Harvard Pilgrim Health Care
Prescription Drug List

PREMIUM FORMULARY
THREE-TIER DRUG LIST (2017)

BY CATEGORY

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 **by drug category and class**, 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.

Request an Exception
If your provider believes you need a medication that Harvard Pilgrim either doesn’t cover or limits, you or your provider can ask for an exception. For more information on requesting an exception, visit harvardpilgrim.org/rx or call Member Services.

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
ANALGESICS		
ANALGESICS, MISCELLANEOUS		
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
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	
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
ALAGESIC LQ ORAL SOLUTION	1	
ALFENTANIL 500 MCG/ML AMPUL	1	
ALFENTANIL 500 MCG/ML AMPULE	3	
ALLZITAL 25-325 MG TABLET	3	
ARYMO ER 15 MG TABLET	1	Max. 3 per day
ARYMO ER 30 MG TABLET	1	Max. 3 per day
ARYMO ER 60 MG TABLET	1	Max. 3 per day
ASCOMP WITH CODEINE CAPSULE	1	
ASPIRIN-CAFF-DIHYDROCODEIN CAP	1	
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
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	
BUPAP 50 MG-300 MG TABLET	3	
BUPRENORPHINE 10 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 15 MCG/HR PATCH	2	Max. 4 per 28 days
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
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	
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
CAPACET CAPSULE	1	
CAPITAL WITH CODEINE SUSP	3	
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	
CONZIP 100 MG CAPSULE	1	
CONZIP 200 MG CAPSULE	1	
CONZIP 300 MG CAPSULE	1	
DEMEROL 100 MG TABLET	3	
DEMEROL 50 MG TABLET	3	
DILAUDID 2 MG TABLET	3	
DILAUDID 4 MG TABLET	3	
DILAUDID 8 MG TABLET	3	
DISKETS 40 MG TABLET DISPR	1	
DOLOPHINE HCL 10 MG TABLET	3	
DOLOPHINE HCL 5 MG TABLET	3	
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
EMBEDA ER 100-4 MG CAPSULE	1	Max. 3 per day
EMBEDA ER 20-0.8 MG CAPSULE	1	Max. 3 per day
EMBEDA ER 30-1.2 MG CAPSULE	1	Max. 3 per day
EMBEDA ER 50-2 MG CAPSULE	1	Max. 3 per day
EMBEDA ER 60-2.4 MG CAPSULE	1	Max. 3 per day
EMBEDA ER 80-3.2 MG CAPSULE	1	Max. 3 per day
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	
ESGIC 50-325-40 MG TABLET	3	
ESGIC CAPSULE	3	
ESGIC PLUS CAPSULE	2	
ESGIC-PLUS 50-500-40 MG TABLET	3	
EXALGO ER 12 MG TABLET	3	Max. 2 per day
EXALGO ER 16 MG TABLET	3	Max. 2 per day
EXALGO ER 32 MG TABLET	3	Max. 2 per day
EXALGO ER 8 MG TABLET	3	Max. 2 per day
FENTANYL 100 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 12 MCG/HR PATCH	1	Max. 15 per 30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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	
HYCET 7.5 MG-325 MG/15 ML SOLN	3	
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-IBUPROFEN 10-200	1	
HYDROCODONE-IBUPROFEN 2.5-200	1	
HYDROCODONE-IBUPROFEN 5-200 MG	1	
HYDROCODONE-IBUPROFEN 7.5-200	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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
IBUDONE 10-200 MG TABLET	3	
IBUDONE 5-200 MG 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
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
LEVORPHANOL 2 MG TABLET	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	
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 7.5-325 MG TABLET	3	
LORTAB 7.5-500 TABLET	3	
MAGNACET 10 MG-400 MG TABLET	3	
MAGNACET 5 MG-400 MG TABLET	3	
MAGNACET 7.5 MG-400 MG TABLET	3	
MARGESIC CAPSULE	1	
MARTEN-TAB 325-50 TABLET	1	
MAXIDONE 10-750 MG TABLET	3	
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	
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 5 MG TABLET	1	
METHADOSE 10 MG/ML ORAL CONC	3	
METHADOSE 40 MG TABLET DISPR	1	
MORPHABOND ER 100 MG TABLET	1	Max. 2 per day
MORPHABOND ER 15 MG TABLET	1	Max. 2 per day
MORPHABOND ER 30 MG TABLET	1	Max. 2 per day
MORPHABOND ER 60 MG TABLET	1	Max. 2 per day
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
MS CONTIN 100 MG TABLET	3	Max. 90 per 30 days
MS CONTIN 15 MG TABLET	3	Max. 90 per 30 days
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
NORCO 10-325 TABLET	3	
NORCO 5-325 TABLET	3	
NORCO 7.5-325 TABLET	3	
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
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
OXAYDO 5 MG TABLET	3	
OXAYDO 7.5 MG TABLET	3	
OXECTA 5 MG TABLET	3	
OXECTA 7.5 MG TABLET	3	
OXYCODON-ACETAMINOPHEN 2.5-325	1	
OXYCODON-ACETAMINOPHEN 7.5-300	1	
OXYCODON-ACETAMINOPHEN 7.5-325	1	
OXYCODON-ACETAMINOPHEN 7.5-500	1	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
PENTAZOCIN-ACETAMINOPHN 25-650	1	
PENTAZOCINE-NALOXONE TABLET	1	
PERCOCET 10-325 MG TABLET	3	
PERCOCET 10-650 MG TABLET	3	
PERCOCET 2.5-325 MG TABLET	3	
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	
PHRENILIN FORTE CAPSULE	2	
PRIMLEV 10-300 MG TABLET	3	
PRIMLEV 5-300 MG TABLET	3	
PRIMLEV 7.5-300 MG TABLET	3	
PROMACET 50-650 MG TABLET	1	
RELAGESIC 650-50 MG TABLET	3	
REPREXAIN 10-200 MG TABLET	1	
REPREXAIN 2.5-200 MG TABLET	1	
REPREXAIN 5-200 MG TABLET	1	
RHINOFLEX-650 TABLET	1	
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	
SUBSYS 1,200 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
SYNALGOS-DC CAPSULE	3	
TENCON 50-325 MG TABLET	1	
TRAMADOL ER 100 MG TABLET	1	
TRAMADOL ER 200 MG TABLET	1	
TRAMADOL ER 300 MG TABLET	1	
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	
TREZIX 16-320.5-30 MG CAPSULE	3	
TREZIX CAPSULE	1	
TYLENOL WITH CODEINE #3 TABLET	3	
TYLENOL WITH CODEINE #4 TABLET	3	
ULTRACET TABLET	3	
ULTRAM 50 MG TABLET	3	
ULTRAM ER 100 MG TABLET	3	
ULTRAM ER 200 MG TABLET	3	
ULTRAM ER 300 MG TABLET	3	
VANATOL LQ ORAL SOLUTION	3	
VERDROCET 2.5-325 MG TABLET	3	
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	
XARTEMIS XR 7.5-325 MG TABLET	3	Max. 120 per 30 days
XODOL 10-300 TABLET	3	
XODOL 5-300 TABLET	3	
XODOL 7.5-300 MG TABLET	3	
XOLOX 10-500 MG TABLET	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
XYLON 10-200 MG TABLET	1	
ZAMICET 10-325 MG/15 ML SOLN	3	
ZEBUTAL 50-325-40 MG CAPSULE	1	
ZFLEX TABLET	1	
ZGESIC TABLET	3	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZOHYDRO ER 50 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZYDONE 10-400 MG TABLET	3	
ZYDONE 5-400 MG TABLET	3	
ZYDONE 7.5-400 MG TABLET	3	

NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

ANAPROX 275 MG TABLET	3	
ANAPROX DS 550 MG TABLET	3	
ARTHROTEC 50 MG-200 MCG TAB	3	
ARTHROTEC 75 MG-200 MCG TAB	3	
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*
BAYER ADVANCED 500 MG TABLET	$0	ACA*
BAYER PLUS 500 MG CAPLET	$0	ACA*
CAMBIA 50 MG POWDER PACKET	3	
CATAFLAM 50 MG TABLET	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	
CHOLINE MAG TRISAL LIQUID	1	
COMFORT PAC-IBUPROFEN KIT	3	
COMFORT PAC-NAPROXEN KIT	3	
CVS CHILD ASPIRIN 81 MG CHW TB	$0	ACA*
DAYPRO 600 MG CAPLET	3	
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-MISOPROST 50-200 TB	1	
DICLOFENAC-MISOPROST 75-200 TB	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DICLOTRAL PAK	3	
DIFLUNISAL 500 MG TABLET	1	
DISALCID 500 MG TABLET	3	
DISALCID 750 MG TABLET	3	
DUEXIS 800-26.6 MG TABLET	3	Prior Authorization required;Max. 3 per day
DURLAZA ER 162.5 MG CAPSULE	3	Prior Authorization required HSA*
EC-NAPROSYN EC 375 MG TABLET	3	
EC-NAPROSYN EC 500 MG TABLET	3	
ECOTRIN EC 325 MG TABLET	$0	ACA*
ECPIRIN EC 325 MG TABLET	$0	ACA*
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	
FELDENE 10 MG CAPSULE	3	
FELDENE 20 MG CAPSULE	3	
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	
FLECTOR 1.3% PATCH	2	
FLURBIPROFEN 100 MG TABLET	1	
FLURBIPROFEN 50 MG TABLET	1	
IBUPROFEN 100 MG/5 ML SUSP	1	
IBUPROFEN 400 MG TABLET	1	
IBUPROFEN 600 MG TABLET	1	
IBUPROFEN 800 MG TABLET	1	
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	
KETOPROFEN 50 MG CAPSULE	1	
KETOPROFEN 75 MG CAPSULE	1	
KETOPROFEN ER 200 MG CAPSULE	1	
KETOROLAC 10 MG TABLET	1	Max. 5 Days Supply;Max. quantity of 20 per fill
LODINE 400 MG TABLET	3	
MECLOFENAMATE 100 MG CAPSULE	1	
MECLOFENAMATE 50 MG CAPSULE	1	
MEFENAMIC ACID 250 MG CAPSULE	1	
MELOXICAM 15 MG TABLET	1	
MELOXICAM 7.5 MG TABLET	1	
MELOXICAM 7.5 MG/5 ML SUSP	1	
MINIPRIN EC 81 MG TABLET	$0	ACA*
MOBIC 15 MG TABLET	3	
MOBIC 7.5 MG TABLET	3	
MOBIC 7.5 MG/5 ML SUSPENSION	3	
NABUMETONE 500 MG TABLET	1	
NABUMETONE 750 MG TABLET	1	
NALFON 400 MG CAPSULE	3	
NAPRELAN CR 375 MG TABLET	3	
NAPRELAN CR 500 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NAPRELAN CR 750 MG TABLET	3	
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	
OXAPROZIN 600 MG TABLET	1	
PAIN RELIEF COLLECTION KIT	3	
PENNSAID 1.5% SOLUTION	3	
PENNSAID 2% PUMP	3	Prior Authorization required
PIROXICAM 10 MG CAPSULE	1	
PIROXICAM 20 MG CAPSULE	1	
PONSTEL 250 MG KAPSEALS	3	
PROFENO 600 MG TABLET	3	Prior Authorization required
QC CHILD ASPIRIN 81 MG CHW TAB	$0	ACA*
RA ASPIRIN 325 MG TABLET	$0	ACA*
SALSALATE 500 MG TABLET	1	
SALSALATE 750 MG TABLET	1	
SM BUFF ASPIRIN 325 MG TAB	$0	ACA*
SPRIX 15.75 MG NASAL SPRAY	3	Max. quantity of 5 per fill
ST. JOSEPH ASPIRIN 81 MG CHEW	$0	ACA*
ST. JOSEPH ASPIRIN EC 81 MG TB	$0	ACA*
SULINDAC 150 MG TABLET	1	
SULINDAC 200 MG TABLET	1	
SURE RESULT DSS PREMIUM PACK	3	
TIVORBEX 20 MG CAPSULE	3	
TIVORBEX 40 MG CAPSULE	3	
TOLMETIN SODIUM 200 MG TAB	1	
TOLMETIN SODIUM 400 MG CAP	1	
TOLMETIN SODIUM 600 MG TAB	1	
TRI-BUFFERED ASPIRIN 325 MG TB	$0	ACA*
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
VIVLODEX 10 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
VIVLODEX 5 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
VOLTAREN 1% GEL	3	
VOLTAREN-XR 100 MG TABLET	3	
XRYLIX 1.5% KIT	3	
ZIPSOR 25 MG CAPSULE	3	
ZORVOLEX 18 MG CAPSULE	2	
ZORVOLEX 35 MG CAPSULE	3	

ANESTHETICS

LOCAL ANESTHETICS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALTAFLUOR EYE DROPS	1	
BUCALSEP SOLUTION	3	
EMLA CREAM	3	
FLUORESCEIN-BENOXINATE EYE DRP	3	
FLURESS EYE DROPS	3	
FLUROX EYE DROPS	3	
GLYDO 2% JELLY SYRINGE	1	
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	
LORENZA 4%-1% PATCH	3	
PINNACAINE 20% OTIC DROPS	1	
PONTOCAINE 2% SOLUTION	3	
PRE-ATTACHED LTA KIT	3	
SYNERA PATCH	3	

ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

ACAMPROSATE CALC DR 333 MG TAB	1	
ANTABUSE 250 MG TABLET	3	
ANTABUSE 500 MG TABLET	3	
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
BUPRENORPHIN-NALOXON 8-2 MG SL	1	
BUPRENORPHINE 2 MG TABLET SL	1	
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 SR 150 MG TABLET	$0	Max. 180 Days Supply;Max. 180 in 365 days ACA*
CAMPRAL DR 333 MG TABLET	3	
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*
DISULFIRAM 250 MG TABLET	1	
DISULFIRAM 500 MG TABLET	1	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
NARCAN 4 MG NASAL SPRAY	MD	Max. 2 per 15 days $0 copayment
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*
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
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*
REVIA 50 MG TABLET	3	
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	
VIVITROL 380 MG VIAL + DILUENT	MD	SPP*: Must use CVS Specialty
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	
ZYBAN SR 150 MG TABLET	$0	Max. 180 Days Supply;Max. 180 in 365 days ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES

ANTI-INFECTIVES (SKIN AND MUCOUS MEMBRANE)

ANTI-INFECTIVES (SKIN AND MUCOUS MEMBRANE)

AVC 15% CREAM	2	
CLEOCIN 100 MG VAGINAL OVULE	3	
CLEOCIN 2% VAGINAL CREAM	3	
CLINDAMYCIN 2% VAGINAL CREAM	1	
CLINDESSE 2% VAGINAL CREAM	3	
FEM PH VAGINAL JELLY	3	
GYNAZOLE 1 2% CREAM	3	
METROGEL-VAGINAL 0.75% GEL	3	
METRONIDAZOLE VAGINAL 0.75% GL	1	
NUVESSA VAGINAL 1.3% GEL	3	
RELAGARD VAGINAL GEL	3	
TERAZOL 3 80 MG SUPPOSITORY	3	
TERAZOL 3 CREAM	3	
TERAZOL 7 CREAM	3	
TERCONAZOLE 0.4% CREAM	1	
TERCONAZOLE 0.8% CREAM	1	
TERCONAZOLE 80 MG SUPPOSITORY	1	
VANDAZOLE VAGINAL 0.75% GEL	2	

ANTIANXIETY AGENTS

BENZODIAZEPINES

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	
ATIVAN 0.5 MG TABLET	3	
ATIVAN 1 MG TABLET	3	
ATIVAN 2 MG TABLET	3	
CHLORDIAZEPOXIDE 10 MG CAPSULE	1	
CHLORDIAZEPOXIDE 25 MG CAPSULE	1	
CHLORDIAZEPOXIDE 5 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	
CLORAZEPATE 15 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLORAZEPATE 3.75 MG TABLET	1	
CLORAZEPATE 7.5 MG TABLET	1	
DIASTAT 2.5 MG PEDI SYSTEM	3	
DIASTAT ACUDIAL 12.5-15-20 MG	3	
DIASTAT ACUDIAL 5-7.5-10 MG KT	3	
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	
DORAL 15 MG TABLET	3	
ESTAZOLAM 1 MG TABLET	1	
ESTAZOLAM 2 MG TABLET	1	
FLURAZEPAM 15 MG CAPSULE	1	
FLURAZEPAM 30 MG CAPSULE	1	
HALCION 0.25 MG TABLET	3	
KLONOPIN 0.5 MG TABLET	3	
KLONOPIN 1 MG TABLET	3	
KLONOPIN 2 MG TABLET	3	
LORAZEPAM 0.5 MG TABLET	1	
LORAZEPAM 1 MG TABLET	1	
LORAZEPAM 2 MG TABLET	1	
LORAZEPAM 2 MG/ML ORAL CONCENT	1	
MIDAZOLAM HCL 2 MG/ML SYRUP	1	
NIRAVAM 0.25 MG ODT	3	
NIRAVAM 0.5 MG ODT	3	
NIRAVAM 1 MG ODT	3	
NIRAVAM 2 MG ODT	3	
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
OXAZEPAM 10 MG CAPSULE	1	
OXAZEPAM 15 MG CAPSULE	1	
OXAZEPAM 30 MG CAPSULE	1	
QUAZEPAM 15 MG TABLET	1	
RESTORIL 15 MG CAPSULE	3	
RESTORIL 22.5 MG CAPSULE	3	
RESTORIL 30 MG CAPSULE	3	
RESTORIL 7.5 MG CAPSULE	3	
TEMAZEPAM 15 MG CAPSULE	1	
TEMAZEPAM 22.5 MG CAPSULE	1	
TEMAZEPAM 30 MG CAPSULE	1	
TEMAZEPAM 7.5 MG CAPSULE	1	
TRANXENE T-TAB 15 MG	3	
TRANXENE T-TAB 3.75 MG	3	
TRANXENE T-TAB 7.5 MG	3	
TRIAZOLAM 0.125 MG TABLET	1	
TRIAZOLAM 0.25 MG TABLET	1	
VALIUM 10 MG TABLET	3	
VALIUM 2 MG TABLET	3	
VALIUM 5 MG TABLET	3	
XANAX 0.25 MG TABLET	3	
XANAX 0.5 MG TABLET	3	
XANAX 1 MG TABLET	3	
XANAX 2 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	

ANTIBACTERIALS

AMINOGLYCOSIDES

BETHKIS 300 MG/4 ML AMPULE	2	SPP*: Must use CVS Specialty
KITABIS PAK 300 MG/5 ML	2	SPP*: Must use CVS Specialty
NEOMYCIN 500 MG TABLET	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
TOBRAMYCIN 300 MG/5 ML AMPULE	1	SPP*: Must use CVS Specialty

ANTIBACTERIALS, MISCELLANEOUS

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	
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	
FLAGYL 250 MG TABLET	3	
FLAGYL 375 CAPSULE	3	
FLAGYL 500 MG TABLET	3	
FLAGYL ER 750 MG TABLET	3	
FURADANTIN 25 MG/5 ML SUSP	3	
HIPREX 1 GM TABLET	3	
LINEZOLID 100 MG/5 ML SUSP	1	
LINEZOLID 600 MG TABLET	1	
MACROBID 100 MG CAPSULE	3	
MACRODANTIN 100 MG CAPSULE	3	
MACRODANTIN 25 MG CAPSULE	3	
MACRODANTIN 50 MG CAPSULE	3	
METHENAMINE HIPP 1 GM TABLET	1	
METHENAMINE MD 1 GM TABLET	1	
METHENAMINE MD 500 MG TABLET	1	
METRONIDAZOLE 250 MG TABLET	1	
METRONIDAZOLE 375 MG CAPSULE	1	
METRONIDAZOLE 500 MG TABLET	1	
MONUROL 3 GM SACHET	3	
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	
PRIMSOL 50 MG/5 ML ORAL SOLN	3	
SIVEXTRO 200 MG TABLET	3	Max. quantity of 6 per fill MQC*: 6 tabs/copay
TRIMETHOPRIM 100 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRIMPEX 50 MG/5 ML ORAL SOLN	3	
UROQID-ACID NO.2 500-500 TB	3	
VANCOCIN HCL 125 MG CAPSULE	3	
VANCOCIN HCL 250 MG CAPSULE	3	
VANCOMYCIN HCL 125 MG CAPSULE	1	
VANCOMYCIN HCL 250 MG CAPSULE	1	
XIFAXAN 200 MG TABLET	3	Max. quantity of 9 per fill MQC*: 9 tabs/copay
XIFAXAN 550 MG TABLET	2	
ZYVOX 100 MG/5 ML SUSPENSION	3	
ZYVOX 600 MG TABLET	3	

CEPHALOSPORINS

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	
CEFUROXIME AXETIL 250 MG TAB	1	
CEFUROXIME AXETIL 500 MG TAB	1	
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	
DAXBIA 333 MG CAPSULE	3	
KEFLEX 250 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
KEFLEX 500 MG CAPSULE	3	
KEFLEX 750 MG CAPSULE	3	
SPECTRACEF 400 MG DOSE PACK TB	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	

MACROLIDES

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	
BIAXIN 250 MG TABLET	3	
BIAXIN 250 MG/5 ML SUSPENSION	3	
BIAXIN 500 MG TABLET	3	
BIAXIN XL 500 MG TABLET	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	
DIFICID 200 MG TABLET	2	Limit fills to 1 in 30 days;Max. 20 per 10 days
E.E.S. 200 MG/5 ML GRANULES	1	
E.E.S. 400 FILMTAB	1	
ERY-TAB EC 250 MG TABLET	1	
ERY-TAB EC 333 MG TABLET	3	
ERY-TAB EC 500 MG TABLET	1	
ERYPED 200 MG/5 ML SUSPENSION	3	
ERYPED 400 MG/5 ML SUSPENSION	2	
ERYTHROCIN 250 MG FILMTAB	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-SULFISOX SUSP	1	
KETEK 300 MG TABLET	3	
KETEK 400 MG TABLET	3	
PCE 333 MG TABLET	3	
PCE 500 MG TABLET	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	

MISCELLANEOUS B-LACTAM ANTIBIOTICS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CAYSTON 75 MG INHAL SOLUTION	3	LDD*: IV Solutions. 1-800-658-6046.

PENICILLINS

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	
AMOXICILLIN 125 MG TAB CHEW	1	
AMOXICILLIN 125 MG/5 ML SUSP	1	
AMOXICILLIN 200 MG/5 ML SUSP	1	
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	
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	
DICLOXACILLIN 250 MG CAPSULE	1	
DICLOXACILLIN 500 MG CAPSULE	1	
MOXATAG ER 775 MG TABLET	3	
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	

QUINOLONES

AVELOX 400 MG TABLET	3	
AVELOX ABC PACK 400 MG TAB	3	
BAXDELA 450 MG TABLET	3	Prior Authorization required;Max. 2 per day
CIPRO 10% SUSPENSION	3	
CIPRO 250 MG TABLET	3	
CIPRO 5% SUSPENSION	3	
CIPRO 500 MG TABLET	3	
CIPRO XR 1,000 MG TABLET	3	
CIPRO XR 500 MG TABLET	3	
CIPROFLOXACIN 250 MG/5 ML SUSP	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
FACTIVE 320 MG TABLET	3	
LEVAQUIN 25 MG/ML SOLUTION	3	
LEVAQUIN 250 MG TABLET	3	
LEVAQUIN 500 MG TABLET	3	
LEVAQUIN 750 MG TABLET	3	
LEVOFLOXACIN 25 MG/ML SOLUTION	1	
LEVOFLOXACIN 250 MG TABLET	1	
LEVOFLOXACIN 500 MG TABLET	1	
LEVOFLOXACIN 750 MG TABLET	1	
MOXIFLOXACIN HCL 400 MG TABLET	1	
NOROXIN 400 MG TABLET	3	
OFLOXACIN 200 MG TABLET	1	
OFLOXACIN 300 MG TABLET	1	
OFLOXACIN 400 MG TABLET	1	

SULFONAMIDES

AZULFIDINE 500 MG TABLET	3	
AZULFIDINE ENTAB 500 MG	3	
BACTRIM 400-80 MG TABLET	3	
BACTRIM DS TABLET	3	
SULFADIAZINE 500 MG TABLET	1	
SULFAMETHOXAZOLE-TMP DS TABLET	1	
SULFAMETHOXAZOLE-TMP SS TABLET	1	
SULFAMETHOXAZOLE-TMP SUSP	1	
SULFASALAZINE 500 MG TABLET	1	
SULFASALAZINE DR 500 MG TAB	1	
SULFATRIM PEDIATRIC SUSPENSION	1	

TETRACYCLINES

ACTICLATE 150 MG TABLET	3	
ACTICLATE 75 MG TABLET	3	
ADOXA 150 MG CAPSULE	3	
ALODOX CONVENIENCE KIT	3	
AVIDOXY 100 MG TABLET	3	
BENZODOX 30 KIT	3	
BENZODOX 60 KIT	3	
DEMECLOCYCLINE 150 MG TABLET	1	
DEMECLOCYCLINE 300 MG TABLET	1	
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	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
DOXYCYCLINE MONO 50 MG TABLET	1	
DOXYCYCLINE MONO 75 MG CAPSULE	1	
DOXYCYCLINE MONO 75 MG TABLET	1	
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	
MONDOXYNE NL 100 MG CAPSULE	3	
MONDOXYNE NL 50 MG CAPSULE	3	
MONDOXYNE NL 75 MG CAPSULE	3	
MONODOX 100 MG CAPSULE	3	
MONODOX 50 MG CAPSULE	3	
MONODOX 75 MG CAPSULE	3	
MORGIDOX 100 MG CAPSULE	3	
MORGIDOX 1X100 MG KIT	3	
MORGIDOX 50 MG CAPSULE	3	
OCUDOX CONVENIENCE KIT	3	
ORACEA 40 MG CAPSULE	3	
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
TARGADOX 50 MG TABLET	3	Max. 2 per day
TETRACYCLINE 250 MG CAPSULE	1	
TETRACYCLINE 500 MG CAPSULE	1	
VIBRAMYCIN 100 MG CAPSULE	3	
VIBRAMYCIN 25 MG/5 ML SUSP	3	
VIBRAMYCIN 50 MG/5 ML SYRUP	3	
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

