 per 30 days
MUGARD ORAL WOUND RINSE	2	
MULTAQ 400 MG TABLET	2	
MULTICHEW CHEWABLE TABLET	3	
MULTISTIX 10 SG REAGENT STRIPS	2	
MULTISTIX 5 STRIPS	2	
MULTISTIX 7 REAGENT STRIPS	2	
MULTISTIX 8 SG REAGENT STRIPS	2	
MULTISTIX 9 REAGENT STRIPS	2	
MULTISTIX 9 SG REAGENT STRIPS	2	
MULTISTIX REAGENT STRIPS	2	
MULTIVITAMINS CHEWABLES TABLET	1	
MULTIVITAMINS PEDIATRIC DROPS	1	
MUPIROCIN 2% CREAM	1	
MUPIROCIN 2% OINTMENT	1	
MUSE 1,000 MCG URETHRAL SUPP	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
MUSE 125 MCG URETHRAL SUPPOS	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
MUSE 250 MCG URETHRAL SUPPOS	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
MUSE 500 MCG URETHRAL SUPPOS	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
MY WAY 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
MYALEPT 11.3 MG (5 MG/ML) VIAL	3	LDD*: Accredo (866) 815-4717
MYAMBUTOL 400 MG TABLET	3	
MYCOBUTIN 150 MG CAPSULE	3	
MYCOPHENOLATE 200 MG/ML SUSP	1	
MYCOPHENOLATE 250 MG CAPSULE	1	
MYCOPHENOLATE 500 MG TABLET	1	
MYCOPHENOLIC ACID DR 180 MG TB	1	
MYCOPHENOLIC ACID DR 360 MG TB	1	
MYDAYIS ER 12.5 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDAYIS ER 25 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDAYIS ER 37.5 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDAYIS ER 50 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDFRIN 2.5% EYE DROPS	3	
MYDRIACYL 1% EYE DROPS	3	
MYFERON-150 FORTE CAPSULE	1	
MYFORTIC 180 MG TABLET	3	
MYFORTIC 360 MG TABLET	3	
MYGLUCOHEALTH 30G LANCETS	2	HSA*
MYGLUCOHEALTH TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
MYLERAN 2 MG TABLET	2	CH*
MYNEPHROCAPS SOFTGEL	1	
MYNEPHRON CAPSULE	2	
MYOBLOC 10,000 UNITS/2 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
MYOBLOC 2,500 UNIT/0.5 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MYOBLOC 5,000 UNITS/1 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
MYORISAN 10 MG CAPSULE	1	
MYORISAN 20 MG CAPSULE	1	
MYORISAN 30 MG CAPSULE	1	
MYORISAN 40 MG CAPSULE	1	
MYRBETRIQ ER 25 MG TABLET	2	
MYRBETRIQ ER 50 MG TABLET	2	
MYSOLINE 250 MG TABLET	3	
MYSOLINE 50 MG TABLET	3	
MYTESI 125 MG DR TABLET	3	Step Therapy required
MYZILRA-28 TABLET	0	ACA*

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NABUMETONE 500 MG TABLET	1	
NABUMETONE 750 MG TABLET	1	
NADOLOL 20 MG TABLET	1	HSA*
NADOLOL 40 MG TABLET	1	HSA*
NADOLOL 80 MG TABLET	1	HSA*
NADOLOL-BENDROFLU 40-5 MG TAB	1	HSA*
NADOLOL-BENDROFLU 80-5 MG TAB	1	HSA*
NAFRINSE DAILY-NEUTRAL RINSE	2	
NAFTIFINE HCL 1% CREAM	1	
NAFTIFINE HCL 2% CREAM	1	
NAFTIN 1% CREAM	3	
NAFTIN 1% GEL	2	
NAFTIN 2% CREAM	3	
NAFTIN 2% GEL	2	
NALFON 400 MG CAPSULE	3	
NALOXONE 0.4 MG/ML CARPUJECT	MD	Max. 2 ML(s) per 15 days $0 copayment
NALOXONE 0.4 MG/ML VIAL	MD	Max. 2 ML(s) per 15 days $0 copayment
NALOXONE 2 MG/2 ML SYRINGE	MD	Max. 2 ML(s) per 15 days $0 copayment
NALTREXONE 50 MG TABLET	1	
NAMENDA 10 MG TABLET	3	
NAMENDA 2 MG/ML SOLUTION	3	
NAMENDA 5 MG TABLET	3	
NAMENDA 5-10 MG TITRATION PK	3	
NAMENDA XR 14 MG CAPSULE	3	
NAMENDA XR 21 MG CAPSULE	3	
NAMENDA XR 28 MG CAPSULE	3	
NAMENDA XR 7 MG CAPSULE	3	
NAMENDA XR TITRATION PACK	3	
NAMZARIC 14 MG-10 MG CAPSULE	3	
NAMZARIC 21 MG-10 MG CAPSULE	3	
NAMZARIC 28 MG-10 MG CAPSULE	3	
NAMZARIC 7 MG-10 MG CAPSULE	3	
NAMZARIC TITRATION PACK	3	
NAPHAZOLINE 0.1% EYE DROPS	1	
NAPRELAN CR 375 MG TABLET	3	
NAPRELAN CR 500 MG TABLET	3	
NAPRELAN CR 750 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NAPROSYN 125 MG/5 ML SUSPEN	3	
NAPROSYN 250 MG TABLET	3	
NAPROSYN 375 MG TABLET	3	
NAPROSYN 500 MG TABLET	3	
NAPROXEN 125 MG/5 ML SUSPEN	1	
NAPROXEN 250 MG TABLET	1	
NAPROXEN 375 MG TABLET	1	
NAPROXEN 500 MG TABLET	1	
NAPROXEN DR 375 MG TABLET	1	
NAPROXEN DR 500 MG TABLET	1	
NAPROXEN SOD CR 375 MG TABLET	1	
NAPROXEN SOD CR 500 MG TABLET	1	
NAPROXEN SODIUM 275 MG TAB	1	
NAPROXEN SODIUM 550 MG TAB	1	
NARATRIPTAN HCL 1 MG TABLET	1	Max. quantity of 15 per fill MQC*: 15 tabs/copay
NARATRIPTAN HCL 2.5 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
NARCAN 4 MG NASAL SPRAY	MD	Max. 2 per 15 days $0 copayment
NARDIL 15 MG TABLET	3	
NASACORT AQ NASAL SPRAY	3	
NASCOBAL 500 MCG NASAL SPRAY	3	
NASONEX 50 MCG NASAL SPRAY	3	
NATACYN EYE DROPS	2	
NATAZIA 28 TABLET	0	ACA*
NATEGLINIDE 120 MG TABLET	1	HSA*
NATEGLINIDE 60 MG TABLET	1	HSA*
NATESTO NASAL 5.5 MG/0.122 GM	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older
NATPARA 100 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATPARA 25 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATPARA 50 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATPARA 75 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATROBA 0.9% TOPICAL SUSP	3	
NATURE-THROID 113.75 MG TABLET	1	
NATURE-THROID 130 MG TABLET	1	
NATURE-THROID 146.25 MG TABLET	1	
NATURE-THROID 16.25 MG TABLET	1	
NATURE-THROID 162.5 MG TABLET	1	
NATURE-THROID 195 MG TABLET	1	
NATURE-THROID 260 MG TABLET	1	
NATURE-THROID 32.5 MG TABLET	1	
NATURE-THROID 325 MG TABLET	1	
NATURE-THROID 48.75 MG TABLET	1	
NATURE-THROID 65 MG TABLET	1	
NATURE-THROID 81.25 MG TABLET	1	
NATURE-THROID 97.5 MG TABLET	1	
NEBUPENT 300 MG INHAL POWDER	2	
NEBUSAL 3% VIAL	1	
NEBUSAL 6% VIAL	3	
NECON 0.5-35-28 TABLET	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NECON 1-35-28 TABLET	0	ACA*
NECON 1-50-28 TABLET	0	ACA*
NECON 10-11-28 TABLET	0	ACA*
NECON 7-7-7-28 TABLET	0	ACA*
NEFAZODONE HCL 100 MG TABLET	1	
NEFAZODONE HCL 150 MG TABLET	1	
NEFAZODONE HCL 200 MG TABLET	1	
NEFAZODONE HCL 250 MG TABLET	1	
NEFAZODONE HCL 50 MG TABLET	1	
NEO-BACIT-POLY-HC EYE OINTMENT	1	
NEO-POLYCIN EYE OINTMENT	1	
NEO-POLYCIN HC EYE OINTMENT	1	
NEO-SYNALAR 0.5%-0.025% CREAM	3	
NEO-SYNALAR 0.5-0.025% CRM KIT	3	
NEOMYC-BACIT-POLYMIX EYE OINT	1	
NEOMYC-POLYM-DEXAMET EYE OINTM	1	
NEOMYC-POLYM-DEXAMETH EYE DROP	1	
NEOMYC-POLYM-GRAMICID EYE DROP	1	
NEOMYCIN 500 MG TABLET	1	
NEOMYCIN-POLY-HC EYE DROPS	1	
NEOMYCIN-POLYMYXIN-HC EAR SOLN	1	
NEOMYCIN-POLYMYXIN-HC EAR SUSP	1	
NEORAL 100 MG GELATIN CAPSULE	3	
NEORAL 100 MG/ML SOLUTION	3	
NEORAL 25 MG GELATIN CAPSULE	3	
NEOSALUS CP CREAM	3	
NEOSALUS CREAM	3	
NEOSALUS FOAM	3	
NEOSALUS LOTION	3	
NEOSPORIN EYE DROPS	3	
NEPHRO-VITE RX TABLET	1	
NEPHROCAPS QT TABLET	3	
NEPHROCAPS SOFTGEL	1	
NEPHRON FA TABLET	1	
NEPTAZANE 25 MG TABLET	3	
NEPTAZANE 50 MG TABLET	3	
NERLYNX 40 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
NESINA 12.5 MG TABLET	3	Step Therapy required HSA*
NESINA 25 MG TABLET	3	Step Therapy required HSA*
NESINA 6.25 MG TABLET	3	Step Therapy required HSA*
NESSI SPACER	MD	
NEUAC 1.2-5% KIT	3	
NEUAC GEL	1	
NEULASTA 6 MG/0.6 ML SYRINGE	2	Prior Authorization required;Max. 1.2 ML(s) per 28 days SPP*: CVS Specialty
NEULASTA ONPRO 6 MG/0.6 ML KIT	2	Prior Authorization required;Max. 1.2 ML(s) per 28 days SPP*: CVS Specialty
NEUMEGA 5 MG VIAL	2	SPP*: Must use CVS Specialty
NEUPOGEN 300 MCG/0.5 ML SYR	2	Prior Authorization required SPP*: CVS Specialty
NEUPOGEN 300 MCG/ML VIAL	2	Prior Authorization required SPP*: CVS Specialty
NEUPOGEN 480 MCG/0.8 ML SYR	3	Prior Authorization required SPP*: CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NEUPOGEN 480 MCG/1.6 ML VIAL	2	Prior Authorization required SPP*: CVS Specialty
NEUPRO 1 MG/24 HR PATCH	3	
NEUPRO 2 MG/24 HR PATCH	3	
NEUPRO 3 MG/24 HR PATCH	3	
NEUPRO 4 MG/24 HR PATCH	3	
NEUPRO 6 MG/24 HR PATCH	3	
NEUPRO 8 MG/24 HR PATCH	3	
NEURIN-SL TABLET SL	1	
NEURONTIN 100 MG CAPSULE	3	
NEURONTIN 250 MG/5 ML SOLN	3	
NEURONTIN 300 MG CAPSULE	3	
NEURONTIN 400 MG CAPSULE	3	
NEURONTIN 600 MG TABLET	3	
NEURONTIN 800 MG TABLET	3	
NEUTEK 2TEK TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
NEUTRAL SODIUM FLUORIDE	1	ACA*: Children through age 5; HSA
NEUTRASAL 538 MG POWDER PACKET	3	
NEUTRASAL POWDER PACKET	3	
NEVANAC 0.1% DROPTAINER	3	
NEVIRAPINE 200 MG TABLET	1	
NEVIRAPINE 50 MG/5 ML SUSP	1	
NEVIRAPINE ER 100 MG TABLET	1	
NEVIRAPINE ER 400 MG TABLET	1	
NEXAVAR 200 MG TABLET	3	CH*; SPP*: CVS Specialty
NEXIUM 24HR 20 MG CAPSULE	1	
NEXIUM 24HR 20 MG TABLET	1	
NEXIUM DR 10 MG PACKET	2	
NEXIUM DR 2.5 MG PACKET	2	
NEXIUM DR 20 MG CAPSULE	3	Prior Authorization required
NEXIUM DR 20 MG PACKET	2	
NEXIUM DR 40 MG CAPSULE	3	Prior Authorization required
NEXIUM DR 40 MG PACKET	2	
NEXIUM DR 5 MG PACKET	2	
NEXPLANON 68 MG IMPLANT	MD	SPP*: Must use CVS Specialty
NEXT CHOICE ONE DOSE 1.5 MG TB	0	Max. quantity of 1 per fill ACA*
NIACIN ER 1,000 MG TABLET	1	HSA*
NIACIN ER 500 MG TABLET	1	HSA*
NIACIN ER 750 MG TABLET	1	HSA*
NIACOR 500 MG TABLET	1	HSA*
NIASPAN ER 1,000 MG TABLET	3	HSA*
NIASPAN ER 500 MG TABLET	3	HSA*
NIASPAN ER 750 MG TABLET	3	HSA*
NICARDIPINE 20 MG CAPSULE	1	HSA*
NICARDIPINE 30 MG CAPSULE	1	HSA*
NICODERM CQ 14 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICODERM CQ 21 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICODERM CQ 7 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NICORELIEF 2 MG GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICORELIEF 4 MG GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICORETTE 2 MG CHEWING GUM	3	Max. 180 Days Supply;Max. 480 in 30 days
NICORETTE 2 MG MINI LOZENGE	3	Max. 180 Days Supply;Max. 480 in 30 days
NICORETTE 4 MG CHEWING GUM	3	Max. 180 Days Supply;Max. 480 in 30 days
NICORETTE 4 MG MINI LOZENGE	3	Max. 180 Days Supply;Max. 480 in 30 days
NICOTINE 14 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE 2 MG CHEWING GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 2 MG LOZENGE	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 21 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE 22 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE 4 MG CHEWING GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 4 MG LOZENGE	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 7 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE TRANSDERMAL SYSTEM	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTROL CARTRIDGE INHALER	0	Max. 180 Days Supply;Max. quantity of 168 per fill ACA*
NICOTROL NS 10 MG/ML SPRAY	0	Max. 180 Days Supply;Max. quantity of 40 per fill;Max. 180 ML(s) in 365 days ACA*; Max 4 units/fill; Limit 180 days supply per year
NIFEDICAL XL 30 MG TABLET	1	HSA*
NIFEDICAL XL 60 MG TABLET	1	HSA*
NIFEDIPINE 10 MG CAPSULE	1	HSA*
NIFEDIPINE 20 MG CAPSULE	1	HSA*
NIFEDIPINE ER 30 MG TABLET	1	
NIFEDIPINE ER 30 MG TABLET	1	HSA*
NIFEDIPINE ER 60 MG TABLET	1	HSA*
NIFEDIPINE ER 60 MG TABLET	1	
NIFEDIPINE ER 90 MG TABLET	1	
NIFEDIPINE ER 90 MG TABLET	1	HSA*
NIKKI 3 MG-0.02 MG TABLET	0	ACA*
NILANDRON 150 MG TABLET	3	CH*
NILUTAMIDE 150 MG TABLET	2	CH*
NIMODIPINE 30 MG CAPSULE	1	HSA*
NINLARO 2.3 MG CAPSULE	3	CH*; SPP*: CVS Specialty
NINLARO 3 MG CAPSULE	3	CH*; SPP*: CVS Specialty
NINLARO 4 MG CAPSULE	3	CH*; SPP*: CVS Specialty
NIRAVAM 0.25 MG ODT	3	
NIRAVAM 0.5 MG ODT	3	
NIRAVAM 1 MG ODT	3	
NIRAVAM 2 MG ODT	3	
NISOLDIPINE ER 17 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NISOLDIPINE ER 20 MG TABLET	1	HSA*
NISOLDIPINE ER 25.5 MG TABLET	1	HSA*
NISOLDIPINE ER 30 MG TABLET	1	HSA*
NISOLDIPINE ER 34 MG TABLET	1	HSA*
NISOLDIPINE ER 40 MG TABLET	1	HSA*
NISOLDIPINE ER 8.5 MG TABLET	1	HSA*
NITRO-BID 2% OINTMENT	2	HSA*
NITRO-DUR 0.1 MG/HR PATCH	3	HSA*
NITRO-DUR 0.2 MG/HR PATCH	3	HSA*
NITRO-DUR 0.3 MG/HR PATCH	2	HSA*
NITRO-DUR 0.4 MG/HR PATCH	3	HSA*
NITRO-DUR 0.6 MG/HR PATCH	3	HSA*
NITRO-DUR 0.8 MG/HR PATCH	2	HSA*
NITROFURANTOIN 25 MG/5 ML SUSP	1	
NITROFURANTOIN MCR 100 MG CAP	1	
NITROFURANTOIN MCR 25 MG CAP	1	
NITROFURANTOIN MCR 50 MG CAP	1	
NITROFURANTOIN MONO-MCR 100 MG	1	
NITROGLYCERIN 0.1 MG/HR PATCH	1	HSA*
NITROGLYCERIN 0.2 MG/HR PATCH	1	HSA*
NITROGLYCERIN 0.3 MG TABLET SL	2	HSA*
NITROGLYCERIN 0.4 MG TABLET SL	2	HSA*
NITROGLYCERIN 0.4 MG/HR PATCH	1	HSA*
NITROGLYCERIN 0.6 MG TABLET SL	2	HSA*
NITROGLYCERIN 0.6 MG/HR PATCH	1	HSA*
NITROGLYCERIN ER 2.5 MG CAP	1	HSA*
NITROGLYCERIN ER 6.5 MG CAP	1	HSA*
NITROGLYCERIN ER 9 MG CAPSULE	1	HSA*
NITROGLYCERIN LINGUAL 0.4 MG	1	HSA*
NITROLINGUAL 0.4 MG SPRAY	3	HSA*
NITROMIST 400 MCG SPRAY	3	HSA*
NITROSTAT 0.3 MG TABLET SL	3	HSA*
NITROSTAT 0.4 MG TABLET SL	3	HSA*
NITROSTAT 0.6 MG TABLET SL	3	HSA*
NITYR 10 MG TABLET	3	Prior Authorization required PA NTM*; LDD*: Diplomat Pharmacy (877) 977-9118
NITYR 2 MG TABLET	3	Prior Authorization required PA NTM*; LDD*: Diplomat Pharmacy (877) 977-9118
NITYR 5 MG TABLET	3	Prior Authorization required PA NTM*; LDD*: Diplomat Pharmacy (877) 977-9118
NIVATOPIC PLUS CREAM	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NIZATIDINE 15 MG/ML SOLUTION	1	
NIZATIDINE 150 MG CAPSULE	1	
NIZATIDINE 300 MG CAPSULE	1	
NIZORAL 2% SHAMPOO	3	
NO-STICK GLUCOSE TEST STRIPS	2	HSA*
NODOLOR CAPSULE	1	
NOLIX 0.05% LOTION	3	
NOR-Q-D TABLET	3	
NORA-BE TABLET	0	ACA*
NORCO 10-325 TABLET	3	
NORCO 5-325 TABLET	3	
NORCO 7.5-325 TABLET	3	
NORDITROPIN FLEXPRO 10 MG/1.5	3	Prior Authorization required SPP*: Must use CVS Specialty
NORDITROPIN FLEXPRO 15 MG/1.5	3	Prior Authorization required SPP*: Must use CVS Specialty
NORDITROPIN FLEXPRO 30 MG/3 ML	3	Prior Authorization required SPP*: Must use CVS Specialty
NORDITROPIN FLEXPRO 5 MG/1.5	3	Prior Authorization required SPP*: Must use CVS Specialty
NORET-ESTR-FE 0.4-0.035(21)-75	0	ACA*
NORETH-ESTRAD-FE 1-0.02(21)-75	0	ACA*
NORETH-ESTRAD-FE 1-0.02(24)-75	0	ACA*
NORETHIN-ESTRA-FE 0.8-0.025 MG	0	ACA*
NORETHIN-ETH ESTRAD 1 MG-5 MCG	1	
NORETHIND-ETH ESTRAD 0.5-2.5	1	
NORETHIND-ETH ESTRAD 1-0.02 MG	0	ACA*
NORETHINDRONE 0.35 MG TABLET	0	ACA*
NORETHINDRONE 5 MG TABLET	1	
NORG-EE 0.18-0.215-0.25/0.035	0	ACA*
NORG-ETHIN ESTRA 0.25-0.035 MG	0	ACA*
NORINYL 1+50-28 TABLET	3	
NORINYL 1-35 28 TABLET	0	ACA*
NORITATE 1% CREAM	2	
NORLYDA 0.35 MG TABLET	0	ACA*
NORLYROC 0.35 MG TABLET	0	ACA*
NORM-JECT 1 ML SYRINGE	3	
NORMLGEL AG 0.11% WOUND GEL	3	
NOROXIN 400 MG TABLET	3	
NORPACE 100 MG CAPSULE	3	
NORPACE 150 MG CAPSULE	3	
NORPACE CR 100 MG CAPSULE	3	
NORPACE CR 150 MG CAPSULE	3	
NORPRAMIN 10 MG TABLET	3	
NORPRAMIN 100 MG TABLET	3	
NORPRAMIN 150 MG TABLET	3	
NORPRAMIN 25 MG TABLET	3	
NORPRAMIN 50 MG TABLET	3	
NORPRAMIN 75 MG TABLET	3	
NORTHERA 100 MG CAPSULE	3	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NORTHERA 200 MG CAPSULE	3	SPP*: Must use CVS Specialty
NORTHERA 300 MG CAPSULE	3	SPP*: Must use CVS Specialty
NORTREL 0.5-35-28 TABLET	0	ACA*
NORTREL 1-35 21 TABLET	0	ACA*
NORTREL 1-35 28 TABLET	0	ACA*
NORTREL 7-7-7-28 TABLET	0	ACA*
NORTRIPTYLINE 10 MG/5 ML SOL	1	
NORTRIPTYLINE HCL 10 MG CAP	1	
NORTRIPTYLINE HCL 25 MG CAP	1	
NORTRIPTYLINE HCL 50 MG CAP	1	
NORTRIPTYLINE HCL 75 MG CAP	1	
NORVASC 10 MG TABLET	3	HSA*
NORVASC 2.5 MG TABLET	3	HSA*
NORVASC 5 MG TABLET	3	HSA*
NORVIR 100 MG SOFTGEL CAP	2	
NORVIR 100 MG TABLET	2	
NORVIR 80 MG/ML SOLUTION	2	
NOVA MAX GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
NOVA SAFETY 23G LANCETS	2	HSA*
NOVA SAFETY 28G LANCETS	2	HSA*
NOVA SUREFLEX THIN LANCETS	2	HSA*
NOVAMAX PLUS KETONE TEST STRIP	3	Max. 204 per 30 days
NOVAREL 10,000 UNITS VIAL	2	Max. 30 Days Supply IVF*
NOVAREL 5,000 UNIT VIAL	2	Max. 30 Days Supply IVF*
NOVOEIGHT 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
NOVOLIN 70-30 100 UNIT/ML VIAL	3	Prior Authorization required HSA*
NOVOLIN N 100 UNITS/ML VIAL	3	Prior Authorization required HSA*
NOVOLIN R 100 UNITS/ML VIAL	3	Prior Authorization required HSA*
NOVOLOG 100 UNIT/ML CARTRIDGE	3	Prior Authorization required HSA*
NOVOLOG 100 UNIT/ML VIAL	3	Prior Authorization required HSA*
NOVOLOG 100 UNITS/ML FLEXPEN	3	Prior Authorization required HSA*
NOVOLOG MIX 70-30 FLEXPEN SYRN	3	Prior Authorization required HSA*
NOVOLOG MIX 70-30 VIAL	3	Prior Authorization required HSA*
NOVOSEVEN RT 2 MG VIAL	MD	SPP*: Must use CVS Specialty
NOXAFIL 40 MG/ML SUSPENSION	3	
NOXAFIL DR 100 MG TABLET	3	
NOXIFOL-D3 2,500 UNIT-1 MG TAB	3	
NP THYROID 120 MG TABLET	1	
NP THYROID 15 MG TABLET	1	
NP THYROID 30 MG TABLET	1	
NP THYROID 60 MG TABLET	1	
NP THYROID 90 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NUCYNTA 100 MG TABLET	2	
NUCYNTA 50 MG TABLET	2	
NUCYNTA 75 MG TABLET	2	
NUCYNTA ER 100 MG TABLET	2	Max. 2 per day
NUCYNTA ER 150 MG TABLET	2	Max. 2 per day
NUCYNTA ER 200 MG TABLET	2	Max. 2 per day
NUCYNTA ER 250 MG TABLET	2	Max. 2 per day
NUCYNTA ER 50 MG TABLET	2	Max. 2 per day
NUEDEXTA 20-10 MG CAPSULE	2	
NULOJIX 250 MG VIAL	MD	SPP*: Must use CVS Specialty
NULYTELY WITH FLAVOR PACKS SOL	3	
NUPLAZID 17 MG TABLET	3	Prior Authorization required;Max. 2 per day SPP*: Must use CVS Specialty
NUTRICAP CAPLET	3	
NUTROPIN 10 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
NUTROPIN AQ 20 MG/2ML PEN CART	3	Prior Authorization required SPP*: Must use CVS Specialty
NUTROPIN AQ NUSPIN 10 INJECTOR	3	Prior Authorization required SPP*: Must use CVS Specialty
NUTROPIN AQ NUSPIN 20 INJECTOR	3	Prior Authorization required SPP*: Must use CVS Specialty
NUTROPIN AQ NUSPIN 5 INJECTOR	3	Prior Authorization required SPP*: Must use CVS Specialty
NUTROPIN AQ PEN CARTRIDGE	3	Prior Authorization required SPP*: Must use CVS Specialty
NUVAIL NAIL 16% SOLUTION	3	
NUVARING VAGINAL RING	0	ACA*
NUVESSA VAGINAL 1.3% GEL	3	
NUVIGIL 150 MG TABLET	3	Prior Authorization required;Max. 1 per day
NUVIGIL 200 MG TABLET	3	Prior Authorization required;Max. 1 per day
NUVIGIL 250 MG TABLET	3	Prior Authorization required;Max. 1 per day
NUVIGIL 50 MG TABLET	3	Prior Authorization required;Max. 1 per day
NUWIQ 250 UNIT VIAL PACK	MD	SPP*: Must use CVS Specialty
NYAMYC 100,000 UNITS/GM POWDER	1	
NYATA 100,000 UNIT/GM POWDER	1	
NYMALIZE 60 MG/20 ML SOLUTION	3	HSA*
NYSTATIN 100,000 UNIT/GM CREAM	1	
NYSTATIN 100,000 UNIT/GM POWD	1	
NYSTATIN 100,000 UNIT/ML SUSP	1	
NYSTATIN 100,000 UNITS/GM OINT	1	
NYSTATIN 150,000,000 UNITS PWD	1	
NYSTATIN 500,000 UNIT ORAL TAB	1	
NYSTATIN-TRIAMCINOLONE CREAM	1	
NYSTATIN-TRIAMCINOLONE OINTM	1	
NYSTOP 100,000 UNITS/GM POWDER	1	