ANTICANCER AGENTS

ANTICANCER AGENTS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
ALECENSA 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ALKERAN 2 MG TABLET	3	CH*
ALUNBRIG 30 MG TABLET	3	Prior Authorization required;Max. 6 per day CH*; SPP*: CVS Specialty
ANASTROZOLE 1 MG TABLET	1	CH*; HSA*
ARIMIDEX 1 MG TABLET	3	CH*; HSA*
AROMASIN 25 MG TABLET	3	CH*; HSA*
BEXAROTENE 75 MG CAPSULE	1	CH*
BICALUTAMIDE 50 MG TABLET	1	CH*
BOSULIF 100 MG TABLET	3	CH*; SPP*: CVS Specialty
BOSULIF 400 MG TABLET	3	CH*; SPP*: CVS Specialty
BOSULIF 500 MG TABLET	3	CH*; SPP*: CVS Specialty
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
CALQUENCE 100 MG CAPSULE	3	Prior Authorization required;Max. 2 per day CH*; PA NTM*; LDD*: Onco360 Pharmacy 1-877-662-6633
CAPECITABINE 150 MG TABLET	1	CH*; SPP*: CVS Specialty
CAPECITABINE 500 MG TABLET	1	CH*; SPP*: CVS Specialty
CAPRELSA 100 MG TABLET	3	CH*
CAPRELSA 300 MG TABLET	3	CH*
CASODEX 50 MG TABLET	3	CH*
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.
COTELLIC 20 MG TABLET	3	CH*; SPP*: CVS Specialty
CYCLOPHOSPHAMIDE 25 MG CAPSULE	2	CH*
CYCLOPHOSPHAMIDE 25 MG TAB	1	CH*
CYCLOPHOSPHAMIDE 50 MG CAPSULE	2	CH*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CYCLOPHOSPHAMIDE 50 MG TABLET	1	CH*
DROXIA 200 MG CAPSULE	3	
DROXIA 300 MG CAPSULE	3	
DROXIA 400 MG CAPSULE	3	
EMCYT 140 MG CAPSULE	2	CH*
ERIVEDGE 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ETOPOSIDE 50 MG CAPSULE	1	CH*
EXEMESTANE 25 MG TABLET	1	CH*; HSA*
FARESTON 60 MG TABLET	2	CH*; 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
FEMARA 2.5 MG TABLET	3	CH*; HSA*
FLUTAMIDE 125 MG CAPSULE	1	CH*
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
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*
HEXALEN 50 MG CAPSULE	2	CH*
HYCAMTIN 0.25 MG CAPSULE	3	CH*; SPP*: CVS Specialty
HYCAMTIN 1 MG CAPSULE	3	CH*; SPP*: CVS Specialty
HYDREA 500 MG CAPSULE	3	CH*
HYDROXYUREA 500 MG CAPSULE	1	CH*
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
ICLUSIG 15 MG TABLET	3	CH*
ICLUSIG 45 MG TABLET	3	CH*
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
IMATINIB MESYLATE 100 MG TAB	2	Max. 30 Days Supply CH*; SPP*: CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
INLYTA 1 MG TABLET	3	CH*; SPP*: CVS Specialty
INLYTA 5 MG TABLET	3	CH*; SPP*: CVS Specialty
IRESSA 250 MG TABLET	3	CH*; SPP*: 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
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
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
LETROZOLE 2.5 MG TABLET	1	CH*; HSA*
LEUKERAN 2 MG TABLET	2	CH*
LEUPROLIDE 2WK 14 MG/2.8 ML KT	1	Max. 30 Days Supply IVF*
LOMUSTINE 10 MG CAPSULE	1	CH*
LOMUSTINE 100 MG CAPSULE	1	CH*
LOMUSTINE 40 MG CAPSULE	1	CH*
LONSURF 15 MG-6.14 MG TABLET	3	CH*; SPP*: CVS Specialty
LONSURF 20 MG-8.19 MG TABLET	3	CH*; SPP*: CVS Specialty
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
LYNPARZA 100 MG TABLET	3	CH*
LYNPARZA 150 MG TABLET	3	CH*
LYNPARZA 50 MG CAPSULE	3	CH*
LYSODREN 500 MG TABLET	2	CH*
MATULANE 50 MG CAPSULE	2	CH*; LDD*: Walgreens Specialty (800) 424-9002
MEGESTROL 20 MG TABLET	1	CH*
MEGESTROL 40 MG TABLET	1	CH*
MEKINIST 0.5 MG TABLET	3	CH*; SPP*: CVS Specialty
MEKINIST 2 MG TABLET	3	CH*; SPP*: CVS Specialty
MELPHALAN 2 MG TABLET	2	CH*
MERCAPTOPURINE 50 MG TABLET	1	CH*
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	
MYLERAN 2 MG TABLET	2	CH*
NERLYNX 40 MG TABLET	3	Prior Authorization required CH*; SPP*: CVS Specialty
NEXAVAR 200 MG TABLET	3	CH*; SPP*: CVS Specialty
NILANDRON 150 MG TABLET	3	CH*
NILUTAMIDE 150 MG TABLET	2	CH*
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
ODOMZO 200 MG CAPSULE	3	CH*; SPP*: CVS Specialty
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
PURINETHOL 50 MG TABLET	3	CH*
PURIXAN 20 MG/ML ORAL SUSP	3	CH*
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
REVLIMID 5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
RHEUMATREX 2.5 MG TABLET	2	
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
SOLTAMOX 10 MG/5 ML SOLN	3	CH*; HSA*
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
STIVARGA 40 MG TABLET	3	CH*; SPP*: CVS Specialty
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
TABLOID 40 MG TABLET	2	CH*
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
TAMOXIFEN 10 MG TABLET	1	CH*; HSA*
TAMOXIFEN 20 MG TABLET	1	CH*; HSA*
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
TARGRETIN 1% GEL	3	HSA*
TARGRETIN 75 MG CAPSULE	3	CH*
TASIGNA 150 MG CAPSULE	2	CH*; SPP*: CVS Specialty
TASIGNA 200 MG CAPSULE	2	CH*; SPP*: CVS Specialty
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TEMODAR 250 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TEMODAR 5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
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
TOPOTECAN HCL 4 MG VIAL	1	
TRETINOIN 10 MG CAPSULE	1	CH*
TREXALL 10 MG TABLET	3	
TREXALL 15 MG TABLET	3	
TREXALL 5 MG TABLET	3	
TREXALL 7.5 MG TABLET	3	
TYKERB 250 MG TABLET	2	CH*; SPP*: CVS Specialty
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
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
VOTRIENT 200 MG TABLET	3	CH*; SPP*: CVS Specialty
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
XATMEP 2.5 MG/ML ORAL SOLUTION	3	
XELODA 150 MG TABLET	3	CH*; SPP*: CVS Specialty
XELODA 500 MG TABLET	3	CH*; SPP*: CVS Specialty
XTANDI 40 MG CAPSULE	2	CH*; SPP*: CVS Specialty
ZEJULA 100 MG CAPSULE	3	Prior Authorization required;Max. 3 per day CH*; LDD*: Diplomat Pharmacy (877) 977-9118
ZELBORAF 240 MG TABLET	3	CH*; SPP*: CVS Specialty
ZOLINZA 100 MG CAPSULE	3	CH*; SPP*: CVS Specialty
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
ZYKADIA 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZYTIGA 250 MG TABLET	2	CH*; SPP*: CVS Specialty
ZYTIGA 500 MG TABLET	2	CH*; SPP*: CVS Specialty

ANTICHOLINERGIC AGENTS

ANTIMUSCARINICS/ANTISPASMODICS

BEVESPI AEROSPHERE INHALER	3	
CHLORDIAZEPOXIDE-CLIDINIUM CAP	1	
LIBRAX CAPSULE	3	
PROPANTHELINE 15 MG TABLET	1	

ANTICONVULSANTS

ANTICONVULSANTS

APTIOM 200 MG TABLET	3	
APTIOM 400 MG TABLET	3	
APTIOM 600 MG TABLET	3	
APTIOM 800 MG TABLET	3	
BANZEL 200 MG TABLET	2	
BANZEL 40 MG/ML SUSPENSION	2	
BANZEL 400 MG TABLET	2	
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
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	
CELONTIN 300 MG KAPSEAL	2	
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	
DILANTIN 100 MG CAPSULE	3	
DILANTIN 125 MG/5 ML SUSP	3	
DILANTIN 30 MG CAPSULE	2	
DILANTIN 50 MG INFATAB	3	
DIVALPROEX DR 125 MG CAP SPRNK	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DIVALPROEX SOD DR 125 MG TAB	1	
DIVALPROEX SOD DR 250 MG TAB	1	
DIVALPROEX SOD DR 500 MG TAB	1	
DIVALPROEX SOD ER 250 MG TAB	1	
DIVALPROEX SOD ER 500 MG TAB	1	
EPITOL 200 MG TABLET	1	
EQUETRO 100 MG CAPSULE	3	
EQUETRO 200 MG CAPSULE	3	
EQUETRO 300 MG CAPSULE	3	
ETHOSUXIMIDE 250 MG CAPSULE	1	
ETHOSUXIMIDE 250 MG/5 ML SOLN	1	
FANATREX ORAL SUSPENSION	3	
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	
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	
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	
GRALISE 30-DAY STARTER PACK	3	
GRALISE ER 300 MG TABLET	3	
GRALISE ER 600 MG TABLET	3	
HORIZANT ER 300 MG TABLET	3	
HORIZANT ER 600 MG TABLET	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	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LAMICTAL ODT START KIT (GREEN)	3	
LAMICTAL ODT START KT (ORANGE)	3	
LAMICTAL TAB START KIT (BLUE)	3	
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	
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	2	
LAMOTRIGINE TAB START KT-GREEN	2	
LAMOTRIGINE TAB START KT-ORANG	2	
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	
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
MYSOLINE 250 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MYSOLINE 50 MG TABLET	3	
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	
OXCARBAZEPINE 150 MG TABLET	1	
OXCARBAZEPINE 300 MG TABLET	1	
OXCARBAZEPINE 300 MG/5 ML SUSP	1	
OXCARBAZEPINE 600 MG TABLET	1	
OXTELLAR XR 150 MG TABLET	3	
OXTELLAR XR 300 MG TABLET	3	
OXTELLAR XR 600 MG TABLET	3	
PEGANONE 250 MG 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	
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	
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	
POTIGA 200 MG TABLET	3	
POTIGA 300 MG TABLET	3	
POTIGA 400 MG TABLET	3	
POTIGA 50 MG TABLET	3	
PRIMIDONE 250 MG TABLET	1	
PRIMIDONE 50 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	
ROWEEPRA 1,000 MG TABLET	3	
ROWEEPRA 500 MG TABLET	3	
ROWEEPRA 750 MG TABLET	3	
SABRIL 500 MG POWDER PACKET	3	SPP*: Must use CVS Specialty
SABRIL 500 MG TABLET	2	SPP*: Must use CVS Specialty
SMARTRX GABA-V KIT	3	
SPRITAM 1,000 MG TABLET	3	
SPRITAM 250 MG TABLET	3	
SPRITAM 500 MG TABLET	3	
SPRITAM 750 MG TABLET	3	
STAVZOR DR 125 MG CAPSULE	3	
STAVZOR DR 250 MG CAPSULE	3	
STAVZOR DR 500 MG CAPSULE	3	
TEGRETOL 100 MG/5 ML SUSP	3	
TEGRETOL 200 MG TABLET	3	
TEGRETOL XR 100 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TEGRETOL XR 200 MG TABLET	3	
TEGRETOL XR 400 MG TABLET	3	
TIAGABINE HCL 2 MG TABLET	1	
TIAGABINE HCL 4 MG TABLET	1	
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	
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	
TOPIRAMATE ER 150 MG CAPSULE	1	
TOPIRAMATE ER 200 MG CAPSULE	1	
TOPIRAMATE ER 25 MG CAPSULE	1	
TOPIRAMATE ER 50 MG CAPSULE	1	
TRILEPTAL 150 MG TABLET	3	
TRILEPTAL 300 MG TABLET	3	
TRILEPTAL 300 MG/5 ML SUSP	3	
TRILEPTAL 600 MG 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	
VALPROIC ACID 250 MG CAPSULE	1	
VALPROIC ACID 250 MG/5 ML SOLN	1	
VIGABATRIN 500 MG POWDER PACKT	2	SPP*: Must use CVS Specialty
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	
VIMPAT STARTER KIT	2	
ZARONTIN 250 MG CAPSULE	3	
ZARONTIN 250 MG/5 ML SOLUTION	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	

ANTIDEMENTIA AGENTS

ANTIDEMENTIA AGENTS

ARICEPT 10 MG TABLET	3	
ARICEPT 23 MG TABLET	3	
ARICEPT 5 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ARICEPT ODT 10 MG TABLET	3	
ARICEPT ODT 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	
EXELON 1.5 MG CAPSULE	3	
EXELON 13.3 MG/24HR PATCH	3	
EXELON 2 MG/ML ORAL SOLUTION	3	
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	
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	
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	
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	
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	
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	

ANTIDEPRESSANTS

ANTIDEPRESSANTS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
AMOXAPINE 100 MG TABLET	1	
AMOXAPINE 150 MG TABLET	1	
AMOXAPINE 25 MG TABLET	1	
AMOXAPINE 50 MG TABLET	1	
ANAFRANIL 25 MG CAPSULE	3	
ANAFRANIL 50 MG CAPSULE	3	
ANAFRANIL 75 MG CAPSULE	3	
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
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
BUDEPRION SR 150 MG TABLET	1	
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	1	
BUPROPION HCL SR 200 MG TABLET	1	
BUPROPION HCL XL 150 MG TABLET	1	
BUPROPION HCL XL 300 MG TABLET	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
CHLORDIAZEPO-AMITRIPTYL 5-12.5	1	
CHLORDIAZEPOX-AMITRIPTYL 10-25	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	
CLOMIPRAMINE 25 MG CAPSULE	1	
CLOMIPRAMINE 50 MG CAPSULE	1	
CLOMIPRAMINE 75 MG CAPSULE	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
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	
DESVENLAFAXINE ER 100 MG TAB	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DESVENLAFAXINE ER 50 MG TAB	2	
DESVENLAFAXINE SUC ER 100 MG	2	
DESVENLAFAXINE SUC ER 25 MG TB	2	
DESVENLAFAXINE SUC ER 50 MG TB	2	
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 50 MG CAPSULE	1	
DOXEPIN 75 MG CAPSULE	1	
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	
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
EMSAM 12 MG/24 HOURS PATCH	3	
EMSAM 6 MG/24 HOURS PATCH	3	
EMSAM 9 MG/24 HOURS PATCH	3	
ESCITALOPRAM 10 MG TABLET	1	
ESCITALOPRAM 20 MG TABLET	1	
ESCITALOPRAM 5 MG TABLET	1	
ESCITALOPRAM OXALATE 5 MG/5 ML	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
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
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	
FORFIVO XL 450 MG TABLET	2	
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	
IRENKA DR 40 MG CAPSULE	1	Step Therapy required STA*: 18 and older

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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
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
MAPROTILINE 25 MG TABLET	1	
MAPROTILINE 50 MG TABLET	1	
MAPROTILINE 75 MG TABLET	1	
MARPLAN 10 MG 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	
NARDIL 15 MG TABLET	3	
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	
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	
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	
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	
PAMELOR 10 MG CAPSULE	3	
PAMELOR 25 MG CAPSULE	3	
PAMELOR 50 MG CAPSULE	3	
PAMELOR 75 MG CAPSULE	3	
PARNATE 10 MG TABLET	3	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PAROXETINE HCL 40 MG TABLET	1	
PAROXETINE MESYLATE 7.5 MG CAP	2	
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
PAXIL CR 37.5 MG TABLET	3	Step Therapy required STA*: 18 and older
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	
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
PHENELZINE SULFATE 15 MG TAB	1	
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
PROTRIPTYLINE HCL 10 MG TABLET	1	
PROTRIPTYLINE HCL 5 MG TABLET	1	
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
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	
SARAFEM 10 MG TABLET	2	Step Therapy required STA*: 18 and older
SARAFEM 20 MG TABLET	3	Step Therapy required STA*: 18 and older
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	
SURMONTIL 100 MG CAPSULE	3	
SURMONTIL 25 MG CAPSULE	3	
SURMONTIL 50 MG CAPSULE	3	
SYMBYAX 12-25 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SYMBYAX 12-50 MG CAPSULE	3	
SYMBYAX 3-25 MG CAPSULE	3	
SYMBYAX 6-25 MG CAPSULE	3	
SYMBYAX 6-50 MG CAPSULE	3	
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	
TRANYLCYPROMINE SULF 10 MG TAB	1	
TRAZODONE 100 MG TABLET	1	
TRAZODONE 150 MG TABLET	1	
TRAZODONE 300 MG TABLET	1	
TRAZODONE 50 MG TABLET	1	
TRIMIPRAMINE MALEATE 100 MG CP	1	
TRIMIPRAMINE MALEATE 25 MG CAP	1	
TRIMIPRAMINE MALEATE 50 MG CAP	1	
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
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	
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
VIVACTIL 10 MG TABLET	3	
VIVACTIL 5 MG TABLET	3	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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

ANTIDIABETIC AGENTS

ANTIDIABETIC AGENTS, MISCELLANEOUS

ACARBOSE 100 MG TABLET	1	HSA*
ACARBOSE 25 MG TABLET	1	HSA*
ACARBOSE 50 MG TABLET	1	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*
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*
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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
BYDUREON 2 MG PEN INJECT	2	Max. 1 per 7 days;Step Therapy required HSA*
BYDUREON 2 MG VIAL	2	Max. 1 per 7 days;Step Therapy required HSA*
BYDUREON BCISE 2 MG AUTOINJECT	2	Max. 3.4 ML(s) 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*
CYCLOSET 0.8 MG TABLET	2	HSA*
DUETACT 30-2 MG TABLET	3	HSA*
DUETACT 30-4 MG TABLET	3	HSA*
FARXIGA 10 MG TABLET	3	HSA*
FARXIGA 5 MG TABLET	3	HSA*
FORTAMET ER 1,000 MG TABLET	3	HSA*
FORTAMET ER 500 MG TABLET	3	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*
GLUMETZA ER 1,000 MG TABLET	3	Prior Authorization required HSA*
GLUMETZA ER 500 MG TABLET	3	Prior Authorization required HSA*
GLYSET 100 MG TABLET	3	HSA*
GLYSET 25 MG TABLET	3	HSA*
GLYSET 50 MG TABLET	3	HSA*
GLYXAMBI 10 MG-5 MG TABLET	3	HSA*
GLYXAMBI 25 MG-5 MG TABLET	3	HSA*
INVOKAMET 150-1,000 MG TABLET	2	HSA*
INVOKAMET 150-500 MG TABLET	2	HSA*
INVOKAMET 50-1,000 MG TABLET	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
INVOKAMET XR 50-500 MG TABLET	2	HSA*
INVOKANA 100 MG TABLET	2	HSA*
INVOKANA 300 MG TABLET	2	HSA*
JANUMET 50-1,000 MG TABLET	2	HSA*
JANUMET 50-500 MG TABLET	2	HSA*
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*
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*
KAZANO 12.5-1,000 MG TABLET	3	HSA*
KAZANO 12.5-500 MG TABLET	3	HSA*
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.
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
METFORMIN HCL ER 500 MG TABLET	2	Prior Authorization required HSA*; (generic Glumetza)
METFORMIN HCL ER 750 MG TABLET	1	HSA*
MIFEPREX 200 MG TABLET	3	
MIGLITOL 100 MG TABLET	1	HSA*
MIGLITOL 25 MG TABLET	1	HSA*
MIGLITOL 50 MG TABLET	1	HSA*
NATEGLINIDE 120 MG TABLET	1	HSA*
NATEGLINIDE 60 MG TABLET	1	HSA*
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*
ONGLYZA 2.5 MG TABLET	3	Step Therapy required HSA*
ONGLYZA 5 MG TABLET	3	Step Therapy required HSA*
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*
OZEMPIC 0.25-0.5 MG DOSE PEN	3	Prior Authorization required;Max. 3.2 ML(s) per 30 days HSA*; PA NTM*
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*
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*
PRECOSE 100 MG TABLET	3	HSA*
PRECOSE 25 MG TABLET	3	HSA*
PRECOSE 50 MG TABLET	3	HSA*
QTERN 10 MG-5 MG TABLET	3	Prior Authorization required HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
RIOMET 500 MG/5 ML SOLUTION	3	HSA*
STARLIX 120 MG TABLET	3	HSA*
STARLIX 60 MG TABLET	3	HSA*
SYMLINPEN 120 PEN INJECTOR	2	HSA*
SYMLINPEN 60 PEN INJECTOR	2	HSA*
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*
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*
TRADJENTA 5 MG TABLET	2	HSA*
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*
VICTOZA 3-PAK 18 MG/3 ML PEN	2	Max. 9 ML(s) per 30 days;Step Therapy required HSA*
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*

INSULINS

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*
AFREZZA 60-4 UNIT / 30-8 UNIT	3	Prior Authorization required;Max. 15 per day HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
APIDRA 100 UNITS/ML VIAL	3	HSA*
APIDRA SOLOSTAR 100 UNITS/ML	3	HSA*
BASAGLAR 100 UNIT/ML KWIKPEN	3	Prior Authorization required HSA*
FIASP 100 UNIT/ML FLEXTOUCH	3	Prior Authorization required HSA*; PA NTM*
FIASP 100 UNIT/ML VIAL	3	Prior Authorization required HSA*; PA NTM*
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*
HUMULIN 70-30 PEN	2	HSA*
HUMULIN 70-30 VIAL	2	HSA*
HUMULIN 70/30 KWIKPEN	2	HSA*
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*
LANTUS 100 UNIT/ML VIAL	2	HSA*
LANTUS SOLOSTAR 100 UNIT/ML	2	HSA*
LEVEMIR 100 UNITS/ML VIAL	2	HSA*
LEVEMIR FLEXTOUCH 100 UNITS/ML	2	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NOVOLOG MIX 70-30 FLEXPEN SYRN	3	Prior Authorization required HSA*
NOVOLOG MIX 70-30 VIAL	3	Prior Authorization required HSA*
SOLIQUA 100 UNIT-33 MCG/ML PEN	3	Prior Authorization required HSA*
TOUJEO SOLOSTAR 300 UNITS/ML	2	HSA*
TRESIBA FLEXTOUCH 100 UNITS/ML	3	Prior Authorization required HSA*
TRESIBA FLEXTOUCH 200 UNITS/ML	3	Prior Authorization required HSA*
XULTOPHY 100 UNIT-3.6MG/ML PEN	3	Prior Authorization required HSA*

SULFONYLUREAS

AMARYL 1 MG TABLET	3	HSA*
AMARYL 2 MG TABLET	3	HSA*
AMARYL 4 MG TABLET	3	HSA*
CHLORPROPAMIDE 100 MG TABLET	1	HSA*
CHLORPROPAMIDE 250 MG TABLET	1	HSA*
DIABETA 1.25 MG TABLET	2	HSA*
DIABETA 2.5 MG TABLET	2	HSA*
DIABETA 5 MG TABLET	2	HSA*
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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
GLYNASE 1.5 MG PRESTAB	3	HSA*
GLYNASE 3 MG PRESTAB	3	HSA*
GLYNASE 6 MG PRESTAB	3	HSA*
TOLAZAMIDE 250 MG TABLET	1	HSA*
TOLAZAMIDE 500 MG TABLET	1	HSA*
TOLBUTAMIDE 500 MG TABLET	1	HSA*

ANTIFUNGALS

ANTIFUNGALS

ALA-QUIN 3-0.5% CREAM	3	
ANCOBON 250 MG CAPSULE	3	
ANCOBON 500 MG CAPSULE	3	
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	
CLOTRIMAZOLE 1% CREAM	1	
CLOTRIMAZOLE 1% SOLUTION	1	
CLOTRIMAZOLE 10 MG TROCHE	1	
CLOTRIMAZOLE-BETAMETHASONE CRM	1	
CLOTRIMAZOLE-BETAMETHASONE LOT	1	
CRESEMBA 186 MG CAPSULE	3	
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	
ECONAZOLE NITRATE 1% CREAM	1	
ECOZA 1% FOAM	3	
ERTACZO 2% CREAM	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EXELDERM 1% CREAM	3	
EXELDERM 1% SOLUTION	3	
EXTINA 2% FOAM	3	
FIRST-DUKE'S MOUTHWASH	3	
FIRST-MARY'S MOUTHWASH	3	
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	
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	
ITRACONAZOLE 100 MG CAPSULE	1	Max. 84 Days Supply;Prior Authorization required;Max. 168 in 365 days
JUBLIA 10% TOPICAL SOLUTION	3	Prior Authorization required;Max. 2 ML(s) per 15 days
KERYDIN 5% TOPICAL SOLUTION	3	Prior Authorization required
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	
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
LOPROX 0.77% CREAM	3	
LOPROX 0.77% GEL	3	
LOPROX 0.77% TOPICAL SUSP	3	
LOPROX 1% SHAMPOO	3	
LOTRISONE CREAM	3	
LUZU 1% CREAM	3	
MENTAX 1% CREAM	2	
MICONAZOLE 3 200 MG VAG SUPP	1	
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	
NIZORAL 2% SHAMPOO	3	
NOXAFIL 40 MG/ML SUSPENSION	3	
NOXAFIL DR 100 MG TABLET	3	
NYAMYC 100,000 UNITS/GM POWDER	1	
NYATA 100,000 UNIT/GM POWDER	1	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NYSTATIN-TRIAMCINOLONE OINTM	1	
NYSTOP 100,000 UNITS/GM POWDER	1	
ONMEL 200 MG TABLET	3	Max. 84 Days Supply;Prior Authorization required;Max. 28 per 28 days
ORAVIG 50 MG BUCCAL TABLET	3	
OXICONAZOLE NITRATE 1% CREAM	1	
OXISTAT 1% CREAM	3	
OXISTAT 1% LOTION	3	
PEDI-DRI TOPICAL POWDER	1	
PEDIADERM AF KIT	3	
PEDIPIROX-4 NAIL KIT	3	Prior Authorization required
PENLAC 8% SOLUTION	3	Prior Authorization required
SPORANOX 10 MG/ML SOLUTION	3	
SPORANOX 100 MG CAPSULE	3	Max. 84 Days Supply;Prior Authorization required;Max. 168 in 365 days
TERBINAFINE HCL 250 MG TABLET	1	Max. quantity of 28 per fill;Max. 84 in 365 days
TRIPLE DYE SWAB	1	
VFEND 200 MG TABLET	3	
VFEND 40 MG/ML SUSPENSION	3	
VFEND 50 MG TABLET	3	
VORICONAZOLE 200 MG TABLET	1	
VORICONAZOLE 40 MG/ML SUSP	1	
VORICONAZOLE 50 MG TABLET	1	
VUSION OINTMENT	3	
XOLEGEL 2% GEL	3	