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OBREDON 2.5-200 MG/5 ML SOLN	3	
OCALIVA 10 MG TABLET	3	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
OCALIVA 5 MG TABLET	3	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
OCELLA 3 MG-0.03 MG TABLET	0	ACA*
OCTREOTIDE 1,000 MCG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
OCTREOTIDE ACET 100 MCG/ML VL	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCTREOTIDE ACET 200 MCG/ML VL	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCTREOTIDE ACET 50 MCG/ML SYR	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCTREOTIDE ACET 500 MCG/ML VL	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCUDOX CONVENIENCE KIT	3	
OCUFEN 0.03% EYE DROPS	3	
OCUFLOX 0.3% EYE DROPS	3	
ODEFSEY TABLET	3	
ODOMZO 200 MG CAPSULE	3	CH*; SPP*: CVS Specialty
OFEV 100 MG CAPSULE	2	Max. 2 per day SPP*: Must use CVS Specialty
OFEV 150 MG CAPSULE	2	Max. 2 per day SPP*: Must use CVS Specialty
OFLOXACIN 0.3% EAR DROPS	1	
OFLOXACIN 0.3% EYE DROPS	1	
OFLOXACIN 200 MG TABLET	1	
OFLOXACIN 300 MG TABLET	1	
OFLOXACIN 400 MG TABLET	1	
OGESTREL TABLET	0	ACA*
OLANZAPINE 10 MG TABLET	1	
OLANZAPINE 10 MG VIAL	MD	SPP*: Must use CVS Specialty
OLANZAPINE 15 MG TABLET	1	
OLANZAPINE 2.5 MG TABLET	1	
OLANZAPINE 20 MG TABLET	1	
OLANZAPINE 5 MG TABLET	1	
OLANZAPINE 7.5 MG TABLET	1	
OLANZAPINE ODT 10 MG TABLET	1	
OLANZAPINE ODT 15 MG TABLET	1	
OLANZAPINE ODT 20 MG TABLET	1	
OLANZAPINE ODT 5 MG TABLET	1	
OLANZAPINE-FLUOXETINE 12-25 MG	1	
OLANZAPINE-FLUOXETINE 12-50 MG	1	
OLANZAPINE-FLUOXETINE 3-25 MG	1	
OLANZAPINE-FLUOXETINE 6-25 MG	1	
OLANZAPINE-FLUOXETINE 6-50 MG	1	
OLEPTRO ER 150 MG TABLET	3	
OLEPTRO ER 300 MG TABLET	3	
OLMESARTAN MEDOXOMIL 20 MG TAB	2	HSA*
OLMESARTAN MEDOXOMIL 40 MG TAB	2	HSA*
OLMESARTAN MEDOXOMIL 5 MG TAB	2	HSA*
OLMESARTAN-HCTZ 20-12.5 MG TAB	2	HSA*
OLMESARTAN-HCTZ 40-12.5 MG TAB	2	HSA*
OLMESARTAN-HCTZ 40-25 MG TAB	2	HSA*
OLMSRTN-AMLDPN-HCTZ 20-5-12.5	2	HSA*
OLMSRTN-AMLDPN-HCTZ 40-10-12.5	2	HSA*
OLMSRTN-AMLDPN-HCTZ 40-10-25MG	2	HSA*
OLMSRTN-AMLDPN-HCTZ 40-5-12.5	2	HSA*
OLMSRTN-AMLDPN-HCTZ 40-5-25 MG	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
OLOPATADINE 665 MCG NASAL SPRY	1	
OLOPATADINE HCL 0.1% EYE DROPS	1	
OLOPATADINE HCL 0.2% EYE DROP	1	
OLUX-E 0.05% FOAM	3	
OLYSIO 150 MG CAPSULE	3	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
OMECLAMOX-PAK COMBO PACK	3	
OMEGA-3 ETHYL ESTERS 1 GM CAP	1	HSA*
OMEPRAZOLE DR 10 MG CAPSULE	1	
OMEPRAZOLE DR 20 MG CAPSULE	1	
OMEPRAZOLE DR 40 MG CAPSULE	1	
OMEPRAZOLE+SYRSPEND SF ALKA KT	3	
OMEPRAZOLE-BICARB 20-1,100 CAP	3	
OMEPRAZOLE-BICARB 20-1,680 PKT	2	
OMEPRAZOLE-BICARB 40-1,100 CAP	3	
OMEPRAZOLE-BICARB 40-1,680 PKT	2	
OMNARIS 50 MCG NASAL SPRAY	3	
OMNIPRED 1% EYE DROPS	3	
OMNITROPE 10 MG/1.5 ML CRTG	1	Prior Authorization required SPP*: Must use CVS Specialty
OMNITROPE 5 MG/1.5 ML CRTG	1	Prior Authorization required SPP*: Must use CVS Specialty
OMNITROPE 5.8 MG VIAL	1	Prior Authorization required SPP*: Must use CVS Specialty
ON CALL 30G LANCET	2	HSA*
ON CALL EXPRESS TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ON CALL PLUS 30G LANCET	2	HSA*
ON CALL PLUS TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ON CALL VIVID TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ON-THE-GO 30G LANCETS	2	HSA*
ONDANSETRON 4 MG/5 ML SOLUTION	1	Max. quantity of 100 per fill MQC*: 100mL (2 bottles)/copay
ONDANSETRON HCL 24 MG TABLET	1	Max. quantity of 3 per fill MQC*: 3 tabs/copay
ONDANSETRON HCL 4 MG TABLET	1	Max. quantity of 18 per fill MQC*: 18 tabs/copay
ONDANSETRON HCL 8 MG TABLET	1	Max. quantity of 9 per fill MQC*: 9 tabs/copay
ONDANSETRON ODT 4 MG TABLET	1	Max. quantity of 18 per fill MQC*: 18 tabs/copay
ONDANSETRON ODT 8 MG TABLET	1	Max. quantity of 9 per fill MQC*: 9 tabs/copay
ONE TOUCH DELICA 33G LANCETS	2	HSA*
ONE WAY VALVED MOUTHPIECE	MD	
ONETOUCH DELICA 30G LANCETS	2	HSA*
ONETOUCH DELICA 33G LANCETS	2	HSA*
ONETOUCH FINEPOINT 25G LANCETS	2	HSA*
ONETOUCH SURESOFT LANCING DEV	2	HSA*
ONETOUCH ULTRA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ONETOUCH ULTRASOFT LANCETS	2	HSA*
ONETOUCH VERIO TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ONEXTON GEL PUMP	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ONFI 10 MG TABLET	2	Prior Authorization required for members 18 and older
ONFI 2.5 MG/ML SUSPENSION	2	Prior Authorization required for members 18 and older
ONFI 20 MG TABLET	2	Prior Authorization required for members 18 and older
ONGLYZA 2.5 MG TABLET	3	Step Therapy required HSA*
ONGLYZA 5 MG TABLET	3	Step Therapy required HSA*
ONMEL 200 MG TABLET	3	Max. 84 Days Supply;Prior Authorization required;Max. 28 per 28 days
ONSOLIS 1,200 MCG SOLUBLE FILM	3	Max. 120 in 30 days
ONSOLIS 200 MCG SOLUBLE FILM	3	Max. 120 in 30 days
ONSOLIS 400 MCG SOLUBLE FILM	3	Max. 120 in 30 days
ONSOLIS 600 MCG SOLUBLE FILM	3	Max. 120 in 30 days
ONSOLIS 800 MCG SOLUBLE FILM	3	Max. 120 in 30 days
ONZETRA XSAIL 11 MG	3	Prior Authorization required;Max. quantity of 16 per fill MQC*: 16 caps(8 doses)/copay
OPANA 10 MG TABLET	3	
OPANA 5 MG TABLET	3	
OPANA ER 10 MG TABLET	3	Max. 3 per day
OPANA ER 15 MG TABLET	3	Max. 3 per day
OPANA ER 20 MG TABLET	3	Max. 3 per day
OPANA ER 30 MG TABLET	3	Max. 3 per day
OPANA ER 40 MG TABLET	3	Max. 3 per day
OPANA ER 5 MG TABLET	3	Max. 3 per day
OPANA ER 7.5 MG TABLET	3	Max. 3 per day
OPCICON ONE-STEP 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
OPIUM TINCTURE 10 MG/ML	1	
OPSUMIT 10 MG TABLET	2	SPP*: Must use CVS Specialty
OPTICHAMBER ADULT MASK-LARGE	MD	
OPTICHAMBER DIAMOND VHC	MD	
OPTIUM EZ TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
OPTIUM TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
OPTIVAR 0.05% DROPS	3	
OPTUMRX TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ORACEA 40 MG CAPSULE	3	
ORACIT ORAL SOLUTION	2	
ORAFATE 1 GM/10 ML PASTE	3	
ORALAIR 100 IR STARTER PACK	3	SPP*: Must use CVS Specialty
ORALAIR 100-300 IR CHILD SAMPL	3	SPP*: Must use CVS Specialty
ORALAIR 300 IR SUBLINGUAL TAB	3	SPP*: Must use CVS Specialty
ORALONE 0.1% PASTE	1	
ORAMAGICRX ORAL RINSE	3	
ORAP 1 MG TABLET	3	
ORAP 2 MG TABLET	3	
ORAPRED 15 MG/5 ML SOLUTION	3	
ORAPRED ODT 10 MG TABLET	3	
ORAPRED ODT 15 MG TABLET	3	
ORAPRED ODT 30 MG TABLET	3	
ORAVIG 50 MG BUCCAL TABLET	3	
ORENCIA 125 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) per 7 days SPP*: Must use CVS Specialty
ORENCIA 50 MG/0.4 ML SYRINGE	3	Prior Authorization required;Max. 0.4 ML(s) per 7 days SPP*: Must use CVS Specialty
ORENCIA 87.5 MG/0.7 ML SYRINGE	3	Prior Authorization required;Max. 0.7 ML(s) per 7 days SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ORENCIA CLICKJECT 125 MG/ML	3	Prior Authorization required;Max. 1 ML(s) per 7 days SPP*: Must use CVS Specialty
ORENITRAM ER 0.125 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 0.25 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 1 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 2.5 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 5 MG TABLET	3	SPP*: Must use CVS Specialty
ORFADIN 10 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 2 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 20 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 4 MG/ML SUSPENSION	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 5 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORKAMBI 100 MG-125 MG TABLET	3	Prior Authorization required;Max. 112 per 28 days LDD*: Diplomat Pharmacy (877) 977-9118
ORKAMBI 200 MG-125 MG TABLET	3	Prior Authorization required;Max. 112 per 28 days LDD*: Diplomat Pharmacy (877) 977-9118
ORPHENADRINE COMP FORTE TAB	1	
ORPHENADRINE COMP TABLET	1	
ORPHENADRINE ER 100 MG TABLET	1	
ORSYTHIA-28 TABLET	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 65MM	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 70MM	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 75MM	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 80MM	0	ACA*
ORTHO ALL-FLEX FITTING SET	0	ACA*
ORTHO EVRA PATCH	3	
ORTHO MICRONOR 0.35 MG TABLET	3	
ORTHO TRI-CYCLEN 28 TABLET	3	
ORTHO TRI-CYCLEN LO TABLET	3	
ORTHO-CEPT 28 DAY TABLET	3	
ORTHO-CYCLEN 28 TABLET	3	
ORTHO-NOVUM 1-35-28 TABLET	3	
ORTHO-NOVUM 7-7-7-28 TABLET	3	
OSELTAMIVIR 6 MG/ML SUSPENSION	2	Max. 240 ML(s) in 180 days
OSELTAMIVIR PHOS 30 MG CAPSULE	2	Max. 10 Days Supply;Max. 20 in 180 days
OSELTAMIVIR PHOS 45 MG CAPSULE	2	Max. 10 Days Supply;Max. 20 in 180 days
OSELTAMIVIR PHOS 75 MG CAPSULE	2	Max. 10 Days Supply;Max. 10 in 180 days
OSENI 12.5-15 MG TABLET	3	HSA*
OSENI 12.5-30 MG TABLET	3	HSA*
OSENI 12.5-45 MG TABLET	3	HSA*
OSENI 25-15 MG TABLET	3	HSA*
OSENI 25-30 MG TABLET	3	HSA*
OSENI 25-45 MG TABLET	3	HSA*
OSMOPREP TABLET	3	
OSPHENA 60 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
OTEZLA 28 DAY STARTER PACK	3	Prior Authorization required SPP*: Must use CVS Specialty
OTEZLA 30 MG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
OTEZLA STARTER PACK	3	Prior Authorization required SPP*: Must use CVS Specialty
OTIC CARE OTIC SOLUTION	3	
OTICIN DROPS	1	
OTICIN HC DROPS	3	
OTO-END 10 EAR DROPS	3	
OTOMAX-HC EAR DROPS	1	
OTOVEL 0.3%-0.025% EAR DROPS	3	Max. quantity of 2 per fill
OTREXUP 10 MG/0.4 ML AUTO-INJ	2	
OTREXUP 12.5 MG/0.4 ML AUTOINJ	2	
OTREXUP 15 MG/0.4 ML AUTO-INJ	2	
OTREXUP 17.5 MG/0.4 ML AUTOINJ	2	
OTREXUP 20 MG/0.4 ML AUTO-INJ	2	
OTREXUP 22.5 MG/0.4 ML AUTOINJ	2	
OTREXUP 25 MG/0.4 ML AUTO-INJ	2	
OTREXUP 7.5 MG/0.4 ML AUTO-INJ	2	
OVACE PLUS 10% SHAMPOO	3	
OVACE PLUS 10% WASH	3	
OVCON-35 28 TABLET	3	
OVIDE 0.5% LOTION	3	
OVIDREL 250 MCG/0.5 ML SYRG	2	Max. 30 Days Supply IVF*
OXALIS OINTMENT	3	
OXANDRIN 10 MG TABLET	3	Max. 30 Days Supply
OXANDRIN 2.5 MG TABLET	3	Max. 30 Days Supply
OXANDROLONE 10 MG TABLET	1	Max. 30 Days Supply
OXANDROLONE 2.5 MG TABLET	1	Max. 30 Days Supply
OXAPROZIN 600 MG TABLET	1	
OXAYDO 5 MG TABLET	3	
OXAYDO 7.5 MG TABLET	3	
OXAZEPAM 10 MG CAPSULE	1	
OXAZEPAM 15 MG CAPSULE	1	
OXAZEPAM 30 MG CAPSULE	1	
OXCARBAZEPINE 150 MG TABLET	1	
OXCARBAZEPINE 300 MG TABLET	1	
OXCARBAZEPINE 300 MG/5 ML SUSP	1	
OXCARBAZEPINE 600 MG TABLET	1	
OXECTA 5 MG TABLET	3	
OXECTA 7.5 MG TABLET	3	
OXICONAZOLE NITRATE 1% CREAM	1	
OXISTAT 1% CREAM	3	
OXISTAT 1% LOTION	3	
OXSORALEN 1% LOTION	2	
OXSORALEN-ULTRA 10 MG CAP	3	
OXTELLAR XR 150 MG TABLET	3	
OXTELLAR XR 300 MG TABLET	3	
OXTELLAR XR 600 MG TABLET	3	
OXYBUTYNIN 5 MG TABLET	1	
OXYBUTYNIN 5 MG/5 ML SYRUP	1	
OXYBUTYNIN CL ER 10 MG TABLET	1	
OXYBUTYNIN CL ER 15 MG TABLET	1	
OXYBUTYNIN CL ER 5 MG TABLET	1	
OXYCODON-ACETAMINOPHEN 2.5-325	1	
OXYCODON-ACETAMINOPHEN 7.5-300	1	
OXYCODON-ACETAMINOPHEN 7.5-325	1	
OXYCODON-ACETAMINOPHEN 7.5-500	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
OXYCODONE HCL 10 MG TABLET	1	
OXYCODONE HCL 100 MG/5 ML SOLN	1	
OXYCODONE HCL 15 MG TABLET	1	
OXYCODONE HCL 20 MG TABLET	1	
OXYCODONE HCL 30 MG TABLET	1	
OXYCODONE HCL 5 MG CAPSULE	1	
OXYCODONE HCL 5 MG TABLET	1	
OXYCODONE HCL 5 MG/5 ML SOLN	1	
OXYCODONE HCL ER 10 MG TABLET	1	Max. 4 per day;Max. 180 in 30 days
OXYCODONE HCL ER 15 MG TABLET	1	Max. 4 per day;Max. 180 in 30 days
OXYCODONE HCL ER 20 MG TABLET	1	Max. 4 per day;Max. 180 in 30 days
OXYCODONE HCL ER 30 MG TABLET	1	Max. 4 per day;Max. 180 in 30 days
OXYCODONE HCL ER 40 MG TABLET	1	Max. 4 per day;Max. 180 in 30 days
OXYCODONE HCL ER 60 MG TABLET	1	Max. 4 per day;Max. 180 in 30 days
OXYCODONE HCL ER 80 MG TABLET	1	Max. 4 per day;Max. 180 in 30 days
OXYCODONE-ACETAMINOPHEN 10-300	1	
OXYCODONE-ACETAMINOPHEN 10-325	1	
OXYCODONE-ACETAMINOPHEN 10-650	1	
OXYCODONE-ACETAMINOPHEN 5-300	1	
OXYCODONE-ACETAMINOPHEN 5-325	1	
OXYCODONE-ACETAMINOPHEN 5-500	1	
OXYCODONE-ACETAMINOPHN 5-325/5	1	
OXYCODONE-ASPIRIN 4.8355-325	1	
OXYCODONE-IBUPROFEN 5-400 TAB	1	
OXYCONTIN 10 MG TABLET	2	Max. 4 per day;Max. 180 in 30 days
OXYCONTIN 15 MG TABLET	2	Max. 4 per day;Max. 180 in 30 days
OXYCONTIN 20 MG TABLET	2	Max. 4 per day;Max. 180 in 30 days
OXYCONTIN 30 MG TABLET	2	Max. 4 per day;Max. 180 in 30 days
OXYCONTIN 40 MG TABLET	2	Max. 4 per day;Max. 180 in 30 days
OXYCONTIN 60 MG TABLET	2	Max. 4 per day;Max. 180 in 30 days
OXYCONTIN 80 MG TABLET	2	Max. 4 per day;Max. 180 in 30 days
OXYMORPHONE HCL 10 MG TABLET	1	
OXYMORPHONE HCL 5 MG TABLET	1	
OXYMORPHONE HCL ER 10 MG TAB	1	Max. 3 per day
OXYMORPHONE HCL ER 15 MG TAB	1	Max. 3 per day
OXYMORPHONE HCL ER 20 MG TAB	1	Max. 3 per day
OXYMORPHONE HCL ER 30 MG TAB	1	Max. 3 per day
OXYMORPHONE HCL ER 40 MG TAB	1	Max. 3 per day
OXYMORPHONE HCL ER 5 MG TABLET	1	Max. 3 per day
OXYMORPHONE HCL ER 7.5 MG TAB	1	Max. 3 per day
OXYTROL 3.9 MG/24HR PATCH	3	
OZURDEX 0.7 MG IMPLANT	MD	SPP*: Must use CVS Specialty

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PACERONE 100 MG TABLET	1	
PACERONE 200 MG TABLET	1	
PACERONE 400 MG TABLET	1	
PAIN EASE SPRAY	3	
PAIN RELIEF COLLECTION KIT	3	
PALGIC 4 MG TABLET	3	
PALGIC 4 MG/5 ML LIQUID	1	
PALIPERIDONE ER 1.5 MG TABLET	1	
PALIPERIDONE ER 3 MG TABLET	1	
PALIPERIDONE ER 6 MG TABLET	1	
PALIPERIDONE ER 9 MG TABLET	1	
PAMELOR 10 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PAMELOR 25 MG CAPSULE	3	
PAMELOR 50 MG CAPSULE	3	
PAMELOR 75 MG CAPSULE	3	
PAMINE 2.5 MG TABLET	3	
PAMINE FORTE 5 MG TABLET	3	
PANCREAZE DR 10,500 UNIT CAP	2	
PANCREAZE DR 16,800 UNIT CAP	2	
PANCREAZE DR 2,600 UNIT CAP	2	
PANCREAZE DR 21,000 UNIT CAP	2	
PANCREAZE DR 4,200 UNIT CAP	2	
PANCRELIPASE DR 5,000 UNIT CAP	1	
PANDA MASK SMALL	MD	
PANDEL 0.1% CREAM	3	
PANRETIN 0.1% GEL	3	
PANTOPRAZOLE SOD DR 20 MG TAB	1	
PANTOPRAZOLE SOD DR 40 MG TAB	1	
PAPAVERINE 150 MG CAPSULE SA	1	
PARADIGM INFUSION 24" SET	MD	
PARADIGM INSULIN PUMP	MD	
PARADIGM RESERVOIR 1.8 ML	MD	
PARADIGM RESERVOIR 3 ML	MD	
PARAFON FORTE DSC 500 MG CAPLT	3	
PARCOPA 10 MG-100 MG ODT	3	
PARCOPA 25 MG-100 MG ODT	3	
PARCOPA 25 MG-250 MG ODT	3	
PAREGORIC LIQUID	1	
PAREMYD EYE DROPS	3	
PARICALCITOL 1 MCG CAPSULE	1	
PARICALCITOL 2 MCG CAPSULE	1	
PARICALCITOL 4 MCG CAPSULE	1	
PARLODEL 2.5 MG TABLET	3	
PARLODEL 5 MG CAPSULE	3	
PARNATE 10 MG TABLET	3	
PAROEX 0.12% ORAL RINSE	1	
PAROMOMYCIN 250 MG CAPSULE	1	
PAROXETINE ER 12.5 MG TABLET	1	
PAROXETINE ER 25 MG TABLET	1	
PAROXETINE ER 37.5 MG TABLET	1	
PAROXETINE HCL 10 MG TABLET	1	
PAROXETINE HCL 20 MG TABLET	1	
PAROXETINE HCL 30 MG TABLET	1	
PAROXETINE HCL 40 MG TABLET	1	
PAROXETINE MESYLATE 7.5 MG CAP	2	
PASER GRANULES 4 GM PACKET	3	
PATADAY 0.2% EYE DROPS	3	
PATANASE 665 MCG NASAL SPRAY	3	
PATANOL 0.1% EYE DROPS	3	
PAXIL 10 MG TABLET	3	Step Therapy required STA*: 18 and older
PAXIL 10 MG/5 ML SUSPENSION	2	Step Therapy required STA*: 18 and older
PAXIL 20 MG TABLET	3	Step Therapy required STA*: 18 and older
PAXIL 30 MG TABLET	3	Step Therapy required STA*: 18 and older
PAXIL 40 MG TABLET	3	Step Therapy required STA*: 18 and older
PAXIL CR 12.5 MG TABLET	3	Step Therapy required STA: 18 and over
PAXIL CR 25 MG TABLET	3	Step Therapy required STA*: 18 and older