ANTIGOUT AGENTS

ANTIGOUT AGENTS, OTHER

ALLOPURINOL 100 MG TABLET	1	
ALLOPURINOL 300 MG TABLET	1	
COLCHICINE 0.6 MG CAPSULE	1	
COLCHICINE 0.6 MG TABLET	1	
COLCRYS 0.6 MG TABLET	3	
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*
MITIGARE 0.6 MG CAPSULE	3	
PROBENECID 500 MG TABLET	1	
PROBENECID-COLCHICINE TABS	1	
ULORIC 40 MG TABLET	2	
ULORIC 80 MG TABLET	2	
ZURAMPIC 200 MG TABLET	3	Prior Authorization required;Max. 1 per day
ZYLOPRIM 100 MG TABLET	3	
ZYLOPRIM 300 MG TABLET	3	

ANTIHISTAMINES

ANTIHISTAMINES

ARBINOXA 4 MG TABLET	1	
ARBINOXA 4 MG/5 ML LIQUID	1	
CARBINOXAMINE 4 MG/5 ML LIQUID	1	
CARBINOXAMINE MALEATE 4 MG TAB	1	
CETIRIZINE HCL 1 MG/ML SOLN	1	
CLARINEX 0.5 MG/ML (2.5 MG/5)	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLARINEX 5 MG TABLET	3	
CLARINEX-D 12 HOUR TABLET	3	
CLARINEX-D 24 HOUR TABLET	3	
CLEMASTINE 0.5 MG/5 ML SYRUP	1	
CLEMASTINE FUM 2.68 MG TAB	1	
CYPROHEPTADINE 2 MG/5 ML SYRUP	1	
CYPROHEPTADINE 4 MG TABLET	1	
DESLORATADINE 2.5 MG ODT	1	
DESLORATADINE 5 MG ODT	1	
DESLORATADINE 5 MG TABLET	1	
DICOPANOL ORAL SUSPENSION	3	
FEXOFENADINE-PSE ER 180-240 TB	1	
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	
KARBINAL ER 4 MG/ 5 ML SUSP	3	
LEVOCETIRIZINE 2.5 MG/5 ML SOL	1	
LEVOCETIRIZINE 5 MG TABLET	1	
PALGIC 4 MG TABLET	3	
PALGIC 4 MG/5 ML LIQUID	1	
PROMETHAZINE 6.25 MG/5 ML SYRP	1	
PROMETHAZINE VC SYRUP	1	
RESPA A.R. TABLET SA	1	
RYVENT 6 MG TABLET	3	
SEMPREX-D 8 MG-60 MG CAPSULE	3	
XYZAL 2.5 MG/5 ML SOLUTION	3	
XYZAL 5 MG TABLET	3	

ANTIMIGRAINE AGENTS

ANTIMIGRAINE AGENTS

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
ALSUMA 6 MG/0.5 ML AUTO-INJECT	2	Max. quantity of 3 per fill MQC*: 6 injections/copay
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
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
CAFERGOT TABLET	3	
D.H.E.45 1 MG/ML AMPUL	3	
DIHYDROERGOTAMINE 1 MG/ML AMP	1	
DIHYDROERGOTAMINE 4 MG/ML SPRY	1	
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
ERGOMAR 2 MG TABLET SL	2	
ERGOTAMINE-CAFFEINE 1-100MG TB	1	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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
ISOMETHEPT-DICHLORALP-ACETAMIN	1	
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
MIGERGOT SUPPOSITORY	3	
MIGRANAL NASAL SPRAY	3	
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
NODOLOR CAPSULE	1	
ONZETRA XSAIL 11 MG	3	Prior Authorization required;Max. quantity of 16 per fill MQC*: 16 caps(8 doses)/copay
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
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
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
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
ZEMBRACE SYMTOUCH 3 MG/0.5 ML	3	Prior Authorization required;Max. quantity of 2 per fill MQC*: 4 injections/copay
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
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
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

ANTIMYCOBACTERIALS

ANTIMYCOBACTERIALS

CYCLOSERINE 250 MG CAPSULE	1	
DAPSONE 100 MG TABLET	1	
DAPSONE 25 MG TABLET	1	
ETHAMBUTOL HCL 100 MG TABLET	1	
ETHAMBUTOL HCL 400 MG TABLET	1	
ISONIAZID 100 MG TABLET	1	
ISONIAZID 300 MG TABLET	1	
ISONIAZID 50 MG/5 ML SOLUTION	1	
MYAMBUTOL 400 MG TABLET	3	
MYCOBUTIN 150 MG CAPSULE	3	
PASER GRANULES 4 GM PACKET	3	
PRIFTIN 150 MG TABLET	3	
PYRAZINAMIDE 500 MG TABLET	1	
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	
SIRTURO 100 MG TABLET	3	Max. quantity of 32 per fill
TRECATOR 250 MG TABLET	3	

ANTINAUSEA AGENTS

ANTINAUSEA AGENTS

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
ANZEMET 100 MG TABLET	3	Max. quantity of 6 per fill MQC*: 3 tabs/copay

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ANZEMET 50 MG TABLET	3	Max. quantity of 6 per fill MQC*: 6 tabs/copay
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
CESAMET 1 MG CAPSULE	3	Max. quantity of 18 per fill MQC*: 18 tabs/copay
COMPAZINE 10 MG TABLET	3	
COMPAZINE 25 MG SUPPOSITORY	3	
COMPAZINE 5 MG TABLET	3	
COMPRO 25 MG SUPPOSITORY	1	
DICLEGIS DR 10-10 MG TABLET	3	
DRONABINOL 10 MG CAPSULE	1	
DRONABINOL 2.5 MG CAPSULE	1	
DRONABINOL 5 MG CAPSULE	1	
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
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
MARINOL 10 MG CAPSULE	3	
MARINOL 2.5 MG CAPSULE	3	
MARINOL 5 MG CAPSULE	3	
MECLIZINE 12.5 MG TABLET	1	
MECLIZINE 25 MG TABLET	1	
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
PHENADOZ 12.5 MG SUPPOSITORY	1	
PHENADOZ 25 MG SUPPOSITORY	1	
PHENERGAN 12.5 MG SUPPOSITORY	3	
PHENERGAN 25 MG SUPPOSITORY	3	
PHENERGAN 50 MG SUPPOSITORY	3	
PROCHLORPERAZINE 10 MG TAB	1	
PROCHLORPERAZINE 25 MG SUPP	1	
PROCHLORPERAZINE 5 MG TABLET	1	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PROMETHEGAN 12.5 MG SUPPOS	1	
PROMETHEGAN 25 MG SUPPOSITORY	1	
PROMETHEGAN 50 MG SUPPOSITORY	1	
SANCUSO 3.1 MG/24 HR PATCH	3	Max. quantity of 4 per fill MQC*: 4 patches/copay
SCOPOLAMINE 1 MG/3 DAY PATCH	2	Max. quantity of 4 per fill MQC*: 1 box (4 patches)/copay
SYNDROS 5 MG/ML SOLUTION	3	
TIGAN 300 MG CAPSULE	3	
TRANSDERM-SCOP 1.5 MG/3 DAY	3	Max. quantity of 4 per fill MQC*: 1 box (4 patches)/copay
TRIMETHOBENZAMIDE 300 MG CAP	1	
VARUBI 90 MG TABLET	3	Max. quantity of 2 per fill MQC*: 2 tabs/copay
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
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

ANTIPARASITE AGENTS

ANTIPARASITE AGENTS

ALBENZA 200 MG TABLET	3	
ALINIA 100 MG/5 ML SUSPENSION	3	
ALINIA 500 MG TABLET	3	
ATOVAQUONE 750 MG/5 ML SUSP	1	
ATOVAQUONE-PROGUANIL 250-100	1	
ATOVAQUONE-PROGUANIL 62.5-25	1	
BENZNIDAZOLE 100 MG TABLET	2	Prior Authorization required
BENZNIDAZOLE 12.5 MG TABLET	2	Prior Authorization required
BILTRICIDE 600 MG TABLET	3	
CHLOROQUINE PH 250 MG TABLET	1	
CHLOROQUINE PH 500 MG TABLET	1	
COARTEM TABLETS	3	Max. quantity of 24 per fill MQC*: 24 tabs/copay
DARAPRIM 25 MG TABLET	2	Prior Authorization required
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
HYDROXYCHLOROQUINE 200 MG TAB	1	
IMPAVIDO 50 MG CAPSULE	3	
IVERMECTIN 3 MG TABLET	1	
MALARONE 250-100 MG TABLET	3	
MALARONE 62.5-25 MG PED TAB	3	
MEFLOQUINE HCL 250 MG TABLET	1	
MEPRON 750 MG/5 ML SUSPENSION	3	
NEBUPENT 300 MG INHAL POWDER	2	
PAROMOMYCIN 250 MG CAPSULE	1	
PLAQUENIL 200 MG TABLET	3	
PRIMAQUINE 26.3 MG TABLET	2	
QUALAQUIN 324 MG CAPSULE	3	
QUININE SULFATE 324 MG CAPSULE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
STROMECTOL 3 MG TABLET	3	
TINDAMAX 250 MG TABLET	3	
TINDAMAX 500 MG TABLET	3	
TINIDAZOLE 250 MG TABLET	1	
TINIDAZOLE 500 MG TABLET	1	
YODOXIN 210 MG TABLET	2	
YODOXIN 650 MG TABLET	2	

ANTIPARKINSONIAN AGENTS

ANTIPARKINSONIAN AGENTS

AMANTADINE 100 MG CAPSULE	1	
AMANTADINE 100 MG TABLET	1	
AMANTADINE 50 MG/5 ML SOLUTION	1	
APOKYN 30 MG/3 ML CARTRIDGE	3	
AZILECT 0.5 MG TABLET	3	
AZILECT 1 MG TABLET	3	
BENZTROPINE MES 0.5 MG TAB	1	
BENZTROPINE MES 1 MG TABLET	1	
BENZTROPINE MES 2 MG TABLET	1	
BROMOCRIPTINE 2.5 MG TABLET	1	
BROMOCRIPTINE 5 MG CAPSULE	1	
CABERGOLINE 0.5 MG TABLET	1	
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	
COMTAN 200 MG TABLET	3	
DUOPA 4.63 MG-20 MG/ML SUSPENS	3	Max. 2800 ML(s) per 28 days LDD*: Accredo (866) 815-4717
ELDEPRYL 5 MG CAPSULE	3	
ENTACAPONE 200 MG TABLET	1	
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
LODOSYN 25 MG TABLET	3	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MIRAPEX ER 3 MG TABLET	3	
MIRAPEX ER 3.75 MG TABLET	3	
MIRAPEX ER 4.5 MG TABLET	3	
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	
PARCOPA 10 MG-100 MG ODT	3	
PARCOPA 25 MG-100 MG ODT	3	
PARCOPA 25 MG-250 MG ODT	3	
PARLODEL 2.5 MG TABLET	3	
PARLODEL 5 MG CAPSULE	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	
RASAGILINE MESYLATE 0.5 MG TAB	2	
RASAGILINE MESYLATE 1 MG TAB	2	
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	
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	
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
RYTARY ER 61.25 MG-245 MG CAP	3	Step Therapy required
SELEGILINE HCL 5 MG CAPSULE	1	
SELEGILINE HCL 5 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
STALEVO 100 TABLET	3	
STALEVO 125 TABLET	3	
STALEVO 150 TABLET	3	
STALEVO 200 TABLET	3	
STALEVO 50 TABLET	3	
STALEVO 75 TABLET	3	
TASMAR 100 MG TABLET	3	
TOLCAPONE 100 MG TABLET	1	
TRIHEXYPHENIDYL 2 MG TABLET	1	
TRIHEXYPHENIDYL 2 MG/5 ML ELX	1	
TRIHEXYPHENIDYL 5 MG TABLET	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*
ZELAPAR 1.25 MG ODT TABLET	3	