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PAXIL CR 37.5 MG TABLET	3	Step Therapy required STA*: 18 and older
PAZEO 0.7% EYE DROPS	3	
PCE 333 MG TABLET	3	
PCE 500 MG TABLET	3	
PEAK-AIR PEAK FLOW METER	MD	
PEDI-DRI TOPICAL POWDER	1	
PEDIADERM AF KIT	3	
PEDIADERM TA 0.1% KIT	3	
PEDIAPRED 5 MG/5 ML SOLN	3	
PEDIATRIC MOUTHPIECE	MD	
PEDIATRIC PANDA MASK	MD	
PEDIATRIC SMALL MASK	MD	
PEDIPIROX-4 NAIL KIT	3	Prior Authorization required
PEG 3350 ELECTROLYTE SOLN	0	ACA*
PEG 3350-ELECTROLYTE SOLUTION	0	ACA*
PEG-3350 AND ELECTROLYTES SOLN	0	ACA*
PEG-PREP KIT	3	
PEGANONE 250 MG TABLET	3	
PEGASYS 180 MCG/0.5 ML SYRINGE	2	SPP*: Must use CVS Specialty
PEGASYS 180 MCG/ML VIAL	2	SPP*: Must use CVS Specialty
PEGASYS PROCLICK 135 MCG/0.5	2	SPP*: Must use CVS Specialty
PEGASYS PROCLICK 180 MCG/0.5	2	SPP*: Must use CVS Specialty
PEGINTRON 120 MCG KIT	2	SPP*: Must use CVS Specialty
PEGINTRON 150 MCG KIT	2	SPP*: Must use CVS Specialty
PEGINTRON 50 MCG KIT	2	SPP*: Must use CVS Specialty
PEGINTRON 80 MCG KIT	2	SPP*: Must use CVS Specialty
PEGINTRON REDIPEN 120 MCG	2	SPP*: Must use CVS Specialty
PEGINTRON REDIPEN 150 MCG	2	SPP*: Must use CVS Specialty
PEGINTRON REDIPEN 50 MCG	2	SPP*: Must use CVS Specialty
PEGINTRON REDIPEN 80 MCG	2	SPP*: Must use CVS Specialty
PENICILLIN VK 125 MG/5 ML SOLN	1	
PENICILLIN VK 250 MG TABLET	1	
PENICILLIN VK 250 MG/5 ML SOLN	1	
PENICILLIN VK 500 MG TABLET	1	
PENLAC 8% SOLUTION	3	Prior Authorization required
PENNSAID 1.5% SOLUTION	3	
PENNSAID 2% PUMP	3	Prior Authorization required
PENTASA 250 MG CAPSULE	2	
PENTASA 500 MG CAPSULE	2	
PENTAZOCIN-ACETAMINOPHN 25-650	1	
PENTAZOCINE-NALOXONE TABLET	1	
PENTOXIFYLLINE ER 400 MG TAB	1	HSA*
PEPCID 20 MG TABLET	3	
PEPCID 40 MG TABLET	3	
PEPCID 40 MG/5 ML ORAL SUSP	3	
PERCOCET 10-325 MG TABLET	3	
PERCOCET 10-650 MG TABLET	3	
PERCOCET 2.5-325 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PERCOCET 5-325 MG TABLET	3	
PERCOCET 7.5-325 MG TABLET	3	
PERCOCET 7.5-500 MG TABLET	3	
PERCODAN 4.8355-325 MG TABLET	3	
PERFOROMIST 20 MCG/2 ML SOLN	2	HSA*
PERIDEX 0.12% ORAL RINSE	3	
PERINDOPRIL ERBUMINE 2 MG TAB	1	HSA*
PERINDOPRIL ERBUMINE 4 MG TAB	1	HSA*
PERINDOPRIL ERBUMINE 8 MG TAB	1	HSA*
PERIOGARD 0.12% ORAL RINSE	1	
PERMETHRIN 5% CREAM	1	
PERPHEN-AMITRIP 2 MG-10 MG TAB	1	
PERPHEN-AMITRIP 2 MG-25 MG TAB	1	
PERPHEN-AMITRIP 4 MG-10 MG TAB	1	
PERPHEN-AMITRIP 4 MG-25 MG TAB	1	
PERPHEN-AMITRIP 4 MG-50 MG TAB	1	
PERPHENAZINE 16 MG TABLET	1	
PERPHENAZINE 2 MG TABLET	1	
PERPHENAZINE 4 MG TABLET	1	
PERPHENAZINE 8 MG TABLET	1	
PERSANTINE 25 MG TABLET	3	HSA*
PERSANTINE 50 MG TABLET	3	HSA*
PERSANTINE 75 MG TABLET	3	HSA*
PERSONAL BEST PEAK FLOW MTR	MD	
PERTZYE DR 16,000 UNIT CAPSULE	3	
PERTZYE DR 24,000 UNIT CAPSULE	3	
PERTZYE DR 4,000 UNIT CAPSULE	3	
PERTZYE DR 8,000 UNIT CAPSULE	3	
PEXEVA 10 MG TABLET	2	Step Therapy required STA*: 18 and older
PEXEVA 20 MG TABLET	2	Step Therapy required STA*: 18 and older
PEXEVA 30 MG TABLET	2	Step Therapy required STA*: 18 and older
PEXEVA 40 MG TABLET	2	Step Therapy required STA*: 18 and older
PFLEX INSPIRATORY TRAINER	MD	
PHARMACIST CHOICE 30G LANCETS	2	HSA*
PHARMACIST CHOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PHARMACIST CHOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PHENADOZ 12.5 MG SUPPOSITORY	1	
PHENADOZ 25 MG SUPPOSITORY	1	
PHENAZOPYRIDINE 100 MG TAB	1	
PHENAZOPYRIDINE 200 MG TAB	1	
PHENELZINE SULFATE 15 MG TAB	1	
PHENERGAN 12.5 MG SUPPOSITORY	3	
PHENERGAN 25 MG SUPPOSITORY	3	
PHENERGAN 50 MG SUPPOSITORY	3	
PHENFLU CD TABLET	3	
PHENFLU CDX TABLET	3	
PHENOBARBITAL 100 MG TABLET	1	
PHENOBARBITAL 15 MG TABLET	1	
PHENOBARBITAL 16.2 MG TABLET	1	
PHENOBARBITAL 20 MG/5 ML ELIX	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PHENOBARBITAL 30 MG TABLET	1	
PHENOBARBITAL 32.4 MG TABLET	1	
PHENOBARBITAL 60 MG TABLET	1	
PHENOBARBITAL 64.8 MG TABLET	1	
PHENOBARBITAL 97.2 MG TABLET	1	
PHENOXYBENZAMINE HCL 10 MG CAP	1	HSA*
PHENTOLAMINE 5 MG VIAL	1	
PHENTOLAMINE 5 MG/ML VIAL	1	
PHENYLEPHRINE 10% EYE DROPS	1	
PHENYLEPHRINE 2.5% EYE DROP	1	
PHENYLHISTINE DH LIQUID	1	
PHENYTEK 200 MG CAPSULE	3	
PHENYTEK 300 MG CAPSULE	3	
PHENYTOIN 125 MG/5 ML SUSP	1	
PHENYTOIN 50 MG INFATAB	1	
PHENYTOIN SOD EXT 100 MG CAP	1	
PHENYTOIN SOD EXT 200 MG CAP	1	
PHENYTOIN SOD EXT 300 MG CAP	1	
PHILITH 0.4-0.035 MG TABLET	0	ACA*
PHOSLO 667 MG GELCAP	3	
PHOSLYRA 667 MG/5 ML SOLUTION	2	
PHOSPHA 250 NEUTRAL TABLET	1	
PHOSPHOLINE IODIDE 0.125%	2	
PHRENILIN FORTE CAPSULE	2	
PHYSICIANS EZ USE B-12 KIT	1	
PICATO 0.015% GEL	2	Max. 30 Days Supply
PICATO 0.05% GEL	2	Max. 30 Days Supply
PIKO 1 FLOW METER	MD	
PILOCARPINE 1% EYE DROPS	1	
PILOCARPINE 2% EYE DROPS	1	
PILOCARPINE 4% EYE DROPS	1	
PILOCARPINE HCL 5 MG TABLET	1	
PILOCARPINE HCL 7.5 MG TABLET	1	
PIMOZIDE 1 MG TABLET	1	
PIMOZIDE 2 MG TABLET	1	
PIMTREA 28 DAY TABLET	0	ACA*
PINDOLOL 10 MG TABLET	1	HSA*
PINDOLOL 5 MG TABLET	1	HSA*
PINNACAINE 20% OTIC DROPS	1	
PIOGLITAZONE HCL 15 MG TABLET	1	HSA*
PIOGLITAZONE HCL 30 MG TABLET	1	HSA*
PIOGLITAZONE HCL 45 MG TABLET	1	HSA*
PIOGLITAZONE-GLIMEPIRIDE 30-2	1	HSA*
PIOGLITAZONE-GLIMEPIRIDE 30-4	1	HSA*
PIOGLITAZONE-METFORMIN 15-500	1	HSA*
PIOGLITAZONE-METFORMIN 15-850	1	HSA*
PIRMELLA 1-35-28 TABLET	0	ACA*
PIRMELLA 7-7-7-28 TABLET	0	ACA*
PIROXICAM 10 MG CAPSULE	1	
PIROXICAM 20 MG CAPSULE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PLAN B ONE-STEP 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
PLAQUENIL 200 MG TABLET	3	
PLAVIX 300 MG TABLET	3	HSA*
PLAVIX 75 MG TABLET	3	HSA*
PLEGRIDY 125 MCG/0.5 ML PEN	3	Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
PLEGRIDY 125 MCG/0.5 ML SYRING	3	Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
PLEGRIDY PEN INJ STARTER PACK	3	Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
PLEGRIDY SYRINGE STARTER PACK	3	Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
PLETAL 100 MG TABLET	3	HSA*
PLETAL 50 MG TABLET	3	HSA*
PLEXION 9.8-4.8% CLEANSER	3	
PNV PRENATAL PLUS MULTIVIT TAB	1	HSA*
POCKET CHAMBER	MD	
POCKET PEAK FLOW METER	MD	
PODOCON-25 LIQUID	1	
PODOFILOX 0.5% TOPICAL SOLN	1	
POLY-IRON 150 FORTE CAPSULE	1	
POLY-TUSSIN AC LIQUID	3	
POLY-VI-FLOR FS 0.25 MG FILM	3	
POLYCIN EYE OINTMENT	1	
POLYETHYLENE GLYCOL 3350 POWD	1	
POLYFIN QR INFUSION SET	MD	
POLYMYXIN B-TMP EYE DROPS	1	
POLYTRIM EYE DROPS	3	
POMALYST 1 MG CAPSULE	3	CH*; SPP*: CVS Specialty
POMALYST 2 MG CAPSULE	3	CH*; SPP*: CVS Specialty
POMALYST 3 MG CAPSULE	3	CH*; SPP*: CVS Specialty
POMALYST 4 MG CAPSULE	3	CH*; SPP*: CVS Specialty
PONSTEL 250 MG KAPSEALS	3	
PONTOCAINE 2% SOLUTION	3	
PORTIA-28 TABLET	0	ACA*
POT CITRATE-CITRIC ACID PACKET	1	
POTABA 500 MG CAPSULE	3	
POTASS CIT-SOD CIT-CITRIC SOLN	1	
POTASSIUM 25 MEQ TABLET EFF	1	
POTASSIUM CIT-CITRIC ACID SOLN	1	
POTASSIUM CITRATE ER 10 MEQ TB	1	
POTASSIUM CITRATE ER 15 MEQ TB	1	
POTASSIUM CITRATE ER 5 MEQ TAB	1	
POTASSIUM CL 10% (20 MEQ/15 ML	1	
POTASSIUM CL 20 MEQ PACKET	1	
POTASSIUM CL 20% (40 MEQ/15 ML	1	
POTASSIUM CL 25 MEQ TAB EFF	1	
POTASSIUM CL ER 10 MEQ CAPSULE	1	
POTASSIUM CL ER 10 MEQ TABLET	1	
POTASSIUM CL ER 20 MEQ TABLET	1	
POTASSIUM CL ER 8 MEQ CAPSULE	1	
POTASSIUM CL ER 8 MEQ TABLET	1	
POTASSIUM HYDROXIDE 5% SOLN	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
POTIGA 200 MG TABLET	3	
POTIGA 300 MG TABLET	3	
POTIGA 400 MG TABLET	3	
POTIGA 50 MG TABLET	3	
PR CREAM KIT	1	
PRADAXA 110 MG CAPSULE	3	HSA*
PRADAXA 150 MG CAPSULE	3	HSA*
PRADAXA 75 MG CAPSULE	3	HSA*
PRALUENT 150 MG/ML PEN	3	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
PRALUENT 150 MG/ML SYRINGE	3	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
PRALUENT 75 MG/ML PEN	3	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
PRALUENT 75 MG/ML SYRINGE	3	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
PRAMCORT 1% CREAM	3	
PRAMIPEXOLE 0.125 MG TABLET	1	
PRAMIPEXOLE 0.25 MG TABLET	1	
PRAMIPEXOLE 0.5 MG TABLET	1	
PRAMIPEXOLE 0.75 MG TABLET	1	
PRAMIPEXOLE 1 MG TABLET	1	
PRAMIPEXOLE 1.5 MG TABLET	1	
PRAMIPEXOLE ER 0.375 MG TABLET	1	
PRAMIPEXOLE ER 0.75 MG TABLET	1	
PRAMIPEXOLE ER 1.5 MG TABLET	1	
PRAMIPEXOLE ER 2.25 MG TABLET	1	
PRAMIPEXOLE ER 3 MG TABLET	1	
PRAMIPEXOLE ER 3.75 MG TABLET	1	
PRAMIPEXOLE ER 4.5 MG TABLET	1	
PRAMOSONE 1% LOTION	2	
PRAMOSONE 1%-1% CREAM	2	
PRAMOSONE 1%-1% OINTMENT	2	
PRAMOSONE 2.5%-1% CREAM	3	
PRAMOSONE 2.5%-1% LOTION	2	
PRAMOSONE 2.5%-1% OINTMENT	2	
PRAMOSONE E 2.5%-1% CREAM	3	
PRAMOXINE-HC OTIC DROPS	3	
PRANDIMET 1 MG-500 MG TABLET	3	HSA*
PRANDIMET 2 MG-500 MG TABLET	3	HSA*
PRANDIN 0.5 MG TABLET	3	HSA*
PRANDIN 1 MG TABLET	3	HSA*
PRANDIN 2 MG TABLET	3	HSA*
PRASUGREL 10 MG TABLET	2	HSA*
PRASUGREL 5 MG TABLET	2	HSA*
PRAVACHOL 20 MG TABLET	3	HSA*
PRAVACHOL 40 MG TABLET	3	HSA*
PRAVACHOL 80 MG TABLET	3	HSA*
PRAVASTATIN SODIUM 10 MG TAB	1	HSA*
PRAVASTATIN SODIUM 20 MG TAB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PRAVASTATIN SODIUM 40 MG TAB	1	HSA*
PRAVASTATIN SODIUM 80 MG TAB	1	HSA*
PRAZOSIN 1 MG CAPSULE	1	HSA*
PRAZOSIN 2 MG CAPSULE	1	HSA*
PRAZOSIN 5 MG CAPSULE	1	HSA*
PRE-ATTACHED LTA KIT	3	
PRECISION PCX PLUS TEST STR	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRECISION PCX TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRECISION POINT OF CARE STR	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRECISION Q-I-D TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRECISION XTR B-KETONE STRIP	2	Max. 204 per 30 days HSA*
PRECISION XTRA MONITOR	MD	Max. 1 in 365 days HSA*
PRECISION XTRA TEST STRIPS	2	Max. 204 per 30 days HSA*
PRECOSE 100 MG TABLET	3	HSA*
PRECOSE 25 MG TABLET	3	HSA*
PRECOSE 50 MG TABLET	3	HSA*
PRED 1%-GATI 0.5%-NEPAF 0.1%	2	
PRED FORTE 1% EYE DROPS	3	
PRED MILD 0.12% EYE DROPS	2	
PRED-G 1% EYE DROPS	3	
PRED-G S.O.P. EYE OINTMENT	3	
PREDNICARBATE 0.1% CREAM	1	
PREDNICARBATE 0.1% OINTMENT	1	
PREDNISOLONE 1%-GATIFLOX 0.5%	2	
PREDNISOLONE 1%-NEPAFENAC 0.1%	2	
PREDNISOLONE 10 MG/5 ML SOLN	1	
PREDNISOLONE 15 MG/5 ML SOLN	1	
PREDNISOLONE 20 MG/5 ML SOLN	1	
PREDNISOLONE 5 MG/5 ML SOLN	1	
PREDNISOLONE AC 1% EYE DROP	1	
PREDNISOLONE ODT 10 MG TABLET	1	
PREDNISOLONE ODT 15 MG TABLET	1	
PREDNISOLONE ODT 30 MG TABLET	1	
PREDNISOLONE SOD 1% EYE DROP	1	
PREDNISOLONE SOD PH 25 MG/5 ML	1	
PREDNISONE 1 MG TABLET	1	
PREDNISONE 10 MG TAB DOSE PACK	1	
PREDNISONE 10 MG TABLET	1	
PREDNISONE 2.5 MG TABLET	1	
PREDNISONE 20 MG TABLET	1	
PREDNISONE 5 MG TAB DOSE PACK	1	
PREDNISONE 5 MG TABLET	1	
PREDNISONE 5 MG/5 ML SOLUTION	1	
PREDNISONE 5 MG/ML SOLUTION	3	
PREDNISONE 50 MG TABLET	1	
PREFEST TABLET	3	
PREGNYL 10,000 UNITS VIAL	2	Max. 30 Days Supply IVF*
PRELONE 15 MG/5 ML SYRUP	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PREMARIN 0.3 MG TABLET	2	
PREMARIN 0.45 MG TABLET	2	
PREMARIN 0.625 MG TABLET	2	
PREMARIN 0.9 MG TABLET	2	
PREMARIN 1.25 MG TABLET	2	
PREMARIN VAGINAL CREAM-APPL	2	
PREMIUM V10 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
PREMPHASE 0.625-5 MG TABLET	2	
PREMPRO 0.3 MG-1.5 MG TABLET	2	
PREMPRO 0.45-1.5 MG TABLET	2	
PREMPRO 0.625-2.5 MG TABLET	2	
PREMPRO 0.625-5 MG TABLET	2	
PRENA1 PEARL SOFTGEL	1	HSA*
PREPOPIK POWDER PACKET	2	
PRESERA FOAM	3	
PRESSURE ACTIVATED 21G LANCETS	2	HSA*
PRESSURE ACTIVATED 28G LANCETS	2	HSA*
PRESTALIA 14 MG-10 MG TABLET	3	Max. 1 per day HSA*
PRESTALIA 3.5 MG-2.5 MG TABLET	3	Max. 1 per day HSA*
PRESTALIA 7 MG-5 MG TABLET	3	Max. 1 per day HSA*
PREVACID 15 MG SOLUTAB	3	
PREVACID 30 MG SOLUTAB	3	
PREVACID DR 15 MG CAPSULE	3	
PREVACID DR 30 MG CAPSULE	3	
PREVALITE PACKET	1	HSA*
PREVIDENT 0.2% RINSE	3	
PREVIDENT 5000 BOOSTER PLUS	3	
PREVIDENT 5000 SENSITIVE PASTE	3	
PREVIFEM TABLET	0	ACA*
PREVPAC PATIENT PACK	3	
PREZCOBIX 800 MG-150 MG TABLET	3	
PREZISTA 100 MG/ML SUSPENSION	2	
PREZISTA 150 MG TABLET	2	
PREZISTA 400 MG TABLET	2	
PREZISTA 600 MG TABLET	2	
PREZISTA 75 MG TABLET	2	
PREZISTA 800 MG TABLET	2	
PRIFTIN 150 MG TABLET	3	
PRILOSEC DR 10 MG CAPSULE	3	
PRILOSEC DR 10 MG SUSPENSION	3	
PRILOSEC DR 2.5 MG SUSPENSION	3	
PRILOSEC DR 20 MG CAPSULE	3	
PRILOSEC DR 40 MG CAPSULE	3	
PRIMAQUINE 26.3 MG TABLET	2	
PRIMEAIRE CHAMBER	MD	
PRIMIDONE 250 MG TABLET	1	
PRIMIDONE 50 MG TABLET	1	
PRIMLEV 10-300 MG TABLET	3	
PRIMLEV 5-300 MG TABLET	3	
PRIMLEV 7.5-300 MG TABLET	3	
PRIMSOL 50 MG/5 ML ORAL SOLN	3	
PRINIVIL 10 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PRINIVIL 20 MG TABLET	3	HSA*
PRINIVIL 5 MG TABLET	3	HSA*
PRISTIQ ER 100 MG TABLET	3	Step Therapy required STA*: 18 and older
PRISTIQ ER 25 MG TABLET	3	Step Therapy required STA*: 18 and older
PRISTIQ ER 50 MG TABLET	3	Step Therapy required STA*: 18 and older
PRO COMFORT 30G LANCETS	2	HSA*
PRO COMFORT 31G LANCET	2	HSA*
PROAIR HFA 90 MCG INHALER	2	HSA*
PROAIR RESPICLICK INHAL POWDER	2	HSA*
PROBENECID 500 MG TABLET	1	
PROBENECID-COLCHICINE TABS	1	
PROCARDIA 10 MG CAPSULE	3	HSA*
PROCARDIA XL 30 MG TABLET	3	HSA*
PROCARDIA XL 60 MG TABLET	3	HSA*
PROCARDIA XL 90 MG TABLET	3	HSA*
PROCENTRA 5 MG/5 ML SOLUTION	3	Max. 60 Days Supply
PROCHAMBER HOLDING CHAMBER	MD	
PROCHLORPERAZINE 10 MG TAB	1	
PROCHLORPERAZINE 25 MG SUPP	1	
PROCHLORPERAZINE 5 MG TABLET	1	
PROCRIT 10,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIT 2,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIT 20,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
PROCRIT 3,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIT 4,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIT 40,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
PROCTO-MED HC 2.5% CREAM	1	
PROCTO-PAK 1% CREAM	1	
PROCTOCORT 1% CREAM	3	
PROCTOCORT 30 MG SUPPOSITORY	3	
PROCTOFOAM-HC 1%-1% FOAM	2	
PROCTOSOL-HC 2.5% CREAM	1	
PROCTOZONE-HC 2.5% CREAM	1	
PROCYSBI DR 25 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
PROCYSBI DR 75 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
PRODIGY NO CODING TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRODIGY PRESSURE ACTIVATED 28G	2	HSA*
PRODIGY SAFETY 26G LANCETS	2	HSA*
PRODIGY TWIST TOP 28G LANCET	2	HSA*
PROFERRIN-FORTE TABLET	3	
PROFILNINE 500 UNITS VIAL	MD	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PROGESTERONE 100 MG CAPSULE	1	HSA*
PROGESTERONE 200 MG CAPSULE	1	HSA*
PROGESTERONE OIL 50 MG/ML VL	1	Max. 30 Days Supply IVF*
PROGLYCEM 50 MG/ML ORAL SUSP	3	HSA*
PROGRAF 0.5 MG CAPSULE	2	
PROGRAF 1 MG CAPSULE	2	
PROGRAF 5 MG CAPSULE	2	
PROLASTIN C 1,000 MG VIAL	MD	Prior Authorization required LDD*: Dohmen Life Sciences. 1-800-305-7881.
PROLENSA 0.07% EYE DROPS	3	
PROLIA 60 MG/ML SYRINGE	MD	Prior Authorization required;Max. 1 ML(s) in 180 days SPP*: Must use CVS Specialty
PROMACET 50-650 MG TABLET	1	
PROMACTA 12.5 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMACTA 25 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMACTA 50 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMACTA 75 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMETHAZINE 12.5 MG SUPPOS	1	
PROMETHAZINE 12.5 MG TABLET	1	
PROMETHAZINE 25 MG SUPPOSITORY	1	
PROMETHAZINE 25 MG TABLET	1	
PROMETHAZINE 50 MG SUPPOSITORY	1	
PROMETHAZINE 50 MG TABLET	1	
PROMETHAZINE 6.25 MG/5 ML SYRP	1	
PROMETHAZINE VC SYRUP	1	
PROMETHAZINE VC-CODEINE SYRUP	1	
PROMETHAZINE-CODEINE SYRUP	1	
PROMETHAZINE-DM SYRUP	1	
PROMETHEGAN 12.5 MG SUPPOS	1	
PROMETHEGAN 25 MG SUPPOSITORY	1	
PROMETHEGAN 50 MG SUPPOSITORY	1	
PROMETRIUM 100 MG CAPSULE	3	
PROMETRIUM 200 MG CAPSULE	3	
PROMISEB COMPLETE KIT	3	
PROMISEB TOPICAL CREAM	3	
PROPAFENONE HCL 150 MG TABLET	1	
PROPAFENONE HCL 225 MG TAB	1	
PROPAFENONE HCL 300 MG TAB	1	
PROPAFENONE HCL ER 225 MG CAP	1	
PROPAFENONE HCL ER 325 MG CAP	1	
PROPAFENONE HCL ER 425 MG CAP	1	
PROPANTHELINE 15 MG TABLET	1	
PROPARACAINE 0.5% EYE DROPS	1	
PROPRANOLOL 10 MG TABLET	1	HSA*
PROPRANOLOL 20 MG TABLET	1	HSA*
PROPRANOLOL 20 MG/5 ML SOLN	1	HSA*
PROPRANOLOL 40 MG TABLET	1	HSA*
PROPRANOLOL 40 MG/5 ML SOLN	1	HSA*
PROPRANOLOL 60 MG TABLET	1	HSA*
PROPRANOLOL 80 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PROPRANOLOL ER 120 MG CAPSULE	1	HSA*
PROPRANOLOL ER 160 MG CAPSULE	1	HSA*
PROPRANOLOL ER 60 MG CAPSULE	1	HSA*
PROPRANOLOL ER 80 MG CAPSULE	1	HSA*
PROPRANOLOL-HCTZ 40-25 MG TAB	1	HSA*
PROPRANOLOL-HCTZ 80-25 MG TAB	1	HSA*
PROPYLTHIOURACIL 50 MG TABLET	1	
PROSCAR 5 MG TABLET	3	
PROSTIGMIN 15 MG TABLET	3	
PROTHELIAL 1 GM/10 ML PASTE	3	
PROTONIX 40 MG SUSPENSION	3	
PROTONIX DR 20 MG TABLET	3	
PROTONIX DR 40 MG TABLET	3	
PROTOPIC 0.03% OINTMENT	3	Prior Authorization required
PROTOPIC 0.1% OINTMENT	3	Prior Authorization required
PROTRIPTYLINE HCL 10 MG TABLET	1	
PROTRIPTYLINE HCL 5 MG TABLET	1	
PROVENTIL HFA 90 MCG INHALER	3	HSA*
PROVERA 10 MG TABLET	3	
PROVERA 2.5 MG TABLET	3	
PROVERA 5 MG TABLET	3	
PROVIGIL 100 MG TABLET	3	Prior Authorization required;Max. 1 per day
PROVIGIL 200 MG TABLET	3	Prior Authorization required;Max. 1 per day
PROZAC 10 MG PULVULE	3	Step Therapy required STA*: 18 and older
PROZAC 20 MG PULVULE	3	Step Therapy required STA*: 18 and older
PROZAC 40 MG PULVULE	3	Step Therapy required STA*: 18 and older
PROZAC WEEKLY 90 MG CAPSULE	3	Step Therapy required STA*: 18 and older
PRUCLAIR NONSTEROIDAL CREAM	1	
PRUDOXIN 5% CREAM	3	
PRUMYX CREAM	1	
PRUTECT TOPICAL EMULSION	1	
PSORCON 0.05% CREAM	3	
PULMICORT 0.25 MG/2 ML RESPUL	3	HSA*
PULMICORT 0.5 MG/2 ML RESPULE	3	HSA*
PULMICORT 1 MG/2 ML RESPULE	3	HSA*
PULMICORT 180 MCG FLEXHALER	2	HSA*
PULMICORT 90 MCG FLEXHALER	2	HSA*
PULMOSAL 7% VIAL	3	
PULMOZYME 1 MG/ML AMPUL	2	SPP*: Must use CVS Specialty
PURINETHOL 50 MG TABLET	3	CH*
PURIXAN 20 MG/ML ORAL SUSP	3	CH*
PUSH BUTTON SAFETY 21G LANCET	2	HSA*
PUSH BUTTON SAFETY 28G LANCET	2	HSA*
PV TRUETRACK SMART SYS STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PYLERA CAPSULE	3	
PYRAZINAMIDE 500 MG TABLET	1	
PYRIDIUM 100 MG TABLET	3	
PYRIDIUM 200 MG TABLET	3	
PYRIDOSTIGMINE BR 60 MG TABLET	1	
PYRIDOSTIGMINE ER 180 MG TAB	1	
PYROGALLIC ACID 25% OINTMENT	3	

Q

QBRELIS 1MG/ML SOLUTION	3	HSA*
QNASL 80 MCG NASAL SPRAY	3	
QNASL CHILDREN'S 40 MCG SPRAY	3	
QUALAQUIN 324 MG CAPSULE	3	
QUARTETTE TABLET	3	Max. 91 Days Supply;Max. 1 per day
QUASENSE 0.15-0.03 MG TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
QUAZEPAM 15 MG TABLET	1	
QUDEXY XR 100 MG CAPSULE	3	
QUDEXY XR 150 MG CAPSULE	3	
QUDEXY XR 200 MG CAPSULE	3	
QUDEXY XR 25 MG CAPSULE	3	
QUDEXY XR 50 MG CAPSULE	3	
QUESTRAN LIGHT POWDER	3	HSA*
QUESTRAN PACKET	3	HSA*
QUETIAPINE ER 150 MG TABLET	2	
QUETIAPINE ER 200 MG TABLET	2	
QUETIAPINE ER 300 MG TABLET	2	
QUETIAPINE ER 400 MG TABLET	2	
QUETIAPINE ER 50 MG TABLET	2	
QUETIAPINE FUMARATE 100 MG TAB	1	
QUETIAPINE FUMARATE 200 MG TAB	1	
QUETIAPINE FUMARATE 25 MG TAB	1	
QUETIAPINE FUMARATE 300 MG TAB	1	
QUETIAPINE FUMARATE 400 MG TAB	1	
QUETIAPINE FUMARATE 50 MG TAB	1	
QUICK RELEASE TEFLN CANNULA	MD	
QUILLICHEW ER 20 MG CHEW TAB	3	Max. 60 Days Supply
QUILLICHEW ER 30 MG CHEW TAB	3	Max. 60 Days Supply
QUILLICHEW ER 40 MG CHEW TAB	3	Max. 60 Days Supply
QUILLIVANT XR 25 MG/5 ML SUSP	3	Max. 60 Days Supply
QUINAPRIL 10 MG TABLET	1	HSA*
QUINAPRIL 20 MG TABLET	1	HSA*
QUINAPRIL 40 MG TABLET	1	HSA*
QUINAPRIL 5 MG TABLET	1	HSA*
QUINAPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
QUINAPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
QUINAPRIL-HCTZ 20-25 MG TAB	1	HSA*
QUINIDINE GLUC ER 324 MG TAB	1	
QUINIDINE SULF ER 300 MG TAB	1	
QUINIDINE SULFATE 200 MG TAB	1	
QUINIDINE SULFATE 300 MG TAB	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
QUININE SULFATE 324 MG CAPSULE	1	
QUINTET AC GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
QUINTET GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
QVAR 40 MCG ORAL INHALER	2	HSA*
QVAR 80 MCG ORAL INHALER	2	HSA*

R

RA ASPIRIN 325 MG TABLET	0	ACA*
RA E-ZJECT 26G LANCETS	2	HSA*
RA E-ZJECT 28G LANCETS	2	HSA*
RA NICOTINE 14 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
RA NICOTINE 21 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
RA NICOTINE 4 MG CHEWING GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
RABAVERT RABIES VACC W-DILUENT	MD	
RABEPRAZOLE SOD DR 20 MG TAB	2	
RADIAGEL	3	
RADIAPLEXRX GEL	3	
RAGWITEK SUBLINGUAL TABLET	3	Max. 1 per day
RAJANI 28 TABLET	0	ACA*
RALOXIFENE HCL 60 MG TABLET	1	HSA*; ACA*
RAMIPRIL 1.25 MG CAPSULE	1	HSA*
RAMIPRIL 10 MG CAPSULE	1	HSA*
RAMIPRIL 2.5 MG CAPSULE	1	HSA*
RAMIPRIL 5 MG CAPSULE	1	HSA*
RANEXA ER 1,000 MG TABLET	2	HSA*
RANEXA ER 500 MG TABLET	2	HSA*
RANITIDINE 15 MG/ML SYRUP	1	
RANITIDINE 150 MG CAPSULE	1	
RANITIDINE 150 MG TABLET	1	
RANITIDINE 300 MG CAPSULE	1	
RANITIDINE 300 MG TABLET	1	
RAPAFLO 4 MG CAPSULE	3	
RAPAFLO 8 MG CAPSULE	3	
RAPAMUNE 0.5 MG TABLET	3	
RAPAMUNE 1 MG TABLET	3	
RAPAMUNE 1 MG/ML ORAL SOLN	3	
RAPAMUNE 2 MG TABLET	3	
RASAGILINE MESYLATE 0.5 MG TAB	2	
RASAGILINE MESYLATE 1 MG TAB	2	
RASUVO 10 MG/0.2 ML AUTOINJ	2	Max. 0.8 ML(s) in 30 days
RASUVO 12.5 MG/0.25 ML AUTOINJ	2	Max. 1 ML(s) in 30 days
RASUVO 15 MG/0.3 ML AUTOINJ	2	Max. 1.2 ML(s) in 30 days
RASUVO 17.5 MG/0.35 ML AUTOINJ	2	Max. 1.4 ML(s) in 30 days
RASUVO 20 MG/0.4 ML AUTOINJ	2	Max. 1.6 ML(s) in 30 days
RASUVO 22.5 MG/0.45 ML AUTOINJ	2	Max. 1.8 ML(s) in 30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RASUVO 25 MG/0.5 ML AUTOINJ	2	Max. 2 ML(s) in 30 days
RASUVO 27.5 MG/0.55 ML AUTOINJ	2	Max. 2.2 ML(s) in 30 days
RASUVO 30 MG/0.6 ML AUTOINJ	2	Max. 2.4 ML(s) in 30 days
RASUVO 7.5 MG/0.15 ML AUTOINJ	2	Max. 0.6 ML(s) in 30 days
RAVICTI 1.1 GRAM/ML LIQUID	3	SPP*: Must use CVS Specialty
RAYALDEE ER 30 MCG CAPSULE	3	Prior Authorization required;Max. 2 per day
RAYOS DR 1 MG TABLET	3	Prior Authorization required
RAYOS DR 2 MG TABLET	3	Prior Authorization required
RAYOS DR 5 MG TABLET	3	Prior Authorization required
RAZADYNE 12 MG TABLET	3	
RAZADYNE 4 MG TABLET	3	
RAZADYNE 4 MG/ML ORAL SOLUTION	3	
RAZADYNE 8 MG TABLET	3	
RAZADYNE ER 16 MG CAPSULE	3	
RAZADYNE ER 24 MG CAPSULE	3	
RAZADYNE ER 8 MG CAPSULE	3	
REA LO 39 CREAM	3	
REA LO 40 CREAM	3	
REA LO 40 LOTION	3	
READYLANCE 21G SAFETY LANCETS	2	HSA*
READYLANCE 23G SAFETY LANCETS	2	HSA*
READYLANCE 26G SAFETY LANCETS	2	HSA*
READYLANCE 28G SAFETY LANCETS	2	HSA*
READYLANCE 30G SAFETY LANCETS	2	HSA*
REBETOL 200 MG CAPSULE	3	SPP*: Must use CVS Specialty
REBETOL 40 MG/ML SOLUTION	2	SPP*: Must use CVS Specialty
REBIF 22 MCG/0.5 ML SYRINGE	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF 44 MCG/0.5 ML SYRINGE	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF REBIDOSE 22 MCG/0.5 ML	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF REBIDOSE 44 MCG/0.5 ML	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF REBIDOSE TITRATION PACK	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF TITRATION PACK	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
RECLIPSEN 28 DAY TABLET	0	ACA*
RECOMBINATE 1,241-1,800 UNIT V	MD	SPP*: Must use CVS Specialty
RECOMBIVAX HB 10 MCG/ML SYR	MD	Not covered for members 17 and younger
RECOMBIVAX HB 10 MCG/ML VIAL	MD	
RECOMBIVAX HB 40 MCG/ML VIAL	MD	Not covered for members 17 and younger
RECOMBIVAX HB 5 MCG/0.5 ML VL	MD	Not covered for members 17 and younger
RECTACORT-HC 25 MG SUPPOSITORY	3	
RECTIV 0.4% OINTMENT	3	
REFUAH PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
REGENECARE 2% WOUND GEL	3	
REGLAN 10 MG TABLET	3	
REGLAN 5 MG TABLET	3	
REGRANEX 0.01% GEL	3	Limit fills to 3 in 365 days;Max. 15 GM(s) in 30 days
RELAGARD VAGINAL GEL	3	
RELAGESIC 650-50 MG TABLET	3	
RELENZA 5 MG DISKHALER	3	Max. quantity of 20 per fill

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RELIAMED 30G LANCETS	2	HSA*
RELIAMED SAFETY 23G LANCETS	2	HSA*
RELIAMED SAFETY 28G LANCETS	2	HSA*
RELIAMED SAFETY SEAL 28G LANCT	2	HSA*
RELIAMED SAFETY SEAL 30G LANCT	2	HSA*
RELION CONFIRM-MICRO TEST STRP	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION MICRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION PRIME TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION THIN 26G LANCETS	2	HSA*
RELION ULTIMA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION ULTRA THIN PLUS 33G	2	HSA*
RELION ULTRA THIN PLUS LANCETS	2	HSA*
RELISTOR 12 MG/0.6 ML SYRINGE	2	
RELISTOR 12 MG/0.6 ML VIAL	2	
RELISTOR 150 MG TABLET	3	Prior Authorization required;Max. 3 per day
RELISTOR 8 MG/0.4 ML SYRINGE	2	
RELPAX 20 MG TABLET	3	Max. quantity of 12 per fill;Step Therapy required MQC*: 12 tabs per copay
RELPAX 40 MG TABLET	3	Max. quantity of 6 per fill;Step Therapy required MQC*: 6 tabs/copay
REMERON 15 MG SOLTAB	3	
REMERON 15 MG TABLET	3	
REMERON 30 MG SOLTAB	3	
REMERON 30 MG TABLET	3	
REMERON 45 MG SOLTAB	3	
REMERON 45 MG TABLET	3	
REMEVEN 50% CREAM	1	
RENA-VITE RX TABLET	1	
RENACIDIN IRRIGATION SOLUTION	3	
RENAGEL 400 MG TABLET	2	
RENAGEL 800 MG TABLET	2	
RENAL CAPS SOFTGEL	1	
RENEW ADVANCED MICRO-LANCETS	2	HSA*
RENO CAPS SOFTGEL	1	
RENVELA 0.8 GM POWDER PACKET	2	
RENVELA 2.4 GM POWDER PACKET	2	
RENVELA 800 MG TABLET	2	
REPAGLINIDE 0.5 MG TABLET	1	HSA*
REPAGLINIDE 1 MG TABLET	1	HSA*
REPAGLINIDE 2 MG TABLET	1	HSA*
REPAGLINIDE-METFORMIN 1-500 MG	1	HSA*
REPAGLINIDE-METFORMIN 2-500 MG	1	HSA*
REPATHA 140 MG/ML SURECLICK	2	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
REPATHA 140 MG/ML SYRINGE	2	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
REPATHA 420 MG/3.5ML PUSHTRONX	2	Prior Authorization required;Max. 3.5 ML(s) per 30 days SPP*: Must use CVS Specialty
REPREXAIN 10-200 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
REPREXAIN 2.5-200 MG TABLET	1	
REPREXAIN 5-200 MG TABLET	1	
REPRONEX 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
REQUIP 0.25 MG TABLET	3	
REQUIP 0.5 MG TABLET	3	
REQUIP 1 MG TABLET	3	
REQUIP 2 MG TABLET	3	
REQUIP 3 MG TABLET	3	
REQUIP 4 MG TABLET	3	
REQUIP 5 MG TABLET	3	
REQUIP XL 12 MG TABLET	3	
REQUIP XL 2 MG TABLET	3	
REQUIP XL 4 MG TABLET	3	
REQUIP XL 6 MG TABLET	3	
REQUIP XL 8 MG TABLET	3	
RESCRIPTOR 100 MG TABLET	2	
RESCRIPTOR 200 MG TABLET	2	
RESERPINE 0.1 MG TABLET	1	HSA*
RESERPINE 0.25 MG TABLET	1	HSA*
RESPA A.R. TABLET SA	1	
RESTASIS 0.05% EYE EMULSION	2	Max. 2 per day
RESTASIS MULTIDOSE 0.05% EYE	2	Max. 2 ML(s) per day
RESTIZAN GEL	3	
RESTORIL 15 MG CAPSULE	3	
RESTORIL 22.5 MG CAPSULE	3	
RESTORIL 30 MG CAPSULE	3	
RESTORIL 7.5 MG CAPSULE	3	
RETIN-A 0.01% GEL	3	Prior Authorization required for members 30 and older
RETIN-A 0.025% CREAM	3	Prior Authorization required for members 30 and older
RETIN-A 0.025% GEL	3	Prior Authorization required for members 30 and older
RETIN-A 0.05% CREAM	3	Prior Authorization required for members 30 and older
RETIN-A 0.1% CREAM	3	Prior Authorization required for members 30 and older
RETIN-A MICRO 0.04% GEL	3	Prior Authorization required for members 30 and older
RETIN-A MICRO 0.1% GEL	3	Prior Authorization required for members 30 and older
RETIN-A MICRO PUMP 0.08% GEL	3	Prior Authorization required for members 30 and older
RETROVIR 10 MG/ML SYRUP	3	
RETROVIR 100 MG CAPSULE	3	
REVATIO 10 MG/ML ORAL SUSP	3	Prior Authorization required SPP*: Must use CVS Specialty
REVATIO 20 MG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
REVEAL TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
REVIA 50 MG TABLET	3	
REVLIMID 10 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 15 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 2.5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 20 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 25 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REXULTI 0.25 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 0.5 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 1 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 2 MG TABLET	3	Max. 1 per day;Step Therapy required

DRUG NAME	TIER	LIMITATIONS/ * NOTES
REXULTI 3 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 4 MG TABLET	3	Max. 1 per day;Step Therapy required
REYATAZ 150 MG CAPSULE	2	
REYATAZ 200 MG CAPSULE	2	
REYATAZ 300 MG CAPSULE	2	
REYATAZ 50 MG POWDER PACKET	2	
REZIRA SOLUTION	3	
RHEUMATREX 2.5 MG TABLET	2	
RHINOCORT AQUA NASAL SPRAY	3	
RHINOFLEX-650 TABLET	1	
RHOFADE 1% CREAM	3	Prior Authorization required
RHOGAM ULTRA-FILTERED PLUS SYR	MD	SPP*: Must use CVS Specialty
RIASTAP VIAL	MD	SPP*: Must use CVS Specialty
RIBASPHERE 200 MG CAPSULE	1	SPP*: Must use CVS Specialty
RIBASPHERE 200 MG TABLET	1	SPP*: Must use CVS Specialty
RIBASPHERE 400 MG TABLET	1	SPP*: Must use CVS Specialty
RIBASPHERE 600 MG TABLET	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 200-400 MG	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 400-400 MG	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 600-400 MG	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 600-600 MG	3	SPP*: Must use CVS Specialty
RIBATAB 400-400 MG DOSEPACK	3	SPP*: Must use CVS Specialty
RIBATAB 400-600 MG DOSEPACK	3	SPP*: Must use CVS Specialty
RIBAVIRIN 200 MG CAPSULE	1	SPP*: Must use CVS Specialty
RIBAVIRIN 200 MG TABLET	1	SPP*: Must use CVS Specialty
RIBAVIRIN 6 GM INHALATION VIAL	2	
RIDAURA 3 MG CAPSULE	3	
RIFABUTIN 150 MG CAPSULE	1	
RIFADIN 150 MG CAPSULE	3	
RIFADIN 300 MG CAPSULE	3	
RIFAMATE CAPSULE	3	
RIFAMPIN 150 MG CAPSULE	1	
RIFAMPIN 300 MG CAPSULE	1	
RIFATER TABLET	3	
RIGHTEST GL300 30G LANCETS	2	HSA*
RIGHTEST GS100 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS250S TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS260 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS300 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS550 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RILUTEK 50 MG TABLET	3	
RILUZOLE 50 MG TABLET	1	
RIMANTADINE HCL 100 MG TABLET	1	
RIOMET 500 MG/5 ML SOLUTION	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RISEDRONATE SOD DR 35 MG TAB	1	Max. 4 per 28 days HSA*
RISEDRONATE SODIUM 150 MG TAB	1	Max. 1 in 30 days HSA*
RISEDRONATE SODIUM 30 MG TAB	1	Max. 1 per day HSA*
RISEDRONATE SODIUM 35 MG TAB	1	Max. 4 per 28 days HSA*
RISEDRONATE SODIUM 5 MG TABLET	1	Max. 1 per day HSA*
RISPERDAL 0.25 MG TABLET	3	
RISPERDAL 0.5 MG TABLET	3	
RISPERDAL 1 MG TABLET	3	
RISPERDAL 1 MG/ML SOLUTION	3	
RISPERDAL 2 MG TABLET	3	
RISPERDAL 3 MG TABLET	3	
RISPERDAL 4 MG TABLET	3	
RISPERDAL CONSTA 12.5 MG SYR	MD	SPP*: Must use CVS Specialty
RISPERDAL CONSTA 25 MG SYR	MD	SPP*: Must use CVS Specialty
RISPERDAL CONSTA 37.5 MG SYR	MD	SPP*: Must use CVS Specialty
RISPERDAL CONSTA 50 MG SYR	MD	SPP*: Must use CVS Specialty
RISPERDAL M-TAB 0.5 MG ODT	3	
RISPERDAL M-TAB 1 MG ODT	3	
RISPERDAL M-TAB 2 MG ODT	3	
RISPERDAL M-TAB 3 MG ODT	3	
RISPERDAL M-TAB 4 MG ODT	3	
RISPERIDONE 0.25 MG ODT	1	
RISPERIDONE 0.25 MG TABLET	1	
RISPERIDONE 0.5 MG ODT	1	
RISPERIDONE 0.5 MG TABLET	1	
RISPERIDONE 1 MG ODT	1	
RISPERIDONE 1 MG TABLET	1	
RISPERIDONE 1 MG/ML SOLUTION	1	
RISPERIDONE 2 MG ODT	1	
RISPERIDONE 2 MG TABLET	1	
RISPERIDONE 3 MG ODT	1	
RISPERIDONE 3 MG TABLET	1	
RISPERIDONE 4 MG ODT	1	
RISPERIDONE 4 MG TABLET	1	
RITALIN 10 MG TABLET	3	Max. 60 Days Supply
RITALIN 20 MG TABLET	3	Max. 60 Days Supply
RITALIN 5 MG TABLET	3	Max. 60 Days Supply
RITALIN LA 10 MG CAPSULE	2	Max. 60 Days Supply
RITALIN LA 20 MG CAPSULE	3	Max. 60 Days Supply
RITALIN LA 30 MG CAPSULE	3	Max. 60 Days Supply
RITALIN LA 40 MG CAPSULE	3	Max. 60 Days Supply
RITALIN LA 60 MG CAPSULE	3	Max. 60 Days Supply
RITALIN SR 20 MG TABLET	3	Max. 60 Days Supply
RITEFLO SPACER	MD	
RIVASTIGMINE 1.5 MG CAPSULE	1	
RIVASTIGMINE 13.3 MG/24HR PTCH	1	
RIVASTIGMINE 3 MG CAPSULE	1	
RIVASTIGMINE 4.5 MG CAPSULE	1	
RIVASTIGMINE 4.6 MG/24HR PATCH	1	
RIVASTIGMINE 6 MG CAPSULE	1	
RIVASTIGMINE 9.5 MG/24HR PATCH	1	
RIVELSA TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RIXUBIS 250 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
RIZATRIPTAN 10 MG ODT	1	Max. quantity of 9 per fill MQC*: 9 tabs/copay
RIZATRIPTAN 10 MG TABLET	1	Max. quantity of 9 per fill MQC*: 9 tabs/copay
RIZATRIPTAN 5 MG ODT	1	Max. quantity of 18 per fill MQC*: 4 patches/copay
RIZATRIPTAN 5 MG TABLET	1	Max. quantity of 18 per fill MQC*: 18 tabs/copay
ROBAXIN 500 MG TABLET	3	
ROBAXIN-750 TABLET	3	
ROBINUL 1 MG TABLET	3	
ROBINUL FORTE 2 MG TABLET	3	
ROCALTROL 0.25 MCG CAPSULE	3	
ROCALTROL 0.5 MCG CAPSULE	3	
ROCALTROL 1 MCG/ML ORAL SOLN	3	
ROPINIROLE HCL 0.25 MG TABLET	1	
ROPINIROLE HCL 0.5 MG TABLET	1	
ROPINIROLE HCL 1 MG TABLET	1	
ROPINIROLE HCL 2 MG TABLET	1	
ROPINIROLE HCL 3 MG TABLET	1	
ROPINIROLE HCL 4 MG TABLET	1	
ROPINIROLE HCL 5 MG TABLET	1	
ROPINIROLE HCL ER 12 MG TABLET	1	
ROPINIROLE HCL ER 2 MG TABLET	1	
ROPINIROLE HCL ER 4 MG TABLET	1	
ROPINIROLE HCL ER 6 MG TABLET	1	
ROPINIROLE HCL ER 8 MG TABLET	1	
ROSADAN 0.75% CREAM	1	
ROSADAN 0.75% CREAM KIT	3	
ROSADAN 0.75% GEL	3	
ROSANIL CLEANSER LOTION	2	
ROSULA 10%-5% CLOTHS	3	
ROSUVASTATIN CALCIUM 10 MG TAB	1	HSA*
ROSUVASTATIN CALCIUM 20 MG TAB	1	HSA*
ROSUVASTATIN CALCIUM 40 MG TAB	1	HSA*
ROSUVASTATIN CALCIUM 5 MG TAB	1	HSA*
ROWASA 4 GM/60 ML ENEMA KIT	3	
ROWEEPRA 1,000 MG TABLET	3	
ROWEEPRA 500 MG TABLET	3	
ROWEEPRA 750 MG TABLET	3	
ROXICET 5-325 ORAL SOLUTION	1	
ROXICET 5-325 TABLET	1	
ROXICODONE 15 MG TABLET	3	
ROXICODONE 30 MG TABLET	3	
ROXICODONE 5 MG TABLET	3	
ROZEREM 8 MG TABLET	3	Step Therapy required STA*: 18 and older
RUBRACA 200 MG TABLET	3	CH*; SPP*: CVS Specialty
RUBRACA 250 MG TABLET	3	CH*; SPP*: CVS Specialty
RUBRACA 300 MG TABLET	3	CH*; SPP*: CVS Specialty
RYDAPT 25 MG CAPSULE	3	Prior Authorization required;Max. 8 per day CH*; SPP*: CVS Specialty
RYTARY ER 23.75 MG-95 MG CAP	3	Step Therapy required
RYTARY ER 36.25 MG-145 MG CAP	3	Step Therapy required
RYTARY ER 48.75 MG-195 MG CAP	3	Step Therapy required

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RYTARY ER 61.25 MG-245 MG CAP	3	Step Therapy required
RYTHMOL 150 MG TABLET	3	
RYTHMOL 225 MG TABLET	3	
RYTHMOL SR 225 MG CAPSULE	3	
RYTHMOL SR 325 MG CAPSULE	3	
RYTHMOL SR 425 MG CAPSULE	3	
RYVENT 6 MG TABLET	3	