ANTIPSYCHOTIC AGENTS

ANTIPSYCHOTIC AGENTS

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	
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	
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	
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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLOZARIL 100 MG TABLET	3	Max. 28 Days Supply
CLOZARIL 25 MG TABLET	3	Max. 28 Days Supply
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	
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
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	
GEODON 20 MG CAPSULE	3	
GEODON 40 MG CAPSULE	3	
GEODON 60 MG CAPSULE	3	
GEODON 80 MG CAPSULE	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	
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
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	
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	
MOLINDONE HCL 10 MG TABLET	1	
MOLINDONE HCL 25 MG TABLET	1	
MOLINDONE HCL 5 MG TABLET	1	
NUPLAZID 17 MG TABLET	3	Prior Authorization required;Max. 2 per day SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
ORAP 1 MG TABLET	3	
ORAP 2 MG TABLET	3	
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	
PERPHENAZINE 16 MG TABLET	1	
PERPHENAZINE 2 MG TABLET	1	
PERPHENAZINE 4 MG TABLET	1	
PERPHENAZINE 8 MG TABLET	1	
PIMOZIDE 1 MG TABLET	1	
PIMOZIDE 2 MG TABLET	1	
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	
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
REXULTI 3 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 4 MG TABLET	3	Max. 1 per day;Step Therapy required
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	
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	
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	
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	
TRIFLUOPERAZINE 1 MG TABLET	1	
TRIFLUOPERAZINE 10 MG TABLET	1	
TRIFLUOPERAZINE 2 MG TABLET	1	
TRIFLUOPERAZINE 5 MG TABLET	1	
VERSACLOZ 50 MG/ML SUSPENSION	3	Max. 28 Days Supply
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
ZIPRASIDONE HCL 20 MG CAPSULE	1	
ZIPRASIDONE HCL 40 MG CAPSULE	1	
ZIPRASIDONE HCL 60 MG CAPSULE	1	
ZIPRASIDONE HCL 80 MG CAPSULE	1	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ANTIVIRALS (SYSTEMIC)		
ANTIRETROVIRALS		
ABACAVIR 20 MG/ML SOLUTION	2	
ABACAVIR 300 MG TABLET	1	
ABACAVIR-LAMIVUDINE 600-300 MG	2	
ABACAVIR-LAMIVUDINE-ZIDOV TAB	1	
APTIVUS 100 MG/ML SOLUTION	3	
APTIVUS 250 MG CAPSULE	3	
ATRIPLA TABLET	2	
COMBIVIR TABLET	3	
COMPLERA TABLET	3	
CRIXIVAN 200 MG CAPSULE	2	
CRIXIVAN 400 MG CAPSULE	2	
DESCOVY 200-25 MG TABLET	3	
DIDANOSINE DR 125 MG CAPSULE	1	
DIDANOSINE DR 200 MG CAPSULE	1	
DIDANOSINE DR 250 MG CAPSULE	1	
DIDANOSINE DR 400 MG CAPSULE	1	
EDURANT 25 MG TABLET	3	
EMTRIVA 10 MG/ML SOLUTION	3	
EMTRIVA 200 MG CAPSULE	3	
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	
EPZICOM TABLET	3	
EVOTAZ 300 MG-150 MG TABLET	3	
FOSAMPRENAVIR 700 MG TABLET	2	
FUZEON 90 MG VIAL	2	SPP*: Must use CVS Specialty
GENVOYA TABLET	3	
INTELENCE 100 MG TABLET	3	
INTELENCE 200 MG TABLET	3	
INTELENCE 25 MG TABLET	3	
INVIRASE 200 MG CAPSULE	2	
INVIRASE 500 MG TABLET	2	
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	
JULUCA 50-25 MG TABLET	3	Prior Authorization required
KALETRA 100-25 MG TABLET	2	
KALETRA 200-50 MG TABLET	2	
KALETRA 80 MG-20 MG/ML SOLN	3	
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	
LEXIVA 50 MG/ML SUSPENSION	2	
LEXIVA 700 MG TABLET	3	
LOPINAVIR-RITONAVIR 80-20MG/ML	2	
NEVIRAPINE 200 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NEVIRAPINE 50 MG/5 ML SUSP	1	
NEVIRAPINE ER 100 MG TABLET	1	
NEVIRAPINE ER 400 MG TABLET	1	
NORVIR 100 MG SOFTGEL CAP	2	
NORVIR 100 MG TABLET	2	
NORVIR 80 MG/ML SOLUTION	2	
ODEFSEY TABLET	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	
RESCRIPTOR 100 MG TABLET	2	
RESCRIPTOR 200 MG TABLET	2	
RETROVIR 10 MG/ML SYRUP	3	
RETROVIR 100 MG CAPSULE	3	
REYATAZ 150 MG CAPSULE	2	
REYATAZ 200 MG CAPSULE	2	
REYATAZ 300 MG CAPSULE	2	
REYATAZ 50 MG POWDER PACKET	2	
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	
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	
STRIBILD TABLET	3	
SUSTIVA 200 MG CAPSULE	2	
SUSTIVA 50 MG CAPSULE	2	
SUSTIVA 600 MG TABLET	2	
TIVICAY 10 MG TABLET	3	
TIVICAY 25 MG TABLET	3	
TIVICAY 50 MG TABLET	3	
TRIUMEQ TABLET	3	
TRIZIVIR TABLET	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	
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	
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	
VIREAD 150 MG TABLET	2	
VIREAD 200 MG TABLET	2	
VIREAD 250 MG TABLET	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VIREAD 300 MG TABLET	2	
VIREAD POWDER	2	
VITEKTA 150 MG TABLET	3	
VITEKTA 85 MG TABLET	3	
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	
ZIAGEN 20 MG/ML SOLUTION	3	
ZIAGEN 300 MG TABLET	3	
ZIDOVUDINE 100 MG CAPSULE	1	
ZIDOVUDINE 300 MG TABLET	1	
ZIDOVUDINE 50 MG/5 ML SYRUP	1	

ANTIVIRALS, MISCELLANEOUS

FLUMADINE 100 MG 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
PREVYMIS 240 MG TABLET	3	Prior Authorization required
PREVYMIS 480 MG TABLET	3	Prior Authorization required
RELENZA 5 MG DISKHALER	3	Max. quantity of 20 per fill
RIMANTADINE HCL 100 MG TABLET	1	
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
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

HCV ANTIVIRALS

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
EPCLUSA 400 MG-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
HARVONI 90-400 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
MAVYRET 100-40 MG TABLET	2	Prior Authorization required;Max. 84 per 28 days SPP*: Must use CVS Specialty
OLYSIO 150 MG CAPSULE	3	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
SOVALDI 400 MG TABLET	2	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
TECHNIVIE DOSE PACK	3	Prior Authorization required;Max. 56 per 28 days Max 56 tabs/28 days supply; SPP*: Must use CVS Specialty
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
VOSEVI 400-100-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZEPATIER 50-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty

INTERFERONS

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
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
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
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

NUCLEOSIDES AND NUCLEOTIDES

ACYCLOVIR 200 MG CAPSULE	1	
ACYCLOVIR 200 MG/5 ML SUSP	1	
ACYCLOVIR 400 MG TABLET	1	
ACYCLOVIR 800 MG TABLET	1	
ADEFOVIR DIPIVOXIL 10 MG TAB	1	
BARACLUDE 0.05 MG/ML SOLUTION	2	
BARACLUDE 0.5 MG TABLET	3	
BARACLUDE 1 MG TABLET	3	
COPEGUS 200 MG TABLET	3	SPP*: Must use CVS Specialty
ENTECAVIR 0.5 MG TABLET	1	
ENTECAVIR 1 MG TABLET	1	
FAMCICLOVIR 125 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FAMCICLOVIR 250 MG TABLET	1	
FAMCICLOVIR 500 MG TABLET	1	
FAMVIR 125 MG TABLET	3	
FAMVIR 250 MG TABLET	3	
FAMVIR 500 MG TABLET	3	
HEPSERA 10 MG TABLET	3	
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
REBETOL 200 MG CAPSULE	3	SPP*: Must use CVS Specialty
REBETOL 40 MG/ML SOLUTION	2	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	
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
TYZEKA 600 MG TABLET	3	
VALACYCLOVIR HCL 1 GRAM TABLET	1	
VALACYCLOVIR HCL 500 MG TABLET	1	
VALCYTE 450 MG TABLET	3	
VALCYTE 50 MG/ML SOLUTION	3	
VALGANCICLOVIR 450 MG TABLET	1	
VALGANCICLOVIR HCL 50 MG/ML	1	
VALTREX 1 GM CAPLET	3	
VALTREX 500 MG CAPLET	3	
VEMLIDY 25 MG TABLET	3	
VIRAZOLE 6 GM VIAL	3	
ZOVIRAX 200 MG CAPSULE	3	
ZOVIRAX 200 MG/5 ML SUSP	3	
ZOVIRAX 400 MG TABLET	3	
ZOVIRAX 800 MG TABLET	3	

BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ANTICOAGULANTS		
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
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*
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*
ELIQUIS 2.5 MG TABLET	2	HSA*
ELIQUIS 5 MG TABLET	2	HSA*
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
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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
HEPARIN SOD 10,000 UNIT/ML VL	1	
HEPARIN SOD 20,000 UNIT/ML VL	1	
HEPARIN SOD 5,000 UNIT/ML VIAL	1	
IPRIVASK 15 MG VIAL	3	HSA*; SPP*: CVS Specialty
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*
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
PRADAXA 110 MG CAPSULE	3	HSA*
PRADAXA 150 MG CAPSULE	3	HSA*
PRADAXA 75 MG CAPSULE	3	HSA*
SAVAYSA 15 MG TABLET	3	HSA*
SAVAYSA 30 MG TABLET	3	HSA*
SAVAYSA 60 MG TABLET	3	HSA*
SODIUM CITRATE 4% SOLN	1	
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
WARFARIN SODIUM 5 MG TABLET	1	HSA*
WARFARIN SODIUM 6 MG TABLET	1	HSA*
WARFARIN SODIUM 7.5 MG TABLET	1	HSA*
XARELTO 10 MG TABLET	2	HSA*
XARELTO 15 MG TABLET	2	HSA*
XARELTO 20 MG TABLET	2	HSA*
XARELTO STARTER PACK	2	HSA*

BLOOD FORMATION MODIFIERS

ARANESP 10 MCG/0.4 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.6 per fill SPP*: CVS Specialty
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
CINRYZE 500 UNIT VIAL	MD	Prior Authorization required;Max. 2 per 3 days SPP*: Must use CVS Specialty
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
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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
NEULASTA 6 MG/0.6 ML SYRINGE	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
NEUPOGEN 480 MCG/1.6 ML VIAL	2	Prior Authorization required SPP*: CVS Specialty
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
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
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