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SABRIL 500 MG POWDER PACKET	3	SPP*: Must use CVS Specialty
SABRIL 500 MG TABLET	2	SPP*: Must use CVS Specialty
SACCHARIN POWDER	3	
SAFESNAP ALLERGY SYRINGE 1 ML	3	
SAFESNAP SYRINGE 10 ML	3	
SAFESNAP SYRINGE 10 ML	3	
SAFESNAP SYRINGE 3 ML	3	
SAFESNAP SYRINGE 3 ML	3	
SAFESNAP SYRINGE 5 ML	3	
SAFESNAP SYRINGE 5 ML	3	
SAFESNAP TUBERCULIN SYR 1 ML	3	
SAFETY 21G LANCETS	2	HSA*
SAFETY 28G LANCETS	2	HSA*
SAFETY LANCETS 26G	2	HSA*
SAFETY SEAL 28G LANCETS	2	HSA*
SAFETY SEAL 30G LANCETS	2	HSA*
SAFETY SYRINGE W-SHIELD 3 ML	3	
SAFETY-LET 30G LANCETS	2	HSA*
SAFETY-LOK 1 ML TB SYRINGE	3	
SAFETY-LOK 10 ML SYRINGE	3	
SAFETY-LOK 10 ML SYRINGE	3	
SAFETY-LOK 3 ML SYRINGE	3	
SAFETY-LOK 3 ML SYRINGE	3	
SAFETY-LOK 3 ML SYRINGE	3	
SAFETY-LOK 5 ML SYRINGE	3	
SAFETY-LOK 5 ML SYRINGE	3	
SAFYRAL TABLET	0	ACA*
SAIZEN 5 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
SAIZEN 8.8 MG CLICK.EASY CARTG	3	Prior Authorization required SPP*: Must use CVS Specialty
SAIZEN 8.8 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
SALACYN 6% CREAM	3	
SALACYN 6% LOTION	1	
SALAGEN 5 MG TABLET	3	
SALAGEN 7.5 MG TABLET	3	
SALEX 6% CREAM KIT	3	
SALEX 6% LOTION KIT	3	
SALEX 6% SHAMPOO	3	
SALICYLIC ACID 26% LIQUID	1	
SALICYLIC ACID 27.5% LIQUID	1	
SALICYLIC ACID 6% CREAM	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SALICYLIC ACID 6% GEL	1	
SALICYLIC ACID 6% LOTION KIT	1	
SALICYLIC ACID 6% SHAMPOO	1	
SALIVAMAX POWDER PACKET	3	
SALSALATE 500 MG TABLET	1	
SALSALATE 750 MG TABLET	1	
SAMSCA 15 MG TABLET	3	
SAMSCA 30 MG TABLET	3	
SANCTURA 20 MG TABLET	3	
SANCTURA XR 60 MG CAPSULE	3	
SANCUSO 3.1 MG/24 HR PATCH	3	Max. quantity of 4 per fill MQC*: 4 patches/copay
SANDIMMUNE 100 MG CAPSULE	3	
SANDIMMUNE 100 MG/ML SOLN	2	
SANDIMMUNE 25 MG CAPSULE	3	
SANDOSTATIN 0.05 MG/ML AMPUL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 0.1 MG/ML AMPUL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 0.2 MG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 0.5 MG/ML AMPUL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 1 MG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN LAR DEPOT 10 MG VL	MD	Prior Authorization required;Max. 1 per 28 days SPP*: Must use CVS Specialty
SANDOSTATIN LAR DEPOT 20 MG KT	MD	Prior Authorization required;Max. 1 per 28 days SPP*: Must use CVS Specialty
SANDOSTATIN LAR DEPOT 30 MG KT	MD	Prior Authorization required;Max. 1 per 28 days SPP*: Must use CVS Specialty
SANTYL OINTMENT	2	
SAPHRIS 10 MG TAB SL BLK CHERY	3	
SAPHRIS 2.5 MG TAB SL BLK CHRY	3	
SAPHRIS 5 MG TAB SL BLK CHERRY	3	
SARAFEM 10 MG TABLET	2	Step Therapy required STA*: 18 and older
SARAFEM 20 MG TABLET	3	Step Therapy required STA*: 18 and older
SAVAYSA 15 MG TABLET	3	HSA*
SAVAYSA 30 MG TABLET	3	HSA*
SAVAYSA 60 MG TABLET	3	HSA*
SAVELLA 100 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA 12.5 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA 25 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA 50 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA TITRATION PACK	2	Step Therapy required STA*: 18 and older
SB LANCETS THIN 28G	2	HSA*
SB LANCETS ULTRA THIN 30G	2	HSA*
SCALACORT 2% LOTION	3	
SCOPOLAMINE 1 MG/3 DAY PATCH	2	Max. quantity of 4 per fill MQC*: 1 box (4 patches)/copay
SEASONIQUE 0.15-0.03-0.01 TAB	3	Max. 91 Days Supply;Max. 1 per day
SEB-PREV 10% WASH	1	
SECONAL SODIUM 100 MG CAPSULE	3	
SECTRAL 200 MG CAPSULE	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SECTRAL 400 MG CAPSULE	3	HSA*
SEEBRI NEOHALER 15.6 MCG INHAL	3	Max. 2 per day HSA*
SELEGILINE HCL 5 MG CAPSULE	1	
SELEGILINE HCL 5 MG TABLET	1	
SELENIUM SULFIDE 2.25% SHAMPOO	1	
SELENIUM SULFIDE 2.5% LOTION	1	
SELZENTRY 150 MG TABLET	2	
SELZENTRY 20 MG/ML ORAL SOLN	2	
SELZENTRY 25 MG TABLET	2	
SELZENTRY 300 MG TABLET	2	
SELZENTRY 75 MG TABLET	2	
SEMPREX-D 8 MG-60 MG CAPSULE	3	
SENSIPAR 30 MG TABLET	3	SPP*: Must use CVS Specialty
SENSIPAR 60 MG TABLET	3	SPP*: Must use CVS Specialty
SENSIPAR 90 MG TABLET	3	SPP*: Must use CVS Specialty
SEREVENT DISKUS 50 MCG	2	Max. 60 in 30 days HSA*
SERNIVO 0.05% SPRAY	3	Max. 4 ML(s) per day
SEROPHENE 50 MG TABLET	3	
SEROQUEL 100 MG TABLET	3	
SEROQUEL 200 MG TABLET	3	
SEROQUEL 25 MG TABLET	3	
SEROQUEL 300 MG TABLET	3	
SEROQUEL 400 MG TABLET	3	
SEROQUEL 50 MG TABLET	3	
SEROQUEL XR 150 MG TABLET	3	
SEROQUEL XR 200 MG TABLET	3	
SEROQUEL XR 300 MG TABLET	3	
SEROQUEL XR 400 MG TABLET	3	
SEROQUEL XR 50 MG TABLET	3	
SEROQUEL XR SAMPLE KIT	3	
SEROSTIM 4 MG VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
SEROSTIM 5 MG VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
SEROSTIM 6 MG VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
SERTRALINE 20 MG/ML ORAL CONC	1	
SERTRALINE HCL 100 MG TABLET	1	
SERTRALINE HCL 25 MG TABLET	1	
SERTRALINE HCL 50 MG TABLET	1	
SETLAKIN 0.15 MG-0.03 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
SEVELAMER 0.8 GM POWDER PACKET	2	
SEVELAMER 2.4 GM POWDER PACKET	2	
SEVELAMER CARBONATE 800 MG TAB	1	
SF 5000 PLUS CREAM	1	
SHAROBEL 0.35 MG TABLET	0	ACA*
SHINGRIX ADJUVANT COMPONENT	0	Not covered for members 49 and younger ACA*; Covered ages 50 and older
SHINGRIX GE ANTIGEN COMPONENT	0	Not covered for members 49 and younger ACA*; Covered ages 50 and older
SHINGRIX VIAL KIT	0	Not covered for members 49 and younger ACA*; Covered ages 50 and older
SHOHL'S MODIFIED SOLUTION	3	
SIDEROL LIQUID	1	
SIDESTREAM PEDIATRIC FACE MASK	MD	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SIGNIFOR 0.3 MG/ML AMPULE	3	LDD*: Accredo (866) 815-4717
SIGNIFOR 0.6 MG/ML AMPULE	3	LDD*: Accredo (866) 815-4717
SIGNIFOR 0.9 MG/ML AMPULE	3	LDD*: Accredo (866) 815-4717
SILDENAFIL 20 MG TABLET	1	Prior Authorization required SPP*: Must use CVS Specialty
SILENOR 3 MG TABLET	3	Step Therapy required STA*: 18 and older
SILENOR 6 MG TABLET	3	Step Therapy required STA*: 18 and older
SILHOUETTE INFUSION SET 43"	MD	
SILICONE MASK-INFANT	MD	
SILICONE MASK-PEDIATRIC	MD	
SILIQ 210 MG/1.5 ML SYRINGE	3	Prior Authorization required SPP*: Must use CVS Specialty; PA NTM*
SILVADENE 1% CREAM	3	
SILVER NITRATE 0.5% SOLN	1	
SILVER NITRATE 10% OINTMENT	1	
SILVER NITRATE 10% SOLUTION	1	
SILVER NITRATE 25% SOLUTION	1	
SILVER NITRATE 50% SOLUTION	1	
SILVER NITRATE APPLICATOR	1	
SILVER SULFADIAZINE 1% CREAM	1	
SILVRSTAT DRESSING GEL	3	
SIMBRINZA 1%-0.2% EYE DROPS	2	
SIMCOR 1,000-20 MG TABLET	2	HSA*
SIMCOR 1,000-40 MG TABLET	2	HSA*
SIMCOR 500-20 MG TABLET	2	HSA*
SIMCOR 500-40 MG TABLET	2	HSA*
SIMCOR 750-20 MG TABLET	2	HSA*
SIMPONI 100 MG/ML PEN INJECTOR	3	Prior Authorization required;Max. 1 ML(s) per 30 days SPP*: Must use CVS Specialty
SIMPONI 100 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) per 30 days SPP*: Must use CVS Specialty
SIMPONI 50 MG/0.5 ML PEN INJEC	3	Prior Authorization required;Max. 0.5 ML(s) per 30 days SPP*: Must use CVS Specialty
SIMPONI 50 MG/0.5 ML SYRINGE	3	Prior Authorization required;Max. 0.5 ML(s) per 30 days SPP*: Must use CVS Specialty
SIMVASTATIN 10 MG TABLET	0	ACA*
SIMVASTATIN 20 MG TABLET	0	ACA*
SIMVASTATIN 40 MG TABLET	0	ACA*
SIMVASTATIN 5 MG TABLET	0	ACA*
SIMVASTATIN 80 MG TABLET	0	ACA*
SINEMET 10-100 MG TABLET	3	
SINEMET 25-100 MG TABLET	3	
SINEMET 25-250 MG TABLET	3	
SINEMET CR 25-100 TABLET	3	
SINEMET CR 50-200 TABLET	3	
SINGLE-LET LANCETS	2	HSA*
SINGULAIR 10 MG TABLET	3	HSA*
SINGULAIR 4 MG GRANULES	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SINGULAIR 4 MG TABLET CHEW	3	HSA*
SINGULAIR 5 MG TABLET CHEW	3	HSA*
SIROLIMUS 0.5 MG TABLET	1	
SIROLIMUS 1 MG TABLET	1	
SIROLIMUS 2 MG TABLET	1	
SIRTURO 100 MG TABLET	3	Max. quantity of 32 per fill
SITAVIG 50 MG BUCCAL TABLET	3	Max. quantity of 1 per fill;Max. 2 in 30 days MQC*: 1 tab/per copay. Max. 2 tabs/30 days
SIVEXTRO 200 MG TABLET	3	Max. quantity of 6 per fill MQC*: 6 tabs/copay
SKELAXIN 800 MG TABLET	3	
SKLICE 0.5% LOTION	3	
SM BUFF ASPIRIN 325 MG TAB	0	ACA*
SM COLOR LANCETS 21G	2	HSA*
SM LANCETS 21G	2	HSA*
SM THIN LANCETS 26G	2	HSA*
SMART CARESENS N TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMART SENSE COLOR 33G LANCETS	2	HSA*
SMART SENSE STANDARD 21G	2	HSA*
SMART SENSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMART SENSE THIN 26G LANCETS	2	HSA*
SMARTDIABETES VANTAGE 30G	2	HSA*
SMARTDIABETES XPRES TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMARTEST LANCET	2	HSA*
SMARTEST TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMARTRX GABA-V KIT	3	
SOD CITRATE-CITRIC ACID SOLN	1	
SOD POLYSTYREN SULF 15 G/60 ML	1	
SOD SULFACE-SULF 9.8-4.8% CLSR	1	
SOD SULFACE-SULFUR 10-5% CLOTH	1	
SOD SULFACET-SULFUR 10-2% CLSR	3	
SOD SULFACET-SULFUR 10-5% CLSR	1	
SOD SULFACETAMIDE 10% SHAMPOO	1	
SOD SULFACETAMIDE-SULFUR LOTN	1	
SODIUM CHLORIDE 0.9% INHAL VL	1	
SODIUM CHLORIDE 0.9% IRRIG.	1	
SODIUM CHLORIDE 10% VIAL	1	
SODIUM CHLORIDE 3% VIAL	1	
SODIUM CHLORIDE 7% VIAL	1	
SODIUM CITRATE 4% SOLN	1	
SODIUM FLUORIDE 0.5 MG/ML DROP	1	ACA*: Children through age 5; HSA
SODIUM PHENYLBUTYRATE 500MG TB	2	
SODIUM PHENYLBUTYRATE POWDER	1	
SODIUM SUCCINATE POWDER	3	
SODIUM SULFACETAMIDE 10% WASH	1	
SOF-SET MICRO INFUSION SET	MD	
SOF-SET ULTIMATE QR SET	MD	
SOFT TOUCH LANCETS	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SOLARAZE 3% GEL	3	
SOLIQUA 100 UNIT-33 MCG/ML PEN	3	Prior Authorization required HSA*
SOLODYN ER 105 MG TABLET	3	Prior Authorization required
SOLODYN ER 115 MG TABLET	3	Prior Authorization required
SOLODYN ER 55 MG TABLET	3	Prior Authorization required
SOLODYN ER 65 MG TABLET	3	Prior Authorization required
SOLODYN ER 80 MG TABLET	3	Prior Authorization required
SOLTAMOX 10 MG/5 ML SOLN	3	CH*; HSA*
SOLUS V2 28G LANCETS	2	HSA*
SOLUS V2 30G TWIST LANCETS	2	HSA*
SOLUS V2 AUDIBLE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SOMA 250 MG TABLET	3	
SOMA 350 MG TABLET	3	
SOMATULINE DEPOT 120 MG/0.5 ML	2	Prior Authorization required;Max. 0.5 ML(s) per 28 days SPP*: Must use CVS Specialty
SOMATULINE DEPOT 60 MG/0.2 ML	2	Prior Authorization required;Max. 0.2 ML(s) per 28 days SPP*: Must use CVS Specialty
SOMATULINE DEPOT 90 MG/0.3 ML	2	Prior Authorization required;Max. 0.3 ML(s) per 28 days SPP*: Must use CVS Specialty
SOMAVERT 10 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 15 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 20 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 25 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 30 MG VIAL	3	SPP*: Must use CVS Specialty
SONAFINE TOPICAL EMULSION	1	
SONATA 10 MG CAPSULE	3	Step Therapy required STA*: 18 and older
SONATA 5 MG CAPSULE	3	Step Therapy required STA*: 18 and older
SOOLANTRA 1% CREAM	3	
SORBITOL 70% SOLUTION	3	
SORIATANE 10 MG CAPSULE	3	
SORIATANE 17.5 MG CAPSULE	3	
SORIATANE 25 MG CAPSULE	3	
SORILUX 0.005% FOAM	3	
SORINE 120 MG TABLET	1	HSA*
SORINE 160 MG TABLET	1	HSA*
SORINE 240 MG TABLET	1	HSA*
SORINE 80 MG TABLET	1	HSA*
SOTALOL 120 MG TABLET	1	HSA*
SOTALOL 160 MG TABLET	1	HSA*
SOTALOL 240 MG TABLET	1	HSA*
SOTALOL 80 MG TABLET	1	HSA*
SOTYLIZE 5 MG/ML ORAL SOLUTION	2	HSA*
SOVALDI 400 MG TABLET	2	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
SPACE CHAMBER PLUS	MD	
SPECTRACEF 400 MG DOSE PACK TB	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SPINOSAD 0.9% TOPICAL SUSP	1	
SPIRIVA 18 MCG CP-HANDIHALER	2	Max. 1 per day HSA*; Max 1 inhaler/30 days supply
SPIRIVA RESPIMAT 1.25 MCG INH	2	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
SPIRIVA RESPIMAT 2.5 MCG INH	2	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
SPIRONOLACTONE 100 MG TABLET	1	HSA*
SPIRONOLACTONE 25 MG TABLET	1	HSA*
SPIRONOLACTONE 50 MG TABLET	1	HSA*
SPIRONOLACTONE-HCTZ 25-25 TAB	1	HSA*
SPORANOX 10 MG/ML SOLUTION	3	
SPORANOX 100 MG CAPSULE	3	Max. 84 Days Supply;Prior Authorization required;Max. 168 in 365 days
SPRAY AND STRETCH SPRAY	3	
SPRINTEC 28 DAY TABLET	0	ACA*
SPRITAM 1,000 MG TABLET	3	
SPRITAM 250 MG TABLET	3	
SPRITAM 500 MG TABLET	3	
SPRITAM 750 MG TABLET	3	
SPRIX 15.75 MG NASAL SPRAY	3	Max. quantity of 5 per fill
SPRYCEL 100 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 140 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 20 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 50 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 70 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 80 MG TABLET	2	CH*; SPP*: CVS Specialty
SPS 15 GM/60 ML SUSPENSION	1	
SPS 30 GM/120 ML ENEMA	1	
SRONYX 0.10-0.02 MG TABLET	0	ACA*
SSD 1% CREAM	1	
SSKI 1 GM/ML SOLUTION	1	
ST. JOSEPH ASPIRIN 81 MG CHEW	0	ACA*
ST. JOSEPH ASPIRIN EC 81 MG TB	0	ACA*
STALEVO 100 TABLET	3	
STALEVO 125 TABLET	3	
STALEVO 150 TABLET	3	
STALEVO 200 TABLET	3	
STALEVO 50 TABLET	3	
STALEVO 75 TABLET	3	
STANNOUS FLUOR 0.63% RINSE	1	
STARLIX 120 MG TABLET	3	HSA*
STARLIX 60 MG TABLET	3	HSA*
STAVUDINE 1 MG/ML SOLUTION	1	
STAVUDINE 15 MG CAPSULE	1	
STAVUDINE 20 MG CAPSULE	1	
STAVUDINE 30 MG CAPSULE	1	
STAVUDINE 40 MG CAPSULE	1	
STAVZOR DR 125 MG CAPSULE	3	
STAVZOR DR 250 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
STAVZOR DR 500 MG CAPSULE	3	
STAXYN 10 MG ODT	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STELARA 45 MG/0.5 ML SYRINGE	MD	Prior Authorization required SPP*: Must use CVS Specialty
STELARA 90 MG/ML SYRINGE	MD	Prior Authorization required SPP*: Must use CVS Specialty
STENDRA 100 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STENDRA 200 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STENDRA 50 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STERILANCE TL TWIST 30G LANCET	2	HSA*
STERILANCE TL TWIST 32G LANCET	2	HSA*
STIMATE 1.5 MG/ML NASAL SPRAY	2	
STIOLTO RESPIMAT INHAL SPRAY	3	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
STIVARGA 40 MG TABLET	3	CH*; SPP*: CVS Specialty
STRATTERA 10 MG CAPSULE	3	
STRATTERA 100 MG CAPSULE	3	
STRATTERA 18 MG CAPSULE	3	
STRATTERA 25 MG CAPSULE	3	
STRATTERA 40 MG CAPSULE	3	
STRATTERA 60 MG CAPSULE	3	
STRATTERA 80 MG CAPSULE	3	
STRENSIQ 18 MG/0.45 ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRENSIQ 28 MG/0.7 ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRENSIQ 40 MG/ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRENSIQ 80 MG/0.8 ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRIANT 30 MG MUCOADHESIVE	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 2 per day
STRIBILD TABLET	3	
STRIVERDI RESPIMAT INHAL SPRAY	3	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
STROMECTOL 3 MG TABLET	3	
STRONG IODINE SOLUTION	1	
STROVITE FORTE CAPLET	1	
STROVITE ONE CAPLET	3	
STROVITE PLUS CAPLET	1	
STROVITE TABLET	1	
SUBOXONE 12 MG-3 MG SL FILM	2	
SUBOXONE 2 MG-0.5 MG SL FILM	2	
SUBOXONE 4 MG-1 MG SL FILM	2	
SUBOXONE 8 MG-2 MG SL FILM	2	
SUBSYS 1,200 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 1,600 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 100 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 200 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 400 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 600 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 800 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SUCLEAR BOWEL PREP KIT	3	
SUCRAID 8,500 UNITS/ML SOLN	3	LDD*: Accredo (866) 815-4717
SUCRALFATE 1 GM TABLET	1	
SULAR ER 17 MG TABLET	3	HSA*
SULAR ER 34 MG TABLET	3	HSA*
SULAR ER 8.5 MG TABLET	3	HSA*
SULF-PRED 10-0.23% EYE DROPS	1	
SULFACETAMIDE 10% EYE DROPS	1	
SULFACETAMIDE 10% EYE OINTMENT	1	
SULFACETAMIDE SOD 10% TOP SUSP	1	
SULFACETAMIDE-SULFUR 10-2% CRM	1	
SULFACETAMIDE-SULFUR 10-5% CRM	1	
SULFADIAZINE 500 MG TABLET	1	
SULFAMETHOXAZOLE-TMP DS TABLET	1	
SULFAMETHOXAZOLE-TMP SS TABLET	1	
SULFAMETHOXAZOLE-TMP SUSP	1	
SULFAMYLON 8.5% CREAM	3	
SULFAMYLON POWDER PACKET	3	
SULFASALAZINE 500 MG TABLET	1	
SULFASALAZINE DR 500 MG TAB	1	
SULFATRIM PEDIATRIC SUSPENSION	1	
SULINDAC 150 MG TABLET	1	
SULINDAC 200 MG TABLET	1	
SUMATRIPTAN 20 MG NASAL SPRAY	1	Max. quantity of 6 per fill MQC*: 6 sprays/copay
SUMATRIPTAN 4 MG/0.5 ML CART	1	Max. quantity of 3 per fill
SUMATRIPTAN 4 MG/0.5 ML INJECT	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 5 MG NASAL SPRAY	1	Max. quantity of 6 per fill MQC*: 6 sprays/copay
SUMATRIPTAN 6 MG/0.5 ML INJECT	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 6 MG/0.5 ML REFILL	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 6 MG/0.5 ML SYRNG	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 6 MG/0.5 ML VIAL	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN SUCC 100 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
SUMATRIPTAN SUCC 25 MG TABLET	1	Max. quantity of 6 per fill MQC*: 24 tabs/copay
SUMATRIPTAN SUCC 50 MG TABLET	1	MQC*: 12 tabs/copay
SUMAVEL DOSEPRO 4 MG/0.5 ML	3	Max. 3 ML(s) per day;Max. quantity of 3 per fill MQC*: 6 pens/copay
SUMAVEL DOSEPRO 6 MG/0.5 ML	3	Max. 10 ML(s) per day;Max. quantity of 3 per fill MQC*: 6 pens/copay
SUPER THIN 28G LANCETS	2	HSA*
SUPER THIN 33G LANCETS	2	HSA*
SUPERVITE LIQUID	3	
SUPRAX 100 MG TABLET CHEWABLE	3	
SUPRAX 100 MG/5 ML SUSPENSION	3	
SUPRAX 200 MG TABLET CHEWABLE	3	
SUPRAX 200 MG/5 ML SUSPENSION	3	
SUPRAX 400 MG CAPSULE	3	
SUPRAX 400 MG TABLET	2	
SUPRAX 500 MG/5 ML SUSPENSION	3	
SUPREP BOWEL PREP KIT	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SURE COMFORT 18G LANCETS	2	HSA*
SURE COMFORT 21G LANCETS	2	HSA*
SURE COMFORT 23G LANCETS	2	HSA*
SURE COMFORT 28G LANCETS	2	HSA*
SURE COMFORT 30G LANCETS	2	HSA*
SURE EDGE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURE RESULT DSS PREMIUM PACK	3	
SURE-LANCE 26G LANCETS	2	HSA*
SURE-LANCE FLAT LANCETS	2	HSA*
SURE-LANCE THIN 28G LANCETS	2	HSA*
SURE-LANCE ULTRA THIN 30G	2	HSA*
SURE-T PARADIGM 23" SET	MD	
SURE-TEST EASYPLUS MINI STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURE-TOUCH LANCET	2	HSA*
SURECHEK TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURESTEP PRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURMONTIL 100 MG CAPSULE	3	
SURMONTIL 25 MG CAPSULE	3	
SURMONTIL 50 MG CAPSULE	3	
SURVANTA 25 MG/ML VIAL	3	
SUSTIVA 200 MG CAPSULE	2	
SUSTIVA 50 MG CAPSULE	2	
SUSTIVA 600 MG TABLET	2	
SUTENT 12.5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SUTENT 25 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SUTENT 37.5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SUTENT 50 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SYEDA 28 TABLET	0	ACA*
SYLATRON 200 MCG KIT	3	SPP*: Must use CVS Specialty
SYLATRON 300 MCG KIT	3	SPP*: Must use CVS Specialty
SYLATRON 600 MCG KIT	3	SPP*: Must use CVS Specialty
SYMBICORT 160-4.5 MCG INHALER	2	Max. 10.2 GM(s) in 30 days HSA*
SYMBICORT 80-4.5 MCG INHALER	2	Max. 10.2 GM(s) in 30 days HSA*
SYMBYAX 12-25 MG CAPSULE	3	
SYMBYAX 12-50 MG CAPSULE	3	
SYMBYAX 3-25 MG CAPSULE	3	
SYMBYAX 6-25 MG CAPSULE	3	
SYMBYAX 6-50 MG CAPSULE	3	
SYMLINPEN 120 PEN INJECTOR	2	HSA*
SYMLINPEN 60 PEN INJECTOR	2	HSA*
SYMPROIC 0.2 MG TABLET	3	Prior Authorization required PA NTM*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SYNAGIS 100 MG/1 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SYNAGIS 50 MG/0.5 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SYNALAR 0.01% SOLUTION	3	
SYNALAR 0.025% CREAM	3	
SYNALAR 0.025% CREAM KIT	3	
SYNALAR 0.025% OINTMENT	3	
SYNALAR 0.025% OINTMENT KIT	3	
SYNALAR TS 0.01% KIT	3	
SYNALGOS-DC CAPSULE	3	
SYNAREL 2 MG/ML NASAL SPRAY	2	Max. 30 Days Supply IVF*
SYNDROS 5 MG/ML SOLUTION	3	
SYNERA PATCH	3	
SYNJARDY 12.5-1,000 MG TABLET	3	HSA*
SYNJARDY 12.5-500 MG TABLET	3	HSA*
SYNJARDY 5-1,000 MG TABLET	3	HSA*
SYNJARDY 5-500 MG TABLET	3	HSA*
SYNJARDY XR 10-1,000 MG TABLET	3	HSA*
SYNJARDY XR 12.5-1,000 MG TAB	3	HSA*
SYNJARDY XR 25-1,000 MG TABLET	3	HSA*
SYNJARDY XR 5-1,000 MG TABLET	3	HSA*
SYNTHROID 100 MCG TABLET	2	
SYNTHROID 112 MCG TABLET	2	
SYNTHROID 125 MCG TABLET	2	
SYNTHROID 137 MCG TABLET	2	
SYNTHROID 150 MCG TABLET	2	
SYNTHROID 175 MCG TABLET	2	
SYNTHROID 200 MCG TABLET	2	
SYNTHROID 25 MCG TABLET	2	
SYNTHROID 300 MCG TABLET	2	
SYNTHROID 50 MCG TABLET	2	
SYNTHROID 75 MCG TABLET	2	
SYNTHROID 88 MCG TABLET	2	
SYPRINE 250 MG CAPSULE	3	Prior Authorization required
SYRINGE 35 ML	3	
SYRINGE W-NEEDLE 1 ML 25X1"	3	
SYRINGE W-O NDL 12 ML-NON-STRL	3	
SYRINGE W-O NDL 20 ML-NON-STRL	3	
SYRINGE W-O NDL 35 ML-NON-STRL	3	
SYRINGE W-O NDL 6 ML NON-STRL	3	
SYRINGE W-O NEEDLE 140 ML	3	
SYRINGE W-O NEEDLE 60 ML	3	
SYRINGE W-O NEEDLE 60 ML	3	

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TABLOID 40 MG TABLET	2	CH*
TACLONEX 0.005%-0.064% SUSPENS	3	
TACLONEX OINTMENT	3	
TACROLIMUS 0.03% OINTMENT	1	Prior Authorization required
TACROLIMUS 0.1% OINTMENT	1	Prior Authorization required

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TACROLIMUS 0.5 MG CAPSULE	1	
TACROLIMUS 1 MG CAPSULE	1	
TACROLIMUS 5 MG CAPSULE	1	
TAFINLAR 50 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TAFINLAR 75 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TAGRISSO 40 MG TABLET	3	CH*; SPP*: CVS Specialty
TAGRISSO 80 MG TABLET	3	CH*; SPP*: CVS Specialty
TAKE ACTION 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
TALTZ 80 MG/ML AUTOINJECTOR	3	Prior Authorization required;Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
TALTZ 80 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
TAMIFLU 30 MG CAPSULE	3	Max. 10 Days Supply;Max. 20 in 180 days
TAMIFLU 45 MG CAPSULE	3	Max. 10 Days Supply;Max. 20 in 180 days
TAMIFLU 6 MG/ML SUSPENSION	3	Max. 240 ML(s) in 180 days
TAMIFLU 75 MG CAPSULE	3	Max. 10 Days Supply;Max. 10 in 180 days
TAMOXIFEN 10 MG TABLET	1	CH*; HSA*
TAMOXIFEN 20 MG TABLET	1	CH*; HSA*
TAMSULOSIN HCL 0.4 MG CAPSULE	1	
TANZEUM 30 MG PEN INJECT	3	Max. 4 per 28 days;Step Therapy required HSA*
TANZEUM 50 MG PEN INJECT	3	Max. 4 per 28 days;Step Therapy required HSA*
TAPAZOLE 10 MG TABLET	3	
TAPAZOLE 5 MG TABLET	3	
TARCEVA 100 MG TABLET	2	CH*; SPP*: CVS Specialty
TARCEVA 150 MG TABLET	2	CH*; SPP*: CVS Specialty
TARCEVA 25 MG TABLET	2	CH*; SPP*: CVS Specialty
TARGADOX 50 MG TABLET	3	Max. 2 per day
TARGRETIN 1% GEL	3	HSA*
TARGRETIN 75 MG CAPSULE	3	CH*
TARINA FE 1-20 TABLET	0	ACA*
TARKA ER 1-240 MG TABLET	3	HSA*
TARKA ER 2-180 MG TABLET	3	HSA*
TARKA ER 2-240 MG TABLET	3	HSA*
TARKA ER 4-240 MG TABLET	3	HSA*
TASIGNA 150 MG CAPSULE	2	CH*; SPP*: CVS Specialty
TASIGNA 200 MG CAPSULE	2	CH*; SPP*: CVS Specialty
TASMAR 100 MG TABLET	3	
TAYTULLA 1 MG-20 MCG CAPSULE	0	ACA*
TAZAROTENE 0.1% CREAM	2	Prior Authorization required for members 30 and older
TAZORAC 0.05% CREAM	3	Prior Authorization required for members 30 and older
TAZORAC 0.05% GEL	3	Prior Authorization required for members 30 and older
TAZORAC 0.1% CREAM	3	Prior Authorization required for members 30 and older
TAZORAC 0.1% GEL	3	Prior Authorization required for members 30 and older
TAZTIA XT 120 MG CAPSULE	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TAZTIA XT 180 MG CAPSULE	1	HSA*
TAZTIA XT 240 MG CAPSULE	1	HSA*
TAZTIA XT 300 MG CAPSULE	1	HSA*
TAZTIA XT 360 MG CAPSULE	1	HSA*
TD GOLD TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TECFIDERA DR 120 MG CAPSULE	2	SPP*: Must use CVS Specialty
TECFIDERA DR 240 MG CAPSULE	2	SPP*: Must use CVS Specialty
TECFIDERA STARTER PACK	2	SPP*: Must use CVS Specialty
TECHLITE 28G LANCETS	2	HSA*
TECHLITE 30G LANCETS	2	HSA*
TECHNIVIE DOSE PACK	3	Prior Authorization required;Max. 56 per 28 days Max 56 tabs/28 days supply; SPP*: Must use CVS Specialty
TEGRETOL 100 MG/5 ML SUSP	3	
TEGRETOL 200 MG TABLET	3	
TEGRETOL XR 100 MG TABLET	3	
TEGRETOL XR 200 MG TABLET	3	
TEGRETOL XR 400 MG TABLET	3	
TEKAMLO 150 MG-10 MG TABLET	2	Max. 1.5 per day HSA*
TEKAMLO 150 MG-5 MG TABLET	2	Max. 1.5 per day HSA*
TEKAMLO 300 MG-10 MG TABLET	2	Max. 1 per day HSA*
TEKAMLO 300 MG-5 MG TABLET	2	Max. 1 per day HSA*
TEKTURNA 150 MG TABLET	2	Max. 1.5 per day HSA*
TEKTURNA 300 MG TABLET	2	Max. 1 per day HSA*
TEKTURNA HCT 150-12.5 MG TAB	2	Max. 45 in 30 days HSA*
TEKTURNA HCT 150-25 MG TABLET	2	Max. 45 in 30 days HSA*
TEKTURNA HCT 300-12.5 MG TAB	2	Max. 30 in 30 days HSA*
TEKTURNA HCT 300-25 MG TABLET	2	Max. 30 in 30 days HSA*
TELCARE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
TELCARE ULTRA THIN 30G LANCETS	2	HSA*
TELMISARTAN 20 MG TABLET	1	HSA*
TELMISARTAN 40 MG TABLET	1	HSA*
TELMISARTAN 80 MG TABLET	1	HSA*
TELMISARTAN-AMLODIPINE 40-10	1	Max. 30 in 30 days HSA*
TELMISARTAN-AMLODIPINE 40-5 MG	1	Max. 30 in 30 days HSA*
TELMISARTAN-AMLODIPINE 80-10	1	Max. 30 in 30 days HSA*
TELMISARTAN-AMLODIPINE 80-5 MG	1	Max. 30 in 30 days HSA*
TELMISARTAN-HCTZ 40-12.5 MG TB	1	HSA*
TELMISARTAN-HCTZ 80-12.5 MG TB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TELMISARTAN-HCTZ 80-25 MG TAB	1	HSA*
TEMAZEPAM 15 MG CAPSULE	1	
TEMAZEPAM 22.5 MG CAPSULE	1	
TEMAZEPAM 30 MG CAPSULE	1	
TEMAZEPAM 7.5 MG CAPSULE	1	
TEMODAR 100 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TEMODAR 140 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TEMODAR 180 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TEMODAR 20 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TEMODAR 250 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TEMODAR 5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TEMOVATE 0.05% CREAM	3	
TEMOVATE 0.05% OINTMENT	3	
TEMOZOLOMIDE 100 MG CAPSULE	1	CH*; SPP*: CVS Specialty
TEMOZOLOMIDE 140 MG CAPSULE	1	CH*; SPP*: CVS Specialty
TEMOZOLOMIDE 180 MG CAPSULE	1	CH*; SPP*: CVS Specialty
TEMOZOLOMIDE 20 MG CAPSULE	1	CH*; SPP*: CVS Specialty
TEMOZOLOMIDE 250 MG CAPSULE	1	CH*; SPP*: CVS Specialty
TEMOZOLOMIDE 5 MG CAPSULE	1	CH*; SPP*: CVS Specialty
TENCON 50-325 MG TABLET	1	
TENCON TABLET	3	
TENEX 1 MG TABLET	3	HSA*
TENEX 2 MG TABLET	3	HSA*
TENORETIC 100 TABLET	3	HSA*
TENORETIC 50 TABLET	3	HSA*
TENORMIN 100 MG TABLET	3	HSA*
TENORMIN 25 MG TABLET	3	HSA*
TENORMIN 50 MG TABLET	3	HSA*
TERAZOL 3 80 MG SUPPOSITORY	3	
TERAZOL 3 CREAM	3	
TERAZOL 7 CREAM	3	
TERAZOSIN 1 MG CAPSULE	1	HSA*
TERAZOSIN 10 MG CAPSULE	1	HSA*
TERAZOSIN 2 MG CAPSULE	1	HSA*
TERAZOSIN 5 MG CAPSULE	1	HSA*
TERBINAFINE HCL 250 MG TABLET	1	Max. quantity of 28 per fill;Max. 84 in 365 days
TERBUTALINE SULFATE 2.5 MG TAB	1	HSA*
TERBUTALINE SULFATE 5 MG TAB	1	HSA*
TERCONAZOLE 0.4% CREAM	1	
TERCONAZOLE 0.8% CREAM	1	
TERCONAZOLE 80 MG SUPPOSITORY	1	
TERSI 2.25% FOAM	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TERUMO ALLERGY 1 ML 27GX1/2"	3	
TERUMO HYPODERMIC NDL-SYRIN	3	
TERUMO SURGUARD2 SYR 20G-10 ML	3	
TERUMO SURGUARD2 SYR 20G-3 ML	3	
TERUMO SURGUARD2 SYR 20G-5 ML	3	
TERUMO SURGUARD2 SYR 21G 3 ML	3	
TERUMO SURGUARD2 SYR 21G-10 ML	3	
TERUMO SURGUARD2 SYR 21G-3 ML	3	
TERUMO SURGUARD2 SYR 21G-5 ML	3	
TERUMO SURGUARD2 SYR 22G 3 ML	3	
TERUMO SURGUARD2 SYR 23G 3 ML	3	
TERUMO SURGUARD2 SYR 25G 3 ML	3	
TERUMO SURGUARD2 SYR 25G-1 ML	3	
TERUMO SURGUARD2 SYR 26G-1 ML	3	
TERUMO SURGUARD2 SYR 27G-1 ML	3	
TERUMO SYRINGE 3 ML	3	
TERUMO SYRINGE 30 ML	3	
TESSALON PERLE 100 MG CAP	3	
TEST N'GO GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TESTIM 1% (50MG) GEL	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 GM(s) per day
TESTONE CIK KIT	3	Max. 2 per 15 days
TESTOSTERON CYP 1,000 MG/10 ML	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 ML(s) in 30 days
TESTOSTERON ENAN 1,000 MG/5 ML	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 5 ML(s) in 30 days
TESTOSTERONE 10 MG GEL PUMP	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 120 GM(s) in 30 days
TESTOSTERONE 12.5 MG/1.25 GRAM	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 300 GM(s) in 30 days
TESTOSTERONE 25 MG/2.5 GM PKT	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 2.5 GM(s) per day
TESTOSTERONE 30 MG/1.5 ML PUMP	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 180 ML(s) in 30 days
TESTOSTERONE 50 MG/5 GRAM GEL	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 GM(s) per day
TESTOSTERONE 50 MG/5 GRAM PKT	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 GM(s) per day
TESTOSTERONE CYP 200 MG/ML	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 4 ML(s) in 30 days
TESTRED 10 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required
TETCAINE 0.5% EYE DROPS	1	
TETRABENAZINE 12.5 MG TABLET	1	SPP*: Must use CVS Specialty
TETRABENAZINE 25 MG TABLET	1	SPP*: Must use CVS Specialty
TETRACAINE 0.5% EYE DROPS	1	
TETRACYCLINE 250 MG CAPSULE	1	
TETRACYCLINE 500 MG CAPSULE	1	
TETRAVISC 0.5% EYE DROPS	3	
TETRIX CREAM	3	
TETRIX CREAM KIT	3	
TEVETEN 600 MG TABLET	3	HSA*
TEVETEN HCT 600-12.5 MG TAB	3	HSA*
TEVETEN HCT 600-25 MG TAB	3	HSA*
TEXACORT 2.5% SOLUTION	3	
TEXAVITE LQ DROPS	3	
THALOMID 100 MG CAPSULE	2	CH*; SPP*: CVS Specialty
THALOMID 150 MG CAPSULE	2	CH*; SPP*: CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
THALOMID 200 MG CAPSULE	2	CH*; SPP*: CVS Specialty
THALOMID 50 MG CAPSULE	2	CH*; SPP*: CVS Specialty
THEO-24 ER 100 MG CAPSULE	2	HSA*
THEO-24 ER 200 MG CAPSULE	2	HSA*
THEO-24 ER 300 MG CAPSULE	2	HSA*
THEO-24 ER 400 MG CAPSULE	2	HSA*
THEOCHRON ER 100 MG TABLET	1	HSA*
THEOCHRON ER 200 MG TABLET	1	HSA*
THEOCHRON ER 300 MG TABLET	1	HSA*
THEOPHYLLINE 80 MG/15 ML SOLN	1	HSA*
THEOPHYLLINE ER 100 MG TABLET	1	HSA*
THEOPHYLLINE ER 200 MG TABLET	1	HSA*
THEOPHYLLINE ER 300 MG TAB	1	HSA*
THEOPHYLLINE ER 400 MG TABLET	1	HSA*
THEOPHYLLINE ER 450 MG TAB	1	HSA*
THEOPHYLLINE ER 600 MG TABLET	1	HSA*
THERAPEUTIC HEMATINIC TAB	1	
THERMAZENE 1% CREAM	3	
THIN LANCETS 28G	2	HSA*
THIOLA 100 MG TABLET	3	Prior Authorization required LDD*: Dohmen Life Sciences (800) 305-7881
THIORIDAZINE 10 MG TABLET	1	
THIORIDAZINE 100 MG TABLET	1	
THIORIDAZINE 25 MG TABLET	1	
THIORIDAZINE 50 MG TABLET	1	
THIOTHIXENE 1 MG CAPSULE	1	
THIOTHIXENE 10 MG CAPSULE	1	
THIOTHIXENE 2 MG CAPSULE	1	
THIOTHIXENE 5 MG CAPSULE	1	
THRESHOLD IMT TRAINER	MD	
THRESHOLD PEP DEVICE	MD	
THROMBIN-JMI 20,000 UNITS PUMP	1	
THROMBIN-JMI 5,000 UNITS VIAL	1	
THYROGEN 1.1 MG VIAL	MD	SPP*: Must use CVS Specialty
THYROID 30 MG TABLET	1	
THYROID 60 MG TABLET	1	
THYROID 90 MG TABLET	1	
THYROLAR-1 STRENGTH TABLET	3	
THYROLAR-1/2 STRENGTH TAB	3	
THYROLAR-1/4 STRENGTH TAB	3	
THYROLAR-2 STRENGTH TABLET	3	
THYROLAR-3 STRENGTH TABLET	3	
TIAGABINE HCL 2 MG TABLET	1	
TIAGABINE HCL 4 MG TABLET	1	
TIAZAC ER 120 MG CAPSULE	3	HSA*
TIAZAC ER 180 MG CAPSULE	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TIAZAC ER 240 MG CAPSULE	3	HSA*
TIAZAC ER 300 MG CAPSULE	3	HSA*
TIAZAC ER 360 MG CAPSULE	3	HSA*
TIAZAC ER 420 MG CAPSULE	3	HSA*
TICLOPIDINE 250 MG TABLET	1	HSA*
TIGAN 300 MG CAPSULE	3	
TIKOSYN 125 MCG CAPSULE	3	
TIKOSYN 250 MCG CAPSULE	3	
TIKOSYN 500 MCG CAPSULE	3	
TILIA FE 28 TABLET	0	ACA*
TIMOLOL 0.25% EYE DROPS	1	
TIMOLOL 0.25% GFS GEL-SOLUTION	1	
TIMOLOL 0.5% EYE DROPS	1	
TIMOLOL 0.5% GFS GEL-SOLUTION	1	
TIMOLOL MALEATE 10 MG TABLET	1	HSA*
TIMOLOL MALEATE 20 MG TABLET	1	HSA*
TIMOLOL MALEATE 5 MG TABLET	1	HSA*
TIMOPTIC 0.25% OCUDOSE DROP	3	
TIMOPTIC 0.5% OCUDOSE DROP	3	
TIMOPTIC-XE 0.25% EYE SOLN	3	
TIMOPTIC-XE 0.5% EYE SOLN	3	
TINDAMAX 250 MG TABLET	3	
TINDAMAX 500 MG TABLET	3	
TINIDAZOLE 250 MG TABLET	1	
TINIDAZOLE 500 MG TABLET	1	
TIROSINT 100 MCG CAPSULE	3	
TIROSINT 112 MCG CAPSULE	3	
TIROSINT 125 MCG CAPSULE	3	
TIROSINT 13 MCG CAPSULE	3	
TIROSINT 137 MCG CAPSULE	3	
TIROSINT 150 MCG CAPSULE	3	
TIROSINT 25 MCG CAPSULE	3	
TIROSINT 50 MCG CAPSULE	3	
TIROSINT 75 MCG CAPSULE	3	
TIROSINT 88 MCG CAPSULE	3	
TISSEEL VHSD 2 ML KIT	3	
TIVICAY 10 MG TABLET	3	
TIVICAY 25 MG TABLET	3	
TIVICAY 50 MG TABLET	3	
TIVORBEX 20 MG CAPSULE	3	
TIVORBEX 40 MG CAPSULE	3	
TIZANIDINE HCL 2 MG CAPSULE	1	
TIZANIDINE HCL 2 MG TABLET	1	
TIZANIDINE HCL 4 MG CAPSULE	1	
TIZANIDINE HCL 4 MG TABLET	1	
TIZANIDINE HCL 6 MG CAPSULE	1	
TL G-FOL OS TABLET	1	
TL GARD RX TABLET	1	
TL ICON CAPSULE	1	
TL-FOL 500 CAPLET	1	
TOBI 300 MG/5 ML SOLUTION	3	SPP*: Must use CVS Specialty
TOBI PODHALER 28 MG INHALE CAP	2	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TOBRADEX EYE DROPS	3	
TOBRADEX EYE OINTMENT	2	
TOBRADEX ST EYE DROPS	3	
TOBRAMYCIN 0.3% EYE DROPS	1	
TOBRAMYCIN 300 MG/5 ML AMPULE	1	SPP*: Must use CVS Specialty
TOBRAMYCIN-DEXAMETH OPHTH SUSP	1	
TOBREX 0.3% EYE DROPS	3	
TOBREX 0.3% EYE OINTMENT	2	
TODAY CONTRACEPTIVE SPONGE	0	ACA*
TOFRANIL 10 MG TABLET	3	
TOFRANIL 25 MG TABLET	3	
TOFRANIL 50 MG TABLET	3	
TOFRANIL-PM 100 MG CAPSULE	3	
TOFRANIL-PM 125 MG CAPSULE	3	
TOFRANIL-PM 150 MG CAPSULE	3	
TOFRANIL-PM 75 MG CAPSULE	3	
TOLAK 4% CREAM	3	
TOLAZAMIDE 250 MG TABLET	1	HSA*
TOLAZAMIDE 500 MG TABLET	1	HSA*
TOLBUTAMIDE 500 MG TABLET	1	HSA*
TOLCAPONE 100 MG TABLET	1	
TOLMETIN SODIUM 200 MG TAB	1	
TOLMETIN SODIUM 400 MG CAP	1	
TOLMETIN SODIUM 600 MG TAB	1	
TOLTERODINE TART ER 2 MG CAP	1	
TOLTERODINE TART ER 4 MG CAP	1	
TOLTERODINE TARTRATE 1 MG TAB	1	
TOLTERODINE TARTRATE 2 MG TAB	1	
TOOMEY SYRINGE 70 ML	3	
TOPAMAX 100 MG TABLET	3	
TOPAMAX 15 MG SPRINKLE CAP	3	
TOPAMAX 200 MG TABLET	3	
TOPAMAX 25 MG SPRINKLE CAP	3	
TOPAMAX 25 MG TABLET	3	
TOPAMAX 50 MG TABLET	3	
TOPCARE UNIVERSAL1 33G LANCETS	2	HSA*
TOPCARE UNIVERSAL1 THIN LANCET	2	HSA*
TOPICORT 0.05% CREAM	3	
TOPICORT 0.05% GEL	3	
TOPICORT 0.05% OINTMENT	3	
TOPICORT 0.25% CREAM	3	
TOPICORT 0.25% OINTMENT	3	
TOPICORT 0.25% SPRAY	3	
TOPIRAGEN 100 MG TABLET	1	
TOPIRAGEN 200 MG TABLET	1	
TOPIRAGEN 25 MG TABLET	1	
TOPIRAGEN 50 MG TABLET	1	
TOPIRAMATE 100 MG TABLET	1	
TOPIRAMATE 15 MG SPRINKLE CAP	1	
TOPIRAMATE 200 MG TABLET	1	
TOPIRAMATE 25 MG SPRINKLE CAP	1	
TOPIRAMATE 25 MG TABLET	1	
TOPIRAMATE 50 MG TABLET	1	
TOPIRAMATE ER 100 MG CAPSULE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TOPIRAMATE ER 150 MG CAPSULE	1	
TOPIRAMATE ER 200 MG CAPSULE	1	
TOPIRAMATE ER 25 MG CAPSULE	1	
TOPIRAMATE ER 50 MG CAPSULE	1	
TOPOTECAN HCL 4 MG VIAL	1	
TOPROL XL 100 MG TABLET	3	HSA*
TOPROL XL 200 MG TABLET	3	HSA*
TOPROL XL 25 MG TABLET	3	HSA*
TOPROL XL 50 MG TABLET	3	HSA*
TORSEMIDE 10 MG TABLET	1	HSA*
TORSEMIDE 100 MG TABLET	1	HSA*
TORSEMIDE 20 MG TABLET	1	HSA*
TORSEMIDE 5 MG TABLET	1	HSA*
TOUJEO SOLOSTAR 300 UNITS/ML	2	HSA*
TOVIAZ ER 4 MG TABLET	2	
TOVIAZ ER 8 MG TABLET	2	
TRACLEER 125 MG TABLET	2	SPP*: Must use CVS Specialty
TRACLEER 62.5 MG TABLET	2	SPP*: Must use CVS Specialty
TRADJENTA 5 MG TABLET	2	HSA*
TRAMADOL HCL 50 MG TABLET	1	
TRAMADOL HCL ER 100 MG CAPSULE	1	
TRAMADOL HCL ER 100 MG TABLET	1	
TRAMADOL HCL ER 150 MG CAPSULE	1	
TRAMADOL HCL ER 200 MG CAPSULE	1	
TRAMADOL HCL ER 200 MG TABLET	1	
TRAMADOL HCL ER 300 MG CAPSULE	1	
TRAMADOL HCL ER 300 MG TABLET	1	
TRAMADOL-ACETAMINOPHN 37.5-325	1	
TRANDATE 100 MG TABLET	3	HSA*
TRANDATE 200 MG TABLET	3	HSA*
TRANDATE 300 MG TABLET	3	HSA*
TRANDOLAPR-VERAPAM ER 1-240 MG	1	HSA*
TRANDOLAPR-VERAPAM ER 2-180 MG	1	HSA*
TRANDOLAPR-VERAPAM ER 2-240 MG	1	HSA*
TRANDOLAPR-VERAPAM ER 4-240 MG	1	HSA*
TRANDOLAPRIL 1 MG TABLET	1	HSA*
TRANDOLAPRIL 2 MG TABLET	1	HSA*
TRANDOLAPRIL 4 MG TABLET	1	HSA*
TRANEXAMIC ACID 650 MG TABLET	1	Max. 30 in 30 days
TRANSDERM-SCOP 1.5 MG/3 DAY	3	Max. quantity of 4 per fill MQC*: 1 box (4 patches)/copay
TRANXENE T-TAB 15 MG	3	
TRANXENE T-TAB 3.75 MG	3	
TRANXENE T-TAB 7.5 MG	3	
TRANYLCYPROMINE SULF 10 MG TAB	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRAVATAN Z 0.004% EYE DROP	2	
TRAVOPROST 0.004% EYE DROP	1	
TRAZODONE 100 MG TABLET	1	
TRAZODONE 150 MG TABLET	1	
TRAZODONE 300 MG TABLET	1	
TRAZODONE 50 MG TABLET	1	
TRECATOR 250 MG TABLET	3	
TRELEGY ELLIPTA 100-62.5-25	3	Prior Authorization required;Max. 60 in 30 days HSA*; PA NTM*
TREMFYA 100 MG/ML SYRINGE	3	Prior Authorization required PA NTM*; SPP*: Must use CVS Specialty
TRESIBA FLEXTOUCH 100 UNITS/ML	3	Prior Authorization required HSA*
TRESIBA FLEXTOUCH 200 UNITS/ML	3	Prior Authorization required HSA*
TRETIN-X 0.025% CREAM COMB PCK	3	Prior Authorization required for members 30 and older
TRETIN-X 0.0375% CREAM	3	Prior Authorization required for members 30 and older
TRETIN-X 0.075% CREAM	3	Prior Authorization required for members 30 and older
TRETIN-X 0.1% COMBO PACK	3	Prior Authorization required for members 30 and older
TRETINOIN 0.01% GEL	1	Prior Authorization required for members 30 and older
TRETINOIN 0.025% CREAM	1	Prior Authorization required for members 30 and older
TRETINOIN 0.025% GEL	1	Prior Authorization required for members 30 and older
TRETINOIN 0.05% CREAM	1	Prior Authorization required for members 30 and older
TRETINOIN 0.05% GEL	1	Prior Authorization required for members 30 and older
TRETINOIN 0.1% CREAM	1	Prior Authorization required for members 30 and older
TRETINOIN 10 MG CAPSULE	1	CH*
TRETINOIN GEL MICRO 0.04% TUBE	1	Prior Authorization required for members 30 and older
TRETINOIN GEL MICRO 0.1% TUBE	1	Prior Authorization required for members 30 and older
TRETTEN 2,500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
TREXALL 10 MG TABLET	3	
TREXALL 15 MG TABLET	3	
TREXALL 5 MG TABLET	3	
TREXALL 7.5 MG TABLET	3	
TREXIMET 10-60 MG TABLET	2	Max. quantity of 9 per fill;Step Therapy required MQC*: 9 tabs/copay
TREXIMET 85-500 MG TABLET	2	Max. quantity of 9 per fill;Step Therapy required MQC*: 9 tabs/copay
TREZIX 16-320.5-30 MG CAPSULE	3	
TREZIX CAPSULE	1	
TRI FEMYNOR 28 TABLET	0	ACA*
TRI-BUFFERED ASPIRIN 325 MG TB	0	ACA*
TRI-ESTARYLLA TABLET	0	ACA*
TRI-LEGEST FE-28 DAY TABLET	0	ACA*
TRI-LINYAH TABLET	0	ACA*
TRI-LO-ESTARYLLA TABLET	0	ACA*
TRI-LO-MARZIA TABLET	0	ACA*
TRI-LO-SPRINTEC TABLET	0	ACA*
TRI-NORINYL 28 TABLET	3	
TRI-PREVIFEM TABLET	0	ACA*
TRI-SPRINTEC TABLET	0	ACA*
TRIAMCINOLONE 0.025% CREAM	1	
TRIAMCINOLONE 0.025% LOTION	1	
TRIAMCINOLONE 0.025% OINT	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRIAMCINOLONE 0.1% CREAM	1	
TRIAMCINOLONE 0.1% LOTION	1	
TRIAMCINOLONE 0.1% OINTMENT	1	
TRIAMCINOLONE 0.1% PASTE	1	
TRIAMCINOLONE 0.147 MG/G SPRAY	1	
TRIAMCINOLONE 0.5% CREAM	1	
TRIAMCINOLONE 0.5% OINTMENT	1	
TRIAMCINOLONE 55 MCG NASAL SPR	1	
TRIAMTERENE-HCTZ 37.5-25 MG CP	1	HSA*
TRIAMTERENE-HCTZ 37.5-25 MG TB	1	HSA*
TRIAMTERENE-HCTZ 50-25 MG CAP	1	HSA*
TRIAMTERENE-HCTZ 75-50 MG TAB	1	HSA*
TRIANEX 0.05% OINTMENT	1	
TRIAZOLAM 0.125 MG TABLET	1	
TRIAZOLAM 0.25 MG TABLET	1	
TRIBENZOR 20-5-12.5 MG TABLET	3	HSA*
TRIBENZOR 40-10-12.5 MG TABLET	3	HSA*
TRIBENZOR 40-10-25 MG TABLET	3	HSA*
TRIBENZOR 40-5-12.5 MG TABLET	3	HSA*
TRIBENZOR 40-5-25 MG TABLET	3	HSA*
TRICITRATES ORAL SOLUTION	1	
TRICON CAPSULE	1	
TRICOR 145 MG TABLET	3	HSA*
TRICOR 48 MG TABLET	3	HSA*
TRIDERM 0.1% CREAM	1	
TRIDERM 0.5% CREAM	1	
TRIDESILON 0.05% CREAM	1	
TRIFLUOPERAZINE 1 MG TABLET	1	
TRIFLUOPERAZINE 10 MG TABLET	1	
TRIFLUOPERAZINE 2 MG TABLET	1	
TRIFLUOPERAZINE 5 MG TABLET	1	
TRIFLURIDINE 1% EYE DROPS	1	
TRIGELS-F FORTE SOFTGEL	1	
TRIGLIDE 160 MG TABLET	2	HSA*
TRIHEXYPHENIDYL 2 MG TABLET	1	
TRIHEXYPHENIDYL 2 MG/5 ML ELX	1	
TRIHEXYPHENIDYL 5 MG TABLET	1	
TRILEPTAL 150 MG TABLET	3	
TRILEPTAL 300 MG TABLET	3	
TRILEPTAL 300 MG/5 ML SUSP	3	
TRILEPTAL 600 MG TABLET	3	
TRILIPIX DR 135 MG CAPSULE	3	HSA*
TRILIPIX DR 45 MG CAPSULE	3	HSA*
TRILYTE WITH FLAVOR PACKETS	0	ACA*
TRIMETHOBENZAMIDE 300 MG CAP	1	
TRIMETHOPRIM 100 MG TABLET	1	
TRIMIPRAMINE MALEATE 100 MG CP	1	
TRIMIPRAMINE MALEATE 25 MG CAP	1	
TRIMIPRAMINE MALEATE 50 MG CAP	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRIMPEX 50 MG/5 ML ORAL SOLN	3	
TRINESSA LO TABLET	0	ACA*
TRINESSA TABLET	0	ACA*
TRINTELLIX 10 MG TABLET	3	Step Therapy required STA*: 18 and older
TRINTELLIX 20 MG TABLET	3	Step Therapy required STA*: 18 and older
TRINTELLIX 5 MG TABLET	3	Step Therapy required STA*: 18 and older
TRIPHROCAPS SOFTGEL	1	
TRIPLE DYE SWAB	1	
TRIUMEQ TABLET	3	
TRIVORA-28 TABLET	0	ACA*
TRIZIVIR TABLET	3	
TROKENDI XR 100 MG CAPSULE	3	
TROKENDI XR 200 MG CAPSULE	3	
TROKENDI XR 25 MG CAPSULE	3	
TROKENDI XR 50 MG CAPSULE	3	
TROPAZONE LOTION	3	
TROPICAMIDE 0.5% EYE DROPS	1	
TROPICAMIDE 1% EYE DROPS	1	
TROSPIUM CHLORIDE 20 MG TABLET	1	
TROSPIUM CHLORIDE ER 60 MG CAP	1	
TRUE METRIX GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TRUEPLUS 26G LANCETS	2	HSA*
TRUEPLUS 33G LANCETS	2	HSA*
TRUEPLUS KETONE TEST STRIPS	2	
TRUEPLUS SAFETY 28G LANCETS	2	HSA*
TRUEPLUS SUPER THIN 28G LANCET	2	HSA*
TRUEPLUS ULTRA THIN 30G LANCET	2	HSA*
TRUETEST GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
TRUETRACK GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
TRULANCE 3 MG TABLET	3	Prior Authorization required
TRULICITY 0.75 MG/0.5 ML PEN	2	Max. 2 ML(s) per 28 days;Step Therapy required HSA*
TRULICITY 1.5 MG/0.5 ML PEN	2	Max. 2 ML(s) per 28 days;Step Therapy required HSA*
TRUSOPT 2% EYE DROPS	3	
TRUVADA 100 MG-150 MG TABLET	2	
TRUVADA 133 MG-200 MG TABLET	2	
TRUVADA 167 MG-250 MG TABLET	2	
TRUVADA 200 MG-300 MG TABLET	2	
TRUZONE PEAK FLOW METER	MD	
TUBERCULIN 1 ML SYRINGE	3	
TUBERCULIN SYRINGE	3	
TUBERCULIN SYRINGES	3	
TUDORZA PRESSAIR 400 MCG INH	2	Max. 1 in 30 days HSA*
TUSNEL C SYRUP	3	
TUSNEL PEDIATRIC LIQUID	3	
TUSSICAPS 10 MG-8 MG CAPSULE	3	
TUSSICAPS 5 MG-4 MG CAPSULE	3	
TUSSIGON 5-1.5 MG TABLET	3	
TUSSIONEX PENNKINETIC SUSP	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TUZISTRA XR 14.7-2.8 MG/5 ML	3	
TWINRIX VACCINE SYRINGE	MD	Not covered for members 17 and younger
TWINRIX VACCINE VIAL	MD	Not covered for members 17 and younger
TWYNSTA 40-10 MG TABLET	3	Max. 30 in 30 days HSA*
TWYNSTA 40-5 MG TABLET	3	Max. 30 in 30 days HSA*
TWYNSTA 80-10 MG TABLET	3	Max. 30 in 30 days HSA*
TWYNSTA 80-5 MG TABLET	3	Max. 30 in 30 days HSA*
TYBOST 150 MG TABLET	3	
TYKERB 250 MG TABLET	2	CH*; SPP*: CVS Specialty
TYLENOL WITH CODEINE #3 TABLET	3	
TYLENOL WITH CODEINE #4 TABLET	3	
TYMLOS 80 MCG DOSE PEN INJECTR	2	Prior Authorization required;Max. 1.56 ML(s) in 30 days HSA*; SPP*: Must use CVS Specialty
TYVASO 1.74 MG/2.9 ML SOLUTION	2	SPP*: Must use CVS Specialty
TYVASO INHALATION REFILL KIT	2	SPP*: Must use CVS Specialty
TYVASO INHALATION STARTER KIT	2	SPP*: Must use CVS Specialty
TYZEKA 600 MG TABLET	3	
TYZINE 0.1% NOSE DROPS	3	
TYZINE 0.1% NOSE SPRAY	3	