HEMATOLOGIC AGENTS, MISCELLANEOUS

ADVATE 2,401-3,600 UNIT VIAL	MD	SPP*: Must use CVS Specialty
ADYNOVATE 1,251-2,500 UNIT VL	MD	SPP*: Must use CVS Specialty
AFSTYLA 500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
AGRYLIN 0.5 MG CAPSULE	3	HSA*
ALPHANATE 2,000-800 UNIT VIAL	MD	SPP*: Must use CVS Specialty
ALPHANINE SD 1,500 UNITS VIAL	MD	SPP*: Must use CVS Specialty
ALPROLIX 3,000 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
AMICAR 0.25 GRAM/ML ORAL SOLN	2	
AMICAR 1,000 MG TABLET	2	
AMICAR 500 MG TABLET	2	
AMINOCAPROIC ACID 1,000 MG TAB	1	
AMINOCAPROIC ACID 25% SOLUTION	1	
AMINOCAPROIC ACID 500 MG TAB	1	
ANAGRELIDE HCL 0.5 MG CAPSULE	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ANAGRELIDE HCL 1 MG CAPSULE	1	HSA*
AVITENE FLOUR	3	
AVITENE SHEET 35MMX35MM	3	
AVITENE SHEET 70MMX35MM	3	
AVITENE SHEET 70MMX70MM	3	
BEBULIN 200-1,200 UNITS VIAL	MD	SPP*: Must use CVS Specialty
BENEFIX 2,000 UNIT RANGE	MD	SPP*: Must use CVS Specialty
CORIFACT KIT	MD	SPP*: Must use CVS Specialty
ELOCTATE 3,000 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
FEIBA NF 2,500 UNIT (NOMINAL)	MD	SPP*: Must use CVS Specialty
GELFOAM POWDER	3	
HELIXATE FS 2,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty; Kogenate Preferred
HEMLIBRA 105 MG/0.7 ML VIAL	MD	PA NTM*; SPP*: Must use CVS Specialty
HEMLIBRA 150 MG/ML VIAL	MD	PA NTM*; SPP*: Must use CVS Specialty
HEMLIBRA 30 MG/ML VIAL	MD	PA NTM*; SPP*: Must use CVS Specialty
HEMLIBRA 60 MG/0.4 ML VIAL	MD	PA NTM*; SPP*: Must use CVS Specialty
HEMOFIL M 1,700 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
HUMATE-P 2,400 UNIT VWF:RCO	MD	SPP*: Must use CVS Specialty
IDELVION 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
IXINITY 500 UNIT RANGE	MD	SPP*: Must use CVS Specialty
KOATE 250 UNIT VIAL	MD	SPP*: Must use CVS Specialty
KOGENATE FS 500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
KOVALTRY 3,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
LYSTEDA 650 MG TABLET	3	Max. 30 in 30 days
MONOCLATE-P 1,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
MONONINE 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
NOVOEIGHT 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
NOVOSEVEN RT 2 MG VIAL	MD	SPP*: Must use CVS Specialty
NUWIQ 250 UNIT VIAL PACK	MD	SPP*: Must use CVS Specialty
PROFILNINE 500 UNITS VIAL	MD	SPP*: Must use CVS Specialty
REBINYN 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
REBINYN 2,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
REBINYN 500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
RECOMBINATE 1,241-1,800 UNIT V	MD	SPP*: Must use CVS Specialty
RIASTAP VIAL	MD	SPP*: Must use CVS Specialty
RIXUBIS 250 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
THROMBIN-JMI 20,000 UNITS PUMP	1	
THROMBIN-JMI 5,000 UNITS VIAL	1	
TISSEEL VHSD 2 ML KIT	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRANEXAMIC ACID 650 MG TABLET	1	Max. 30 in 30 days
TRETTEN 2,500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
ULTRAFOAM 2X6.25X7CM SPONGE	3	
VONVENDI 1,300 UNIT VIAL	MD	SPP*: Must use CVS Specialty
WILATE 1,000-1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
XYNTHA 500 UNIT KIT	MD	SPP*: Must use CVS Specialty
XYNTHA SOLOFUSE 1,000 UNIT KIT	MD	SPP*: Must use CVS Specialty

PLATELET-AGGREGATION INHIBITORS

AGGRENOX 25 MG-200 MG CAPSULE	3	HSA*
ASPIRIN-DIPYRIDAM ER 25-200 MG	1	HSA*
BRILINTA 60 MG TABLET	2	HSA*
BRILINTA 90 MG TABLET	2	HSA*
CILOSTAZOL 100 MG TABLET	1	HSA*
CILOSTAZOL 50 MG TABLET	1	HSA*
CLOPIDOGREL 300 MG TABLET	1	HSA*
CLOPIDOGREL 75 MG TABLET	1	HSA*
DIPYRIDAMOLE 25 MG TABLET	1	HSA*
DIPYRIDAMOLE 50 MG TABLET	1	HSA*
DIPYRIDAMOLE 75 MG TABLET	1	HSA*
EFFIENT 10 MG TABLET	3	HSA*
EFFIENT 5 MG TABLET	3	HSA*
PENTOXIFYLLINE ER 400 MG TAB	1	HSA*
PERSANTINE 25 MG TABLET	3	HSA*
PERSANTINE 50 MG TABLET	3	HSA*
PERSANTINE 75 MG TABLET	3	HSA*
PLAVIX 300 MG TABLET	3	HSA*
PLAVIX 75 MG TABLET	3	HSA*
PLETAL 100 MG TABLET	3	HSA*
PLETAL 50 MG TABLET	3	HSA*
PRASUGREL 10 MG TABLET	2	HSA*
PRASUGREL 5 MG TABLET	2	HSA*
TICLOPIDINE 250 MG TABLET	1	HSA*
ZONTIVITY 2.08 MG TABLET	3	HSA*

CARDIOVASCULAR AGENTS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALPHA-ADRENERGIC AGENTS		
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*
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*
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*
CLORPRES 0.1-15 TABLET	1	HSA*
CLORPRES 0.2-15 TABLET	1	HSA*
CLORPRES 0.3-15 TABLET	1	HSA*
DIBENZYLINE 10 MG CAPSULE	3	HSA*
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*
GUANFACINE 1 MG TABLET	1	HSA*
GUANFACINE 2 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*
MIDODRINE HCL 10 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MIDODRINE HCL 2.5 MG TABLET	1	HSA*
MIDODRINE HCL 5 MG TABLET	1	HSA*
MINIPRESS 1 MG CAPSULE	3	HSA*
MINIPRESS 2 MG CAPSULE	3	HSA*
MINIPRESS 5 MG CAPSULE	3	HSA*
NORTHERA 100 MG CAPSULE	3	SPP*: Must use CVS Specialty
NORTHERA 200 MG CAPSULE	3	SPP*: Must use CVS Specialty
NORTHERA 300 MG CAPSULE	3	SPP*: Must use CVS Specialty
PHENOXYBENZAMINE HCL 10 MG CAP	1	HSA*
PHENTOLAMINE 5 MG VIAL	1	
PHENTOLAMINE 5 MG/ML VIAL	1	
PRAZOSIN 1 MG CAPSULE	1	HSA*
PRAZOSIN 2 MG CAPSULE	1	HSA*
PRAZOSIN 5 MG CAPSULE	1	HSA*
TENEX 1 MG TABLET	3	HSA*
TENEX 2 MG TABLET	3	HSA*

ANGIOTENSIN II RECEPTOR ANTAGONISTS

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*
AVALIDE 150-12.5 MG TABLET	3	HSA*
AVALIDE 300-12.5 MG TABLET	3	HSA*
AVAPRO 150 MG TABLET	3	HSA*
AVAPRO 300 MG TABLET	3	HSA*
AVAPRO 75 MG TABLET	3	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
COZAAR 100 MG TABLET	3	HSA*
COZAAR 25 MG TABLET	3	HSA*
COZAAR 50 MG TABLET	3	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*
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*
ENTRESTO 24 MG-26 MG TABLET	2	Prior Authorization required;Max. 2 per day HSA*
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*
EPROSARTAN MESYLATE 600 MG TAB	1	HSA*
HYZAAR 100-12.5 TABLET	3	HSA*
HYZAAR 100-25 TABLET	3	HSA*
HYZAAR 50-12.5 TABLET	3	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
MICARDIS 20 MG TABLET	3	HSA*
MICARDIS 40 MG TABLET	3	HSA*
MICARDIS 80 MG TABLET	3	HSA*
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*
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*
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*
TELMISARTAN-HCTZ 80-25 MG TAB	1	HSA*
TEVETEN 600 MG TABLET	3	HSA*
TEVETEN HCT 600-12.5 MG TAB	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TEVETEN HCT 600-25 MG TAB	3	HSA*
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*
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*
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*

ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

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*
ACEON 4 MG TABLET	3	HSA*
ACEON 8 MG TABLET	3	HSA*
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*
BENAZEPRIL HCL 10 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*
ENALAPRIL MALEATE 10 MG TAB	1	HSA*
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*
EPANED 1 MG/ML ORAL SOLUTION	3	HSA*
FOSINOPRIL SODIUM 10 MG TAB	1	HSA*
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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LISINOPRIL-HCTZ 20-25 MG TAB	1	HSA*
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*
MAVIK 1 MG TABLET	3	HSA*
MAVIK 2 MG TABLET	3	HSA*
MAVIK 4 MG TABLET	3	HSA*
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*
PERINDOPRIL ERBUMINE 2 MG TAB	1	HSA*
PERINDOPRIL ERBUMINE 4 MG TAB	1	HSA*
PERINDOPRIL ERBUMINE 8 MG TAB	1	HSA*
PRINIVIL 10 MG TABLET	3	HSA*
PRINIVIL 20 MG TABLET	3	HSA*
PRINIVIL 5 MG TABLET	3	HSA*
QBRELIS 1MG/ML SOLUTION	3	HSA*
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*
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*
TARKA ER 1-240 MG TABLET	3	HSA*
TARKA ER 2-180 MG TABLET	3	HSA*
TARKA ER 2-240 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TARKA ER 4-240 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*
UNIRETIC 15-12.5 TABLET	3	HSA*
UNIRETIC 7.5-12.5 MG TABLET	3	HSA*
UNIVASC 15 MG TABLET	3	HSA*
UNIVASC 7.5 MG TABLET	3	HSA*
VASERETIC 10-25 MG TABLET	3	HSA*
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*
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*

ANTIARRHYTHMIC AGENTS

AMIODARONE HCL 100 MG TABLET	1	
AMIODARONE HCL 200 MG TABLET	1	
AMIODARONE HCL 400 MG TABLET	1	
CORDARONE 200 MG TABLET	3	
DISOPYRAMIDE 100 MG CAPSULE	1	
DISOPYRAMIDE 150 MG CAPSULE	1	
DOFETILIDE 125 MCG CAPSULE	2	
DOFETILIDE 250 MCG CAPSULE	2	
DOFETILIDE 500 MCG CAPSULE	2	
FLECAINIDE ACETATE 100 MG TAB	1	
FLECAINIDE ACETATE 150 MG TAB	1	
FLECAINIDE ACETATE 50 MG TAB	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MEXILETINE 150 MG CAPSULE	1	
MEXILETINE 200 MG CAPSULE	1	
MEXILETINE 250 MG CAPSULE	1	
MULTAQ 400 MG TABLET	2	
NORPACE 100 MG CAPSULE	3	
NORPACE 150 MG CAPSULE	3	
NORPACE CR 100 MG CAPSULE	3	
NORPACE CR 150 MG CAPSULE	3	
PACERONE 100 MG TABLET	1	
PACERONE 200 MG TABLET	1	
PACERONE 400 MG TABLET	1	
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	
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	
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	
TIKOSYN 125 MCG CAPSULE	3	
TIKOSYN 250 MCG CAPSULE	3	
TIKOSYN 500 MCG CAPSULE	3	

BETA-ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL 200 MG CAPSULE	1	HSA*
ACEBUTOLOL 400 MG CAPSULE	1	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*
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*
BETAXOLOL 10 MG TABLET	1	HSA*
BETAXOLOL 20 MG TABLET	1	HSA*
BISOPROLOL FUMARATE 10 MG TAB	1	HSA*
BISOPROLOL FUMARATE 5 MG TAB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BISOPROLOL-HCTZ 10-6.25 MG TAB	1	HSA*
BISOPROLOL-HCTZ 2.5-6.25 MG TB	1	HSA*
BISOPROLOL-HCTZ 5-6.25 MG TAB	1	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*
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*
CARVEDILOL ER 10 MG CAPSULE	2	HSA*
CARVEDILOL ER 20 MG CAPSULE	2	HSA*
CARVEDILOL ER 40 MG CAPSULE	2	HSA*
CARVEDILOL ER 80 MG CAPSULE	2	HSA*
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	3	HSA*
COREG CR 20 MG CAPSULE	3	HSA*
COREG CR 40 MG CAPSULE	3	HSA*
COREG CR 80 MG CAPSULE	3	HSA*
CORGARD 20 MG TABLET	3	HSA*
CORGARD 40 MG TABLET	3	HSA*
CORGARD 80 MG TABLET	3	HSA*
CORZIDE 40-5 TABLET	3	HSA*
CORZIDE 80-5 TABLET	3	HSA*
DUTOPROL 100-12.5 MG TABLET	3	HSA*
DUTOPROL 25-12.5 MG TABLET	3	HSA*
DUTOPROL 50-12.5 MG TABLET	3	HSA*
HEMANGEOL 4.28 MG/ML ORAL SOLN	3	HSA*
INDERAL LA 160 MG CAPSULE	3	HSA*
INDERAL LA 60 MG CAPSULE	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
INDERAL LA 80 MG CAPSULE	3	HSA*
INDERAL XL 120 MG CAPSULE	3	HSA*
INNOPRAN XL 120 MG CAPSULE	2	HSA*
INNOPRAN XL 80 MG CAPSULE	2	HSA*
LABETALOL HCL 100 MG TABLET	1	HSA*
LABETALOL HCL 200 MG TABLET	1	HSA*
LABETALOL HCL 300 MG TABLET	1	HSA*
LEVATOL 20 MG TABLET	3	HSA*
LOPRESSOR 100 MG TABLET	3	HSA*
LOPRESSOR 50 MG TABLET	3	HSA*
LOPRESSOR HCT 50-25 TABLET	3	HSA*
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*
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*
PINDOLOL 10 MG TABLET	1	HSA*
PINDOLOL 5 MG TABLET	1	HSA*
PROPRANOLOL 10 MG TABLET	1	HSA*
PROPRANOLOL 20 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*
SECTRAL 200 MG CAPSULE	3	HSA*
SECTRAL 400 MG CAPSULE	3	HSA*
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*
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*
TIMOLOL MALEATE 10 MG TABLET	1	HSA*
TIMOLOL MALEATE 20 MG TABLET	1	HSA*
TIMOLOL MALEATE 5 MG TABLET	1	HSA*
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*
TRANDATE 100 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRANDATE 200 MG TABLET	3	HSA*
TRANDATE 300 MG TABLET	3	HSA*
ZEBETA 10 MG TABLET	3	HSA*
ZEBETA 5 MG TABLET	3	HSA*
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*