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U-CORT 1% CREAM	1	
UCERIS 2 MG RECTAL FOAM	3	
UCERIS 9 MG ER TABLET	3	
ULESFIA 5% LOTION	3	
ULORIC 40 MG TABLET	2	
ULORIC 80 MG TABLET	2	
ULTICARE SAFETY 3 ML 21GX1-1/2	3	
ULTICARE SAFETY 3 ML 22GX1"	3	
ULTICARE SAFETY 3 ML 22GX1-1/2	3	
ULTICARE SAFETY 3 ML 23GX1"	3	
ULTICARE SAFETY 3 ML 25GX1"	3	
ULTICARE SAFETY 3 ML 25GX5/8"	3	
ULTICARE SAFETY SYRINGE 3 ML	3	
ULTICARE SYR 1.5 ML 22GX1 1/2"	3	
ULTICARE TB SAFETY 1 ML 25GX1"	3	
ULTICARE TB SAFETY 1ML 25GX5/8	3	
ULTICARE TB SAFETY 1ML 27GX1/2	3	
ULTICARE TB SAFETY 1ML 28GX1/2	3	
ULTILET 28G LANCETS	2	HSA*
ULTILET 30G LANCETS	2	HSA*
ULTILET 33G LANCETS	2	HSA*
ULTILET BASIC 30G LANCETS	2	HSA*
ULTILET CLASSIC 26G LANCETS	2	HSA*
ULTILET CLASSIC 28G LANCETS	2	HSA*
ULTILET CLASSIC 30G LANCETS	2	HSA*
ULTILET CLASSIC 33G LANCETS	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ULTILET SAFETY 23G LANCETS	2	HSA*
ULTIMA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ULTRA THIN 28G LANCETS	2	HSA*
ULTRA THIN 30G LANCETS	2	HSA*
ULTRA THIN 31G LANCETS	2	HSA*
ULTRA THIN 33G LANCETS	2	HSA*
ULTRA-THIN II 26G LANCET	2	HSA*
ULTRA-THIN II 28G LANCETS	2	HSA*
ULTRA-THIN II 30G LANCETS	2	HSA*
ULTRACET TABLET	3	
ULTRAFOAM 2X6.25X7CM SPONGE	3	
ULTRALANCE 26G LANCETS	2	HSA*
ULTRALANCE 28G LANCETS	2	HSA*
ULTRAM 50 MG TABLET	3	
ULTRAM ER 100 MG TABLET	3	
ULTRAM ER 200 MG TABLET	3	
ULTRAM ER 300 MG TABLET	3	
ULTRATLC LANCETS	2	HSA*
ULTRATRAK TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ULTRATRAK ULTIMATE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ULTRAVATE 0.05% CREAM	3	
ULTRAVATE 0.05% LOTION	3	
ULTRAVATE 0.05% OINTMENT	3	
ULTRAVATE PAC OINTMENT KIT	3	
ULTRAVATE X OINTMENT COMBO PAC	3	
ULTRESA DR 13,800 UNIT CAPSULE	3	
ULTRESA DR 20,700 UNIT CAPSULE	3	
ULTRESA DR 23,000 UNIT CAPSULE	3	
UMECTA 40% EMULSION	3	
UMECTA PD 40% EMULSION	3	
UNILET COMFORTOUCH 26G LANCETS	2	HSA*
UNILET COMFORTOUCH LANCET	2	HSA*
UNILET EXCELITE II LANCET	2	HSA*
UNILET EXCELITE LANCET	2	HSA*
UNILET GP LANCET	2	HSA*
UNILET LANCET SUPERLITE	2	HSA*
UNILET MICRO THIN 33G LANCETS	2	HSA*
UNILET SUPER THIN 30G LANCETS	2	HSA*
UNILET ULTRA THIN 28G LANCETS	2	HSA*
UNIRETIC 15-12.5 TABLET	3	HSA*
UNIRETIC 15-25 MG TABLET	3	HSA*
UNIRETIC 7.5-12.5 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
UNISTIK 3 COMFORT LANCET	2	HSA*
UNISTIK 3 EXTRA 21G LANCETS	2	HSA*
UNISTIK 3 GENTLE ON-THE-GO 30G	2	HSA*
UNISTIK 3 NORMAL 23G LANCETS	2	HSA*
UNISTIK 3 SAFETY 21G LANCETS	2	HSA*
UNISTIK CZT COMFORT 28G LANCET	2	HSA*
UNISTIK CZT NORMAL 23G LANCETS	2	HSA*
UNISTIK SAFETY 28G LANCET	2	HSA*
UNISTIK SAFETY 30G LANCETS	2	HSA*
UNISTIK TOUCH 21G LANCETS	2	HSA*
UNISTIK TOUCH 23G LANCETS	2	HSA*
UNISTIK TOUCH 28G LANCETS	2	HSA*
UNISTIK TOUCH 30G LANCETS	2	HSA*
UNISTRIP1 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
UNITHROID 100 MCG TABLET	1	
UNITHROID 112 MCG TABLET	1	
UNITHROID 125 MCG TABLET	1	
UNITHROID 137 MCG TABLET	1	
UNITHROID 150 MCG TABLET	1	
UNITHROID 175 MCG TABLET	1	
UNITHROID 200 MCG TABLET	1	
UNITHROID 25 MCG TABLET	1	
UNITHROID 300 MCG TABLET	1	
UNITHROID 50 MCG TABLET	1	
UNITHROID 75 MCG TABLET	1	
UNITHROID 88 MCG TABLET	1	
UNIVASC 15 MG TABLET	3	HSA*
UNIVASC 7.5 MG TABLET	3	HSA*
UNIVERSAL 1 33G LANCETS	2	HSA*
UPTRAVI 1,000 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 1,200 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 1,400 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 1,600 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 200 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 200-800 TITRATION PACK	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 400 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 600 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 800 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
URE-K 50% CREAM	1	
UREA 39% CREAM	1	
UREA 40% CREAM	1	
UREA 40% GEL	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
UREA 40% LOTION	1	
UREA 50% NAIL STICK	1	
URECHOLINE 10 MG TABLET	3	
URECHOLINE 25 MG TABLET	3	
URECHOLINE 5 MG TABLET	3	
URECHOLINE 50 MG TABLET	3	
URISTIX 4 REAGENT STRIPS	2	
URISTIX REAGENT STRIPS	2	
UROCIT-K ER 15 MEQ TABLET	3	
UROCIT-K SR 10 MEQ TABLET	3	
UROCIT-K SR 5 MEQ TABLET	3	
UROQID-ACID NO.2 500-500 TB	3	
UROXATRAL 10 MG TABLET	3	Max. 1 per day
URSO 250 MG TABLET	3	
URSO FORTE 500 MG TABLET	3	
URSODIOL 250 MG TABLET	1	
URSODIOL 300 MG CAPSULE	1	
URSODIOL 500 MG TABLET	1	
UTIBRON NEOHALER 27.5-15.6 MCG	3	Max. 2 per day HSA*

V

V-C FORTE CAPSULE	1	
VAGIFEM 10 MCG VAGINAL TAB	3	
VALACYCLOVIR HCL 1 GRAM TABLET	1	
VALACYCLOVIR HCL 500 MG TABLET	1	
VALCHLOR 0.016% GEL	3	Max. 60 GM(s) in 30 days LDD*: Dohmen Life Sciences 1-800-305-7881
VALCYTE 450 MG TABLET	3	
VALCYTE 50 MG/ML SOLUTION	3	
VALGANCICLOVIR 450 MG TABLET	1	
VALGANCICLOVIR HCL 50 MG/ML	1	
VALIUM 10 MG TABLET	3	
VALIUM 2 MG TABLET	3	
VALIUM 5 MG TABLET	3	
VALPROIC ACID 250 MG CAPSULE	1	
VALPROIC ACID 250 MG/5 ML SOLN	1	
VALSARTAN 160 MG TABLET	1	HSA*
VALSARTAN 320 MG TABLET	1	HSA*
VALSARTAN 40 MG TABLET	1	HSA*
VALSARTAN 80 MG TABLET	1	HSA*
VALSARTAN-HCTZ 160-12.5 MG TAB	1	HSA*
VALSARTAN-HCTZ 160-25 MG TAB	1	HSA*
VALSARTAN-HCTZ 320-12.5 MG TAB	1	HSA*
VALSARTAN-HCTZ 320-25 MG TAB	1	HSA*
VALSARTAN-HCTZ 80-12.5 MG TAB	1	HSA*
VALTREX 1 GM CAPLET	3	
VALTREX 500 MG CAPLET	3	
VANATOL LQ ORAL SOLUTION	3	
VANCOCIN HCL 125 MG CAPSULE	3	
VANCOCIN HCL 250 MG CAPSULE	3	
VANCOMYCIN HCL 10 GM VIAL	1	Not covered for members 18 and older

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VANCOMYCIN HCL 125 MG CAPSULE	1	
VANCOMYCIN HCL 250 MG CAPSULE	1	
VANCOMYCIN HCL 5 GM VIAL	1	
VANDAZOLE VAGINAL 0.75% GEL	2	
VANISHPOINT 1 ML TB SYR 25X5/8	3	
VANISHPOINT 1 ML TB SYR 27X1/2	3	
VANISHPOINT 10 ML 21GX1-1/2"	3	
VANISHPOINT 20GX1" 3 ML SYRING	3	
VANISHPOINT 21GX1" 5 ML SYRING	3	
VANISHPOINT 21GX1.5" 3 ML SYR	3	
VANISHPOINT 22GX1" 3 ML SYR	3	
VANISHPOINT 22GX1-1/2" 5 ML SY	3	
VANISHPOINT 23GX1" 3 ML SYRING	3	
VANISHPOINT 23GX1-1/2 3 ML SYR	3	
VANISHPOINT 25GX1" 3 ML SYRING	3	
VANISHPOINT 25GX5/8" 3 ML SYR	3	
VANISHPOINT 3 ML 21GX1" SYRING	3	
VANISHPOINT 3 ML 22GX1.5" SYRG	3	
VANISHPOINT 5 ML 21GX1-1/2"	3	
VANISHPOINT SYRINGE 1 ML 25X1"	3	
VANOS 0.1% CREAM	3	
VANOXIDE-HC LOTION	3	
VAQTA 25 UNITS/0.5 ML SYRINGE	MD	Not covered for members 17 and younger
VAQTA 50 UNITS/ML SYRINGE	MD	Not covered for members 17 and younger
VAQTA 50 UNITS/ML VIAL	MD	Not covered for members 17 and younger
VARUBI 90 MG TABLET	3	Max. quantity of 2 per fill MQC*: 2 tabs/copay
VASCEPA 0.5 GM CAPSULE	2	HSA*
VASCEPA 1 GM CAPSULE	2	HSA*
VASERETIC 10-25 MG TABLET	3	HSA*
VASOLEX OINTMENT	1	
VASOTEC 10 MG TABLET	3	HSA*
VASOTEC 2.5 MG TABLET	3	HSA*
VASOTEC 20 MG TABLET	3	HSA*
VASOTEC 5 MG TABLET	3	HSA*
VCF CONTRACEPTIVE FILM	0	ACA*
VCF CONTRACEPTIVE FOAM	0	ACA*
VCF CONTRACEPTIVE GEL	0	ACA*
VECAMYL 2.5 MG TABLET	3	
VECTICAL 3 MCG/G OINTMENT	3	
VEHICLE-N MILD SOLUTION	3	
VEHICLE-N SOLUTION	3	
VELIVET 28 DAY TABLET	0	ACA*
VELPHORO 500 MG CHEWABLE TAB	3	
VELTASSA 16.8 GM POWDER PACKET	3	LDD*: Walgreens Specialty (800) 424-9002
VELTASSA 25.2 GM POWDER PACKET	3	LDD*: Walgreens Specialty (800) 424-9002
VELTASSA 8.4 GM POWDER PACKET	3	LDD*: Walgreens Specialty (800) 424-9002
VELTIN 1.2%-0.025% GEL	3	Prior Authorization required for members 30 and older
VEMLIDY 25 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VENCLEXTA 10 MG TABLET	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENCLEXTA 100 MG TABLET	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENCLEXTA 50 MG TABLET	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENCLEXTA STARTING PACK	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENELEX OINTMENT	3	
VENLAFAXINE HCL 100 MG TABLET	1	
VENLAFAXINE HCL 25 MG TABLET	1	
VENLAFAXINE HCL 37.5 MG TABLET	1	
VENLAFAXINE HCL 50 MG TABLET	1	
VENLAFAXINE HCL 75 MG TABLET	1	
VENLAFAXINE HCL ER 150 MG CAP	1	
VENLAFAXINE HCL ER 150 MG TAB	3	
VENLAFAXINE HCL ER 225 MG TAB	3	
VENLAFAXINE HCL ER 37.5 MG CAP	1	
VENLAFAXINE HCL ER 37.5 MG TAB	3	
VENLAFAXINE HCL ER 75 MG CAP	1	
VENLAFAXINE HCL ER 75 MG TAB	3	
VENTAVIS 10 MCG/1 ML SOLUTION	3	SPP*: Must use CVS Specialty
VENTAVIS 20 MCG/1 ML SOLUTION	3	SPP*: Must use CVS Specialty
VENTOLIN HFA 90 MCG INHALER	2	HSA*
VERAMYST 27.5 MCG NASAL SPRAY	2	
VERAPAMIL 120 MG TABLET	1	HSA*
VERAPAMIL 360 MG CAP PELLET	1	HSA*
VERAPAMIL 40 MG TABLET	1	HSA*
VERAPAMIL 80 MG TABLET	1	HSA*
VERAPAMIL ER 120 MG CAPSULE	1	HSA*
VERAPAMIL ER 120 MG TABLET	1	HSA*
VERAPAMIL ER 180 MG CAPSULE	1	HSA*
VERAPAMIL ER 180 MG TABLET	1	HSA*
VERAPAMIL ER 240 MG CAPSULE	1	HSA*
VERAPAMIL ER 240 MG TABLET	1	HSA*
VERAPAMIL ER PM 100 MG CAPSULE	1	HSA*
VERAPAMIL ER PM 200 MG CAPSULE	1	HSA*
VERAPAMIL ER PM 300 MG CAPSULE	1	HSA*
VERDESO 0.05% FOAM	3	
VERDROCET 2.5-325 MG TABLET	3	
VEREGEN 15% OINTMENT	2	
VERELAN 120 MG CAP PELLET	3	HSA*
VERELAN 180 MG CAP PELLET	3	HSA*
VERELAN 240 MG CAP PELLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VERELAN 360 MG CAP PELLET	3	HSA*
VERELAN PM 100 MG CAP PELLET	3	HSA*
VERELAN PM 200 MG CAP PELLET	3	HSA*
VERELAN PM 300 MG CAP PELLET	3	HSA*
VERIPRED 20 20 MG/5 ML SOLN	3	
VERSACLOZ 50 MG/ML SUSPENSION	3	Max. 28 Days Supply
VERZENIO 100 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VERZENIO 150 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VERZENIO 200 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VERZENIO 50 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VESICARE 10 MG TABLET	2	
VESICARE 5 MG TABLET	2	
VESTURA 3 MG-0.02 MG TABLET	0	ACA*
VEXOL 1% EYE DROPS	3	
VFEND 200 MG TABLET	3	
VFEND 40 MG/ML SUSPENSION	3	
VFEND 50 MG TABLET	3	
VGO 40 DISPOSABLE DEVICE	2	Max. 1 per day HSA*
VIAGRA 100 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
VIAGRA 25 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
VIAGRA 50 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
VIBERZI 100 MG TABLET	2	
VIBERZI 75 MG TABLET	2	
VIBRAMYCIN 100 MG CAPSULE	3	
VIBRAMYCIN 25 MG/5 ML SUSP	3	
VIBRAMYCIN 50 MG/5 ML SYRUP	3	
VIC-FORTE CAPSULE	1	
VICODIN 5-300 MG TABLET	1	
VICODIN ES 7.5-300 MG TABLET	1	
VICODIN HP 10-300 MG TABLET	1	
VICOPROFEN 7.5-200 MG TABLET	3	
VICTORY GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
VICTOZA 3-PAK 18 MG/3 ML PEN	2	Max. 9 ML(s) per 30 days;Step Therapy required HSA*
VIDEX 2 GM PEDIATRIC SOLN	2	
VIDEX EC 125 MG CAPSULE	3	
VIDEX EC 200 MG CAPSULE	3	
VIDEX EC 250 MG CAPSULE	3	
VIDEX EC 400 MG CAPSULE	3	
VIEKIRA PAK	3	Prior Authorization required;Max. 84 per 28 days SPP*: Must use CVS Specialty
VIEKIRA XR TABLET	3	Prior Authorization required;Max. 84 per 28 days SPP*: Must use CVS Specialty
VIENVA-28 TABLET	0	ACA*
VIGABATRIN 500 MG POWDER PACKT	2	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VIGAMOX 0.5% EYE DROPS	3	
VIIBRYD 10 MG TABLET	3	Step Therapy required STA*: 18 and older
VIIBRYD 10-20 MG STARTER PACK	3	Step Therapy required STA*: 18 and older
VIIBRYD 10-20-40 MG STARTER PK	3	Step Therapy required STA*: 18 and older
VIIBRYD 20 MG TABLET	3	Step Therapy required STA*: 18 and older
VIIBRYD 40 MG TABLET	3	Step Therapy required STA*: 18 and older
VIMOVO DR 375-20 MG TABLET	3	Prior Authorization required;Max. 2 per day
VIMOVO DR 500-20 MG TABLET	3	Prior Authorization required;Max. 2 per day
VIMPAT 10 MG/ML SOLUTION	2	
VIMPAT 100 MG TABLET	2	
VIMPAT 150 MG TABLET	2	
VIMPAT 200 MG TABLET	2	
VIMPAT 50 MG TABLET	2	
VINATE DHA GELCAP	1	HSA*
VIOKACE 10,440-39,150 UNITS TB	3	
VIOKACE 20,880-78,300 UNITS TB	3	
VIORELE 28 DAY TABLET	0	ACA*
VIRACEPT 250 MG TABLET	2	
VIRACEPT 625 MG TABLET	2	
VIRAMUNE 200 MG TABLET	3	
VIRAMUNE 50 MG/5 ML SUSP	3	
VIRAMUNE XR 100 MG TABLET	3	
VIRAMUNE XR 400 MG TABLET	3	
VIRASAL ANTIVIRAL WART REMOVER	3	
VIRAZOLE 6 GM VIAL	3	
VIREAD 150 MG TABLET	2	
VIREAD 200 MG TABLET	2	
VIREAD 250 MG TABLET	2	
VIREAD 300 MG TABLET	2	
VIREAD POWDER	2	
VIROPTIC 1% EYE DROPS	3	
VIRT-CAPS SOFTGEL	1	
VIRT-GARD TABLET	1	
VIRT-PHOS 250 NEUTRAL TABLET	1	
VIRTUSSIN AC LIQUID	1	
VISTARIL 25 MG CAPSULE	3	
VISTARIL 50 MG CAPSULE	3	
VISTOGARD 10 GRAM PACKET	3	
VIT D2 1.25 MG (50,000 UNIT)	1	
VITAFOL CAPLET	1	HSA*
VITAFOL FE+ DOCUSATE COMBO PCK	3	HSA*
VITAMIN D 400 UNIT TABLET	0	ACA*
VITAMIN D-400 TABLET	0	Not covered for members 64 and younger ACA*
VITAMIN D2 400 UNIT TABLET	0	ACA*
VITAMIN D3 400 UNIT SOFTGEL	0	Not covered for members 64 and younger ACA*
VITAMIN D3 400 UNIT TAB CHEW	3	
VITAMIN D3 400 UNIT TABLET	0	Not covered for members 64 and younger ACA*
VITEKTA 150 MG TABLET	3	
VITEKTA 85 MG TABLET	3	
VITUZ SOLUTION	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VIVACTIL 10 MG TABLET	3	
VIVACTIL 5 MG TABLET	3	
VIVELLE-DOT 0.025 MG PATCH	3	
VIVELLE-DOT 0.0375 MG PATCH	3	
VIVELLE-DOT 0.05 MG PATCH	3	
VIVELLE-DOT 0.075 MG PATCH	3	
VIVELLE-DOT 0.1 MG PATCH	3	
VIVITROL 380 MG VIAL + DILUENT	MD	SPP*: Must use CVS Specialty
VIVLODEX 10 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
VIVLODEX 5 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
VIVOTIF EC CAPSULE	3	
VOCAL POINT TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
VOGELXO 12.5 MG/1.25 GRAM PUMP	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 300 GM(s) in 30 days
VOGELXO 50 MG/5 GRAM GEL	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 GM(s) per day
VOL-CARE RX TABLET	1	
VOLTAREN 1% GEL	3	
VOLTAREN-XR 100 MG TABLET	3	
VONVENDI 1,300 UNIT VIAL	MD	SPP*: Must use CVS Specialty
VORICONAZOLE 200 MG TABLET	1	
VORICONAZOLE 40 MG/ML SUSP	1	
VORICONAZOLE 50 MG TABLET	1	
VORTEX ADULT MASK	MD	
VORTEX FROG CHILD MASK	MD	
VORTEX HOLDING CHAMBER	MD	
VORTEX LADYBUG TODDLER MASK	MD	
VORTEX VHC FROG CHILD MASK	MD	
VOSEVI 400-100-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
VOSOL HC EAR DROPS	3	
VOSPIRE ER 4 MG TABLET	3	HSA*
VOSPIRE ER 8 MG TABLET	3	HSA*
VOTRIENT 200 MG TABLET	3	CH*; SPP*: CVS Specialty
VP-VITE RX TABLET	1	
VRAYLAR 1.5 MG CAPSULE	3	Max. 1 per day;Step Therapy required
VRAYLAR 1.5 MG-3 MG PACK	3	Max. 1 per day;Step Therapy required
VRAYLAR 3 MG CAPSULE	3	Max. 1 per day;Step Therapy required
VRAYLAR 4.5 MG CAPSULE	3	Max. 1 per day;Step Therapy required
VRAYLAR 6 MG CAPSULE	3	Max. 1 per day;Step Therapy required
VUSION OINTMENT	3	
VYFEMLA 28 TABLET	0	ACA*
VYTORIN 10-10 MG TABLET	3	Max. 1 per day HSA*
VYTORIN 10-20 MG TABLET	3	Max. 1 per day HSA*
VYTORIN 10-40 MG TABLET	3	Max. 1 per day HSA*
VYTORIN 10-80 MG TABLET	3	Max. 1 per day HSA*
VYVANSE 10 MG CAPSULE	2	Max. 60 Days Supply
VYVANSE 10 MG CHEWABLE TABLET	2	Max. 60 Days Supply
VYVANSE 20 MG CAPSULE	2	Max. 60 Days Supply
VYVANSE 20 MG CHEWABLE TABLET	2	Max. 60 Days Supply
VYVANSE 30 MG CAPSULE	2	Max. 60 Days Supply
VYVANSE 30 MG CHEWABLE TABLET	2	Max. 60 Days Supply
VYVANSE 40 MG CAPSULE	2	Max. 60 Days Supply

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VYVANSE 40 MG CHEWABLE TABLET	2	Max. 60 Days Supply
VYVANSE 50 MG CAPSULE	2	Max. 60 Days Supply
VYVANSE 50 MG CHEWABLE TABLET	2	Max. 60 Days Supply
VYVANSE 60 MG CAPSULE	2	Max. 60 Days Supply
VYVANSE 60 MG CHEWABLE TABLET	2	Max. 60 Days Supply
VYVANSE 70 MG CAPSULE	2	Max. 60 Days Supply

W

WALGREENS ULTRA THIN LANCETS	2	HSA*
WARFARIN SODIUM 1 MG TABLET	1	HSA*
WARFARIN SODIUM 10 MG TABLET	1	HSA*
WARFARIN SODIUM 2 MG TABLET	1	HSA*
WARFARIN SODIUM 2.5 MG TABLET	1	HSA*
WARFARIN SODIUM 3 MG TABLET	1	HSA*
WARFARIN SODIUM 4 MG TABLET	1	HSA*
WARFARIN SODIUM 5 MG TABLET	1	HSA*
WARFARIN SODIUM 6 MG TABLET	1	HSA*
WARFARIN SODIUM 7.5 MG TABLET	1	HSA*
WATCHHALER SPACER	MD	
WATER FOR INJECTION VIAL	1	
WAVESENSE JAZZ TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
WAVESENSE PRESTO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
WELCHOL 3.75G PACKET	2	HSA*
WELCHOL 625 MG TABLET	2	HSA*
WELLBUTRIN 100 MG TABLET	3	Step Therapy required STA*: 18 and older
WELLBUTRIN 75 MG TABLET	3	Step Therapy required STA*: 18 and older
WELLBUTRIN SR 100 MG TABLET	3	Step Therapy required STA*: 18 and older
WELLBUTRIN SR 150 MG TABLET	3	Step Therapy required STA*: 18 and older
WELLBUTRIN SR 200 MG TABLET	3	Step Therapy required STA*: 18 and older
WELLBUTRIN XL 150 MG TABLET	3	Step Therapy required STA*: 18 and older
WELLBUTRIN XL 300 MG TABLET	3	Step Therapy required STA*: 18 and older
WERA 0.5/0.035 MG 28 TABLET	0	ACA*
WESTCORT 0.2% OINTMENT	3	
WESTHROID 130 MG TABLET	1	
WESTHROID 16.25 MG TABLET	1	
WESTHROID 195 MG TABLET	1	
WESTHROID 32.5 MG TABLET	1	
WESTHROID 48.75 MG TABLET	1	
WESTHROID 65 MG TABLET	1	
WESTHROID 97.5 MG TABLET	1	
WIDE SEAL DIAPHRAGM 70MM	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
WILATE 1,000-1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
WINDMILL TRAINER	MD	
WP THYROID 113.75 MG TABLET	1	
WP THYROID 130 MG TABLET	1	
WP THYROID 16.25 MG TABLET	1	
WP THYROID 32.5 MG TABLET	1	
WP THYROID 48.75 MG TABLET	1	
WP THYROID 65 MG TABLET	1	
WP THYROID 81.25 MG TABLET	1	
WP THYROID 97.5 MG TABLET	1	
WYMZYA FE CHEWABLE TABLET	0	ACA*

X

X-VIATE 40% CREAM	1	
X-VIATE 40% GEL	3	
X-VIATE 40% LOTION	1	
XADAGO 100 MG TABLET	3	Prior Authorization required;Max. 1 per day PA NTM*
XADAGO 50 MG TABLET	3	Prior Authorization required;Max. 1 per day PA NTM*
XALATAN 0.005% EYE DROPS	3	
XALKORI 200 MG CAPSULE	3	Max. 2 per day CH*; SPP*: CVS Specialty
XALKORI 250 MG CAPSULE	3	Max. 2 per day CH*; SPP*: CVS Specialty
XANAX 0.25 MG TABLET	3	
XANAX 0.5 MG TABLET	3	
XANAX 1 MG TABLET	3	
XANAX 2 MG TABLET	3	
XANAX XR 0.5 MG TABLET	3	
XANAX XR 1 MG TABLET	3	
XANAX XR 2 MG TABLET	3	
XANAX XR 3 MG TABLET	3	
XARELTO 10 MG TABLET	2	HSA*
XARELTO 15 MG TABLET	2	HSA*
XARELTO 20 MG TABLET	2	HSA*
XARELTO STARTER PACK	2	HSA*
XARTEMIS XR 7.5-325 MG TABLET	3	Max. 120 per 30 days
XATMEP 2.5 MG/ML ORAL SOLUTION	3	
XELJANZ 5 MG TABLET	3	Prior Authorization required;Max. 2 per day SPP*: Must use CVS Specialty
XELJANZ XR 11 MG TABLET	3	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
XELODA 150 MG TABLET	3	CH*; SPP*: CVS Specialty
XELODA 500 MG TABLET	3	CH*; SPP*: CVS Specialty
XENAZINE 12.5 MG TABLET	3	SPP*: Must use CVS Specialty
XENAZINE 25 MG TABLET	3	SPP*: Must use CVS Specialty
XEOMIN 100 UNIT VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
XEOMIN 200 UNIT VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
XEOMIN 50 UNIT VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
XERESE 5%-1% CREAM	3	
XERMELO 250 MG TABLET	3	Prior Authorization required;Max. 3 per day LDD*: Diplomat Pharmacy (877) 977-9118
XGEVA 120 MG/1.7 ML VIAL	MD	Prior Authorization required;Max. 1.7 ML(s) in 28 days SPP*: Must use CVS Specialty
XIAFLEX 0.9 MG VIAL	MD	
XIFAXAN 200 MG TABLET	3	Max. quantity of 9 per fill MQC*: 9 tabs/copay
XIFAXAN 550 MG TABLET	2	
XIGDUO XR 10 MG-1,000 MG TAB	3	HSA*
XIGDUO XR 10 MG-500 MG TABLET	3	HSA*
XIGDUO XR 5 MG-1,000 MG TABLET	3	HSA*
XIGDUO XR 5 MG-500 MG TABLET	3	HSA*
XIIDRA 5% EYE DROPS	2	Max. 2 per day
XIMINO ER 135 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
XIMINO ER 45 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
XIMINO ER 90 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
XODOL 10-300 TABLET	3	
XODOL 5-300 TABLET	3	
XODOL 7.5-300 MG TABLET	3	
XOLAIR 150 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
XOLEGEL 2% GEL	3	
XOLOX 10-500 MG TABLET	3	
XOPENEX 0.31 MG/3 ML SOLUTION	3	HSA*
XOPENEX 0.63 MG/3 ML SOLUTION	3	HSA*
XOPENEX 1.25 MG/3 ML SOLUTION	3	HSA*
XOPENEX CONC 1.25 MG/0.5 ML	3	
XOPENEX HFA 45 MCG INHALER	3	HSA*
XRYLIX 1.5% KIT	3	
XTAMPZA ER 13.5 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 18 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 27 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 36 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 9 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTANDI 40 MG CAPSULE	2	CH*; SPP*: CVS Specialty
XULANE PATCH	0	ACA*
XULTOPHY 100 UNIT-3.6MG/ML PEN	3	Prior Authorization required HSA*
XURIDEN GRANULE PACKET	3	
XYLON 10-200 MG TABLET	1	
XYNTHA 500 UNIT KIT	MD	SPP*: Must use CVS Specialty
XYNTHA SOLOFUSE 1,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
XYREM 500 MG/ML ORAL SOLUTION	3	Prior Authorization required LDD*: Express Scripts. 866-997-3688 x66247.
XYZAL 2.5 MG/5 ML SOLUTION	3	
XYZAL 5 MG TABLET	3	

Y

YALE GLASS TB SYR 0.25 ML	3	
YALE GLASS TB SYRINGE 1 ML	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
YALE GLASS TB SYRINGE 2 ML	3	
YALE NEEDLES 21GX1"	3	
YALE NEEDLES 21GX1.25"	3	
YALE NEEDLES 21GX1.5"	3	
YALE NEEDLES 22GX1"	3	
YALE NEEDLES 22GX1.25"	3	
YALE NEEDLES 23GX1"	3	
YALE SYRINGE 10 ML	3	
YALE SYRINGE 100 ML	3	
YALE SYRINGE 20 ML	3	
YALE SYRINGE 3 ML	3	
YALE SYRINGE 30 ML	3	
YALE SYRINGE 5 ML	3	
YALE SYRINGE 50 ML	3	
YASMIN 28 TABLET	3	
YAZ 28 TABLET	3	
YODOXIN 210 MG TABLET	2	
YODOXIN 650 MG TABLET	2	
YOSPRALA DR 325-40 MG TABLET	3	Max. 1 per day HSA*
YOSPRALA DR 81-40 MG TABLET	3	Max. 1 per day HSA*
YUVAFEM 10 MCG VAGINAL INSERT	2	

Z

ZAFIRLUKAST 10 MG TABLET	1	HSA*
ZAFIRLUKAST 20 MG TABLET	1	HSA*
ZALEPLON 10 MG CAPSULE	1	
ZALEPLON 5 MG CAPSULE	1	
ZAMICET 10-325 MG/15 ML SOLN	3	
ZANABIN ANTIPRURITIC HYDROGEL	3	
ZANAFLEX 2 MG CAPSULE	3	
ZANAFLEX 4 MG CAPSULE	3	
ZANAFLEX 4 MG TABLET	3	
ZANAFLEX 6 MG CAPSULE	3	
ZANTAC 15 MG/ML SYRUP	3	
ZANTAC 150 MG TABLET	3	
ZANTAC 300 MG TABLET	3	
ZARAH TABLET	0	ACA*
ZARONTIN 250 MG CAPSULE	3	
ZARONTIN 250 MG/5 ML SOLUTION	3	
ZAROXOLYN 2.5 MG TABLET	3	HSA*
ZAROXOLYN 5 MG TABLET	3	HSA*
ZARXIO 300 MCG/0.5 ML SYRINGE	3	Prior Authorization required SPP*: Must use CVS Specialty
ZARXIO 480 MCG/0.8 ML SYRINGE	3	Prior Authorization required SPP*: Must use CVS Specialty
ZAVESCA 100 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
ZEBETA 10 MG TABLET	3	HSA*
ZEBETA 5 MG TABLET	3	HSA*
ZEBUTAL 50-325-40 MG CAPSULE	1	
ZEBUTAL CAPSULE	2	
ZEGERID 20 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZEGERID 20 MG PACKET	3	
ZEGERID 40 MG CAPSULE	3	
ZEGERID 40 MG PACKET	3	
ZEJULA 100 MG CAPSULE	3	Prior Authorization required;Max. 3 per day CH*; LDD*: Diplomat Pharmacy (877) 977-9118
ZELAPAR 1.25 MG ODT TABLET	3	
ZELBORAF 240 MG TABLET	3	CH*; SPP*: CVS Specialty
ZEMAIRA 1,000 MG VIAL	MD	Prior Authorization required LDD*: Accredo (866) 815-4717
ZEMBRACE SYMTOUCH 3 MG/0.5 ML	3	Prior Authorization required;Max. quantity of 2 per fill MQC*: 4 injections/copay
ZEMPLAR 1 MCG CAPSULE	3	
ZEMPLAR 2 MCG CAPSULE	3	
ZEMPLAR 4 MCG CAPSULE	3	
ZENATANE 10 MG CAPSULE	1	
ZENATANE 20 MG CAPSULE	1	
ZENATANE 30 MG CAPSULE	1	
ZENATANE 40 MG CAPSULE	1	
ZENCHENT 0.4 MG-35 MCG TABLET	0	ACA*
ZENCHENT FE TABLET CHEWABLE	0	ACA*
ZENPEP DR 10,000 UNITS CAPSULE	2	
ZENPEP DR 15,000 UNITS CAPSULE	2	
ZENPEP DR 20,000 UNITS CAPSULE	2	
ZENPEP DR 25,000 UNITS CAPSULE	2	
ZENPEP DR 3,000 UNITS CAPSULE	2	
ZENPEP DR 40,000 UNITS CAPSULE	2	
ZENPEP DR 5,000 UNITS CAPSULE	2	
ZENZEDI 10 MG TABLET	1	Max. 60 Days Supply
ZENZEDI 15 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 2.5 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 20 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 30 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 5 MG TABLET	1	Max. 60 Days Supply
ZENZEDI 7.5 MG TABLET	3	Max. 60 Days Supply
ZEOSA CHEWABLE TABLET	0	ACA*
ZEPATIER 50-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
ZERIT 1 MG/ML SOLUTION	3	
ZERIT 15 MG CAPSULE	3	
ZERIT 20 MG CAPSULE	3	
ZERIT 30 MG CAPSULE	3	
ZERIT 40 MG CAPSULE	3	
ZESTORETIC 10-12.5 MG TABLET	3	HSA*
ZESTORETIC 20-12.5 MG TABLET	3	HSA*
ZESTORETIC 20-25 MG TABLET	3	HSA*
ZESTRIL 10 MG TABLET	3	HSA*
ZESTRIL 2.5 MG TABLET	3	HSA*
ZESTRIL 20 MG TABLET	3	HSA*
ZESTRIL 30 MG TABLET	3	HSA*
ZESTRIL 40 MG TABLET	3	HSA*
ZESTRIL 5 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZETIA 10 MG TABLET	3	Max. 1 per day HSA*
ZETONNA 37 MCG NASAL SPRAY	3	
ZFLEX TABLET	1	
ZGESIC TABLET	3	
ZIAC 10-6.25 MG TABLET	3	HSA*
ZIAC 2.5-6.25 MG TABLET	3	HSA*
ZIAC 5-6.25 MG TABLET	3	HSA*
ZIAGEN 20 MG/ML SOLUTION	3	
ZIAGEN 300 MG TABLET	3	
ZIANA GEL	3	Prior Authorization required for members 30 and older
ZIDOVUDINE 100 MG CAPSULE	1	
ZIDOVUDINE 300 MG TABLET	1	
ZIDOVUDINE 50 MG/5 ML SYRUP	1	
ZILEUTON ER 600 MG TABLET	2	HSA*
ZINBRYTA 150 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) in 30 days SPP*: Must use CVS Specialty
ZINC SULFATE 220 MG CAPSULE	1	
ZIOPTAN 0.0015% EYE DROPS	3	
ZIPRASIDONE HCL 20 MG CAPSULE	1	
ZIPRASIDONE HCL 40 MG CAPSULE	1	
ZIPRASIDONE HCL 60 MG CAPSULE	1	
ZIPRASIDONE HCL 80 MG CAPSULE	1	
ZIPSOR 25 MG CAPSULE	3	
ZIRGAN 0.15% OPHTHALMIC GEL	3	
ZITHROMAX 1 GM POWDER PACKET	3	
ZITHROMAX 100 MG/5 ML SUSP	3	
ZITHROMAX 200 MG/5 ML SUSP	3	
ZITHROMAX 250 MG TABLET	3	
ZITHROMAX 250 MG Z-PAK TABLET	3	
ZITHROMAX 500 MG TABLET	3	
ZITHROMAX 600 MG TABLET	3	
ZITHROMAX TRI-PAK 500 MG TAB	3	
ZMAX 2 G/60 ML ORAL SUSPENSION	3	
ZOCOR 10 MG TABLET	3	HSA*
ZOCOR 20 MG TABLET	3	HSA*
ZOCOR 40 MG TABLET	3	HSA*
ZOCOR 5 MG TABLET	3	HSA*
ZOCOR 80 MG TABLET	3	HSA*
ZODEX 12 DAY 1.5 MG TABLET	3	Prior Authorization required PA NTM*
ZODEX 6 DAY 1.5 MG TABLET	3	Prior Authorization required PA NTM*
ZODRYL AC 25 SUSPENSION	3	
ZODRYL AC 30 SUSPENSION	3	
ZODRYL AC 35 SUSPENSION	3	
ZODRYL AC 40 SUSPENSION	3	
ZODRYL AC 50 SUSPENSION	3	
ZODRYL AC 60 SUSPENSION	3	
ZODRYL AC 80 SUSPENSION	3	
ZODRYL DAC 25 SUSPENSION	3	
ZODRYL DAC 30 SUSPENSION	3	
ZODRYL DAC 35 SUSPENSION	3	
ZODRYL DAC 40 SUSPENSION	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZODRYL DAC 50 SUSPENSION	3	
ZODRYL DAC 60 SUSPENSION	3	
ZODRYL DAC 80 SUSPENSION	3	
ZODRYL DEC 25 SUSPENSION	3	
ZODRYL DEC 30 SUSPENSION	3	
ZODRYL DEC 35 SUSPENSION	3	
ZODRYL DEC 40 SUSPENSION	3	
ZODRYL DEC 50 SUSPENSION	3	
ZODRYL DEC 60 SUSPENSION	3	
ZODRYL DEC 80 SUSPENSION	3	
ZOFRAN 4 MG TABLET	3	Max. quantity of 18 per fill MQC*: 18 tabs/copay
ZOFRAN 4 MG/5 ML ORAL SOLN	3	Max. quantity of 100 per fill MQC*: 100mL (2 bottles)/copay
ZOFRAN 8 MG TABLET	3	Max. quantity of 9 per fill MQC*: 9 tabs/copay
ZOFRAN ODT 4 MG TABLET	3	Max. quantity of 18 per fill MQC*: 18 tabs/copay
ZOFRAN ODT 8 MG TABLET	3	Max. quantity of 9 per fill MQC*: 9 tabs/copay
ZOHYDRO ER 10 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 15 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 20 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 30 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 40 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 50 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOLEDRONIC ACID 5 MG/100 ML	MD	Prior Authorization required;Max. 100 ML(s) in 365 days SPP*: Must use CVS Specialty
ZOLINZA 100 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ZOLMITRIPTAN 2.5 MG ODT	1	Max. quantity of 12 per fill MQC*: 12 tabs/copay
ZOLMITRIPTAN 2.5 MG TABLET	1	Max. quantity of 12 per fill MQC*: 12 tabs/copay
ZOLMITRIPTAN 5 MG ODT	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ZOLMITRIPTAN 5 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ZOLOFT 100 MG TABLET	3	Step Therapy required STA*: 18 and older
ZOLOFT 20 MG/ML ORAL CONC	3	Step Therapy required STA*: 18 and older
ZOLOFT 25 MG TABLET	3	Step Therapy required STA*: 18 and older
ZOLOFT 50 MG TABLET	3	Step Therapy required STA*: 18 and older
ZOLPIDEM TART 1.75 MG TAB SL	1	
ZOLPIDEM TART 3.5 MG TABLET SL	1	
ZOLPIDEM TART ER 12.5 MG TAB	1	
ZOLPIDEM TART ER 6.25 MG TAB	1	
ZOLPIDEM TARTRATE 10 MG TABLET	1	
ZOLPIDEM TARTRATE 5 MG TABLET	1	
ZOLPIMIST 5 MG ORAL SPRAY	3	Max. 7.7 ML(s) in 30 days;Step Therapy required STA*: 18 and older
ZOMACTON 10 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
ZOMACTON 5 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
ZOMIG 2.5 MG NASAL SPRAY	3	Max. quantity of 12 per fill MQC*: 6 sprays/copay
ZOMIG 2.5 MG TABLET	3	Max. quantity of 12 per fill;Step Therapy required MQC*: 12 tabs/copay

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZOMIG 5 MG NASAL SPRAY	3	Max. quantity of 6 per fill MQC*: 6 sprays/copay
ZOMIG 5 MG TABLET	3	Max. quantity of 6 per fill;Step Therapy required MQC*: 6 tabs/copay
ZOMIG ZMT 2.5 MG TABLET	3	Max. quantity of 12 per fill;Step Therapy required MQC*: 12 tabs/copay
ZOMIG ZMT 5 MG TABLET	3	Max. quantity of 6 per fill;Step Therapy required MQC*: 6 tabs/copay
ZONACORT 11 DAY 1.5 MG TABLET	3	
ZONACORT 7 DAY 1.5 MG TABLET	3	
ZONALON 5% CREAM	3	
ZONATUSS 150 MG CAPSULE	3	
ZONEGRAN 100 MG CAPSULE	3	
ZONEGRAN 25 MG CAPSULE	3	
ZONISAMIDE 100 MG CAPSULE	1	
ZONISAMIDE 25 MG CAPSULE	1	
ZONISAMIDE 50 MG CAPSULE	1	
ZONTIVITY 2.08 MG TABLET	3	HSA*
ZORBTIVE 8.8 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
ZORTRESS 0.25 MG TABLET	3	
ZORTRESS 0.5 MG TABLET	3	
ZORTRESS 0.75 MG TABLET	3	
ZORVOLEX 18 MG CAPSULE	2	
ZORVOLEX 35 MG CAPSULE	3	
ZOSTAVAX VIAL	0	Not covered for members 49 and younger ACA*, SPP*: CVS/Specialty, Covered ages 50 and older
ZOVIA 1-35E TABLET	0	ACA*
ZOVIA 1-50E TABLET	0	ACA*
ZOVIRAX 200 MG CAPSULE	3	
ZOVIRAX 200 MG/5 ML SUSP	3	
ZOVIRAX 400 MG TABLET	3	
ZOVIRAX 5% CREAM	3	Max. 5 GM(s) in 30 days
ZOVIRAX 5% OINTMENT	3	Max. 15 GM(s) in 30 days
ZOVIRAX 800 MG TABLET	3	
ZUBSOLV 0.7-0.18 MG TABLET SL	3	
ZUBSOLV 1.4-0.36 MG TABLET SL	3	
ZUBSOLV 11.4-2.9 MG TABLET SL	3	
ZUBSOLV 2.9-0.71 MG TABLET SL	3	
ZUBSOLV 5.7-1.4 MG TABLET SL	3	
ZUBSOLV 8.6-2.1 MG TABLET SL	3	
ZUPLENZ 4 MG SOLUBLE FILM	3	Max. quantity of 18 per fill MQC*: 18 films/copay
ZUPLENZ 8 MG SOLUBLE FILM	3	Max. quantity of 9 per fill MQC*: 9 films/copay
ZURAMPIC 200 MG TABLET	3	Prior Authorization required;Max. 1 per day
ZUTRIPRO SOLUTION	3	
ZYBAN SR 150 MG TABLET	0	Max. 180 Days Supply;Max. 180 in 365 days ACA*
ZYCLARA 2.5% CREAM PUMP	3	
ZYCLARA 3.75% CREAM PUMP	3	
ZYDELIG 100 MG TABLET	3	CH*; LDD*: Onco360 Pharmacy 1-877-662-6633
ZYDELIG 150 MG TABLET	3	CH*; LDD*: Onco360 Pharmacy 1-877-662-6633
ZYDONE 10-400 MG TABLET	3	
ZYDONE 5-400 MG TABLET	3	
ZYDONE 7.5-400 MG TABLET	3	
ZYFLO 600 MG FILMTAB	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZYFLO CR 600 MG TABLET	3	HSA*
ZYKADIA 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ZYLET EYE DROPS	2	
ZYLOPRIM 100 MG TABLET	3	
ZYLOPRIM 300 MG TABLET	3	
ZYMAXID 0.5% EYE DROPS	3	
ZYPREXA 10 MG TABLET	3	
ZYPREXA 10 MG VIAL	MD	SPP*: Must use CVS Specialty
ZYPREXA 15 MG TABLET	3	
ZYPREXA 2.5 MG TABLET	3	
ZYPREXA 20 MG TABLET	3	
ZYPREXA 5 MG TABLET	3	
ZYPREXA 7.5 MG TABLET	3	
ZYPREXA ZYDIS 10 MG TABLET	3	
ZYPREXA ZYDIS 15 MG TABLET	3	
ZYPREXA ZYDIS 20 MG TABLET	3	
ZYPREXA ZYDIS 5 MG TABLET	3	
ZYTIGA 250 MG TABLET	2	CH*; SPP*: CVS Specialty
ZYTIGA 500 MG TABLET	2	CH*; SPP*: CVS Specialty
ZYVOX 100 MG/5 ML SUSPENSION	3	
ZYVOX 600 MG TABLET	3	

Glossary of Notes *

Keyword	Description
HSA	**HSA Preventive Drug.** If your plan includes the Preventive Drug Benefit, covered preventive health drugs will not be subject to your plan deductible. Applicable copayment will apply. Examples include diabetes medications, medications for high blood pressure, prenatal vitamins.
ACA	**Affordable Care Act**. This medication is eligible for $0 cost share under most benefit plans. Age restrictions may apply. Examples of these medications include oral contraceptives, hormone replacement therapy (HRT), fluoride.
CH	**Oral Chemotherapy Mandate**. This includes oral chemotherapy (anti-cancer) medications used to treat cancer. These drugs may be eligible for a $0 copayment under certain benefit plans.
SPP	**Specialty Pharmacy Medications**. These medications should be obtained from our Specialty Pharmacy vendor CVS Specialty (800)237-2767. All specialty pharmacy drugs are limited to a maximum 30-day supply.
IVF	**IVF/Fertility Pharmacy Medications.** These medications must be obtained from one of our designated IVF Pharmacy vendors - Freedom Drug (877)585-4603 or Village Pharmacy (866)890-8930.
LDD	**Limited Distribution Drug.** Some medications may only be obtained through one or more pharmacies in a limited distribution network as required by the Food and Drug Administration (FDA) or product manufacturer. See specific note for Pharmacy information.
PAQ	**Prior Authorization for Quantity Limit Exceeded.** Some medications require Prior Authorization only when the quantity requested for treatment exceeds the standard quantity limit.
MQC	**Maximum Quantity per Copay.** Some medications may have quantity limitations with fixed-copays per measure of drug that you receive. For example, if your prescription benefit allows for up to 1 package or unit per copay, you will pay two copays for every 2 units or packages of medications that you receive, and so on.
STA	**Step Therapy/Age.** Harvard Pilgrim may require that members above or below a certain age first try one drug to treat a condition before we will cover another drug for that condition. This ensures that certain medications are used safely and effectively for members in specified age groups.
PA NTM	**Prior Authorization for New-to-Market Drugs.** Some medications that have recently come to market may have their use restricted through an initial prior authorization review. This may apply to both new medications and older medications with new indications or uses in order to give the health plan and its Pharmacy and Therapeutics (P&T) Committee time to evaluate the risks and benefits to members of the health plan.