CALCIUM-CHANNEL BLOCKING AGENTS

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*
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*
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*
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*
DILACOR XR 240 MG CAPSULE	3	HSA*
DILT XR 120 MG CAPSULE	1	HSA*
DILT XR 180 MG CAPSULE	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*
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*
TAZTIA XT 120 MG CAPSULE	1	HSA*
TAZTIA XT 180 MG CAPSULE	1	HSA*
TAZTIA XT 240 MG CAPSULE	1	HSA*
TAZTIA XT 300 MG CAPSULE	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TAZTIA XT 360 MG CAPSULE	1	HSA*
TIAZAC ER 120 MG CAPSULE	3	HSA*
TIAZAC ER 180 MG CAPSULE	3	HSA*
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*
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*
VERELAN 120 MG CAP PELLET	3	HSA*
VERELAN 180 MG CAP PELLET	3	HSA*
VERELAN 240 MG CAP PELLET	3	HSA*
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*

CARDIOVASCULAR AGENTS, MISCELLANEOUS

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
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
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DEMSER 250 MG CAPSULE	3	HSA*
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*
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
FIRAZYR 30 MG/3 ML SYRINGE	3	SPP*: Must use CVS Specialty
HYDRALAZINE 10 MG TABLET	1	HSA*
HYDRALAZINE 100 MG TABLET	1	HSA*
HYDRALAZINE 25 MG TABLET	1	HSA*
HYDRALAZINE 50 MG TABLET	1	HSA*
ISOXSUPRINE 10 MG TABLET	1	
ISOXSUPRINE 20 MG TABLET	1	
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*
PAPAVERINE 150 MG CAPSULE SA	1	
RANEXA ER 1,000 MG TABLET	2	HSA*
RANEXA ER 500 MG TABLET	2	HSA*
RESERPINE 0.1 MG TABLET	1	HSA*
RESERPINE 0.25 MG TABLET	1	HSA*
VECAMYL 2.5 MG TABLET	3	
YOSPRALA DR 325-40 MG TABLET	3	Max. 1 per day HSA*
YOSPRALA DR 81-40 MG TABLET	3	Max. 1 per day HSA*

DIHYDROPYRIDINES

ADALAT CC 30 MG TABLET	3	HSA*
ADALAT CC 60 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ADALAT CC 90 MG TABLET	3	HSA*
AFEDITAB CR 30 MG TABLET	1	HSA*
AFEDITAB CR 60 MG TABLET	1	HSA*
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-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*
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*
CARDENE SR 30 MG CAPSULE	3	HSA*
CARDENE SR 60 MG CAPSULE	3	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*
FELODIPINE ER 10 MG TABLET	1	HSA*
FELODIPINE ER 2.5 MG TABLET	1	HSA*
FELODIPINE ER 5 MG TABLET	1	HSA*
ISRADIPINE 2.5 MG CAPSULE	1	HSA*
ISRADIPINE 5 MG CAPSULE	1	HSA*
LOTREL 10-20 MG CAPSULE	3	HSA*
LOTREL 10-40 MG CAPSULE	3	HSA*
LOTREL 2.5-10 MG CAPSULE	3	HSA*
LOTREL 5-10 MG CAPSULE	3	HSA*
LOTREL 5-20 MG CAPSULE	3	HSA*
LOTREL 5-40 MG CAPSULE	3	HSA*
NICARDIPINE 20 MG CAPSULE	1	HSA*
NICARDIPINE 30 MG CAPSULE	1	HSA*
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*
NIMODIPINE 30 MG CAPSULE	1	HSA*
NISOLDIPINE ER 17 MG TABLET	1	HSA*
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*
NORVASC 10 MG TABLET	3	HSA*
NORVASC 2.5 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NORVASC 5 MG TABLET	3	HSA*
NYMALIZE 60 MG/20 ML SOLUTION	3	HSA*
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*
SULAR ER 17 MG TABLET	3	HSA*
SULAR ER 34 MG TABLET	3	HSA*
SULAR ER 8.5 MG TABLET	3	HSA*

DIURETICS

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*
AMILORIDE HCL 5 MG TABLET	1	HSA*
AMILORIDE HCL-HCTZ 5-50 MG TAB	1	HSA*
BUMETANIDE 0.5 MG TABLET	1	HSA*
BUMETANIDE 1 MG TABLET	1	HSA*
BUMETANIDE 2 MG TABLET	1	HSA*
CHLOROTHIAZIDE 250 MG TABLET	1	HSA*
CHLOROTHIAZIDE 500 MG TABLET	1	HSA*
CHLORTHALIDONE 25 MG TABLET	1	HSA*
CHLORTHALIDONE 50 MG TABLET	1	HSA*
DEMADEX 10 MG TABLET	3	HSA*
DEMADEX 100 MG TABLET	3	HSA*
DEMADEX 20 MG TABLET	3	HSA*
DEMADEX 5 MG TABLET	3	HSA*
DIURIL 250 MG/5 ML ORAL SUSP	3	HSA*
DYAZIDE 37.5-25 CAPSULE	3	HSA*
DYRENIUM 100 MG CAPSULE	3	HSA*
DYRENIUM 50 MG CAPSULE	3	HSA*
EDECRIN 25 MG TABLET	3	HSA*
ETHACRYNIC ACID 25 MG TABLET	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*
INDAPAMIDE 1.25 MG TABLET	1	HSA*
INDAPAMIDE 2.5 MG TABLET	1	HSA*
LASIX 20 MG TABLET	3	HSA*
LASIX 40 MG TABLET	3	HSA*
LASIX 80 MG TABLET	3	HSA*
MAXZIDE 37.5 MG-25 MG TABLET	3	HSA*
MAXZIDE 75 MG-50 MG TABLET	3	HSA*
METHYCLOTHIAZIDE 5 MG TABLET	1	HSA*
METOLAZONE 10 MG TABLET	1	HSA*
METOLAZONE 2.5 MG TABLET	1	HSA*
METOLAZONE 5 MG TABLET	1	HSA*
MICROZIDE 12.5 MG CAPSULE	3	HSA*
SAMSCA 15 MG TABLET	3	
SAMSCA 30 MG TABLET	3	
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*
TORSEMIDE 10 MG TABLET	1	HSA*
TORSEMIDE 100 MG TABLET	1	HSA*
TORSEMIDE 20 MG TABLET	1	HSA*
TORSEMIDE 5 MG TABLET	1	HSA*
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*
ZAROXOLYN 2.5 MG TABLET	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZAROXOLYN 5 MG TABLET	3	HSA*

DYSLIPIDEMICS

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*
ADVICOR 750 MG-20 MG TABLET	2	HSA*
ALTOPREV 20 MG TABLET	2	HSA*
ALTOPREV 40 MG TABLET	2	HSA*
ALTOPREV 60 MG TABLET	2	HSA*
AMLODIPINE-ATORVAST 10-10 MG	1	HSA*
AMLODIPINE-ATORVAST 10-20 MG	1	HSA*
AMLODIPINE-ATORVAST 10-40 MG	1	HSA*
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*
ANTARA 130 MG CAPSULE	3	HSA*
ANTARA 30 MG CAPSULE	3	HSA*
ANTARA 43 MG CAPSULE	3	HSA*
ANTARA 90 MG CAPSULE	3	HSA*
ATORVASTATIN 10 MG TABLET	$0	ACA*
ATORVASTATIN 20 MG TABLET	$0	ACA*
ATORVASTATIN 40 MG TABLET	1	HSA*
ATORVASTATIN 80 MG TABLET	1	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
CADUET 5 MG-80 MG TABLET	3	HSA*
CHOLESTYRAMINE LIGHT PACKET	1	HSA*
CHOLESTYRAMINE PACKET	1	HSA*
COLESTID 1 GM TABLET	3	HSA*
COLESTID FLAVORED GRANULES	3	HSA*
COLESTIPOL HCL GRANULES PACKET	1	HSA*
COLESTIPOL MICRONIZED 1 GM TAB	1	HSA*
CRESTOR 10 MG TABLET	3	HSA*
CRESTOR 20 MG TABLET	3	HSA*
CRESTOR 40 MG TABLET	3	HSA*
CRESTOR 5 MG TABLET	3	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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
FIBRICOR 105 MG TABLET	3	HSA*
FIBRICOR 35 MG TABLET	3	HSA*
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*
FLUVASTATIN ER 80 MG TABLET	1	HSA*
FLUVASTATIN SODIUM 20 MG CAP	1	HSA*
FLUVASTATIN SODIUM 40 MG CAP	1	HSA*
GEMFIBROZIL 600 MG TABLET	1	HSA*
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
KYNAMRO 200 MG/ML SYRINGE	3	SPP*: Must use CVS Specialty
LESCOL 20 MG CAPSULE	3	HSA*
LESCOL 40 MG CAPSULE	3	HSA*
LESCOL XL 80 MG TABLET	3	HSA*
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*
LIVALO 1 MG TABLET	3	HSA*
LIVALO 2 MG TABLET	3	HSA*
LIVALO 4 MG TABLET	3	HSA*
LOFIBRA 134 MG CAPSULE	3	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LOFIBRA 160 MG TABLET	3	HSA*
LOFIBRA 200 MG CAPSULE	3	HSA*
LOFIBRA 54 MG TABLET	3	HSA*
LOFIBRA 67 MG CAPSULE	3	HSA*
LOPID 600 MG TABLET	3	HSA*
LOVASTATIN 10 MG TABLET	$0	ACA*
LOVASTATIN 20 MG TABLET	$0	ACA*
LOVASTATIN 40 MG TABLET	$0	ACA*
LOVAZA 1 GM CAPSULE	3	HSA*
MEVACOR 20 MG TABLET	3	HSA*
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*
OMEGA-3 ETHYL ESTERS 1 GM CAP	1	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
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*
PRAVASTATIN SODIUM 40 MG TAB	1	HSA*
PRAVASTATIN SODIUM 80 MG TAB	1	HSA*
PREVALITE PACKET	1	HSA*
QUESTRAN LIGHT POWDER	3	HSA*
QUESTRAN PACKET	3	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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*
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*
TRICOR 145 MG TABLET	3	HSA*
TRICOR 48 MG TABLET	3	HSA*
TRIGLIDE 160 MG TABLET	2	HSA*
TRILIPIX DR 135 MG CAPSULE	3	HSA*
TRILIPIX DR 45 MG CAPSULE	3	HSA*
VASCEPA 0.5 GM CAPSULE	2	HSA*
VASCEPA 1 GM CAPSULE	2	HSA*
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*
WELCHOL 3.75G PACKET	2	HSA*
WELCHOL 625 MG TABLET	2	HSA*
ZETIA 10 MG TABLET	3	Max. 1 per day HSA*
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*

RENIN-ANGIOTENSIN-ALDOSTERONE SYSTEM INHIBITORS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
CAROSPIR 25 MG/5 ML SUSPENSION	3	Prior Authorization required HSA*; PA NTM*
EPLERENONE 25 MG TABLET	1	HSA*
EPLERENONE 50 MG TABLET	1	HSA*
INSPRA 25 MG TABLET	3	HSA*
INSPRA 50 MG TABLET	3	HSA*
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*

VASODILATORS

AMYL NITRITE AMPUL	1	
BIDIL TABLET	2	
DILATRATE-SR 40 MG CAPSULE	2	
GONITRO 0.4 MG SUBLINGUAL PWD	3	HSA*
IMDUR ER 120 MG TABLET	3	
IMDUR ER 30 MG TABLET	3	
IMDUR ER 60 MG TABLET	3	
ISOCHRON 40 MG TABLET SA	3	
ISORDIL 40 MG TABLET	2	
ISORDIL TITRADOSE 5 MG TAB	3	
ISOSORBIDE DN 10 MG TABLET	1	
ISOSORBIDE DN 20 MG TABLET	1	
ISOSORBIDE DN 30 MG TABLET	1	
ISOSORBIDE DN 5 MG TABLET	1	
ISOSORBIDE DN ER 40 MG TABLET	1	
ISOSORBIDE MN 10 MG TABLET	1	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
MINOXIDIL 10 MG TABLET	1	HSA*
MINOXIDIL 2.5 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*
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*
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*
PROGLYCEM 50 MG/ML ORAL SUSP	3	HSA*

CENTRAL NERVOUS SYSTEM AGENTS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CENTRAL NERVOUS SYSTEM AGENTS		
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
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
AMPYRA ER 10 MG TABLET	3	Max. 2 per day SPP*: Must use CVS Specialty
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
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	
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
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*
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
BETASERON 0.3 MG KIT	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
CAFCIT 20 MG/ML ORAL SOLN	3	
CAFFEINE CIT 60 MG/3 ML ORAL	1	
CLONIDINE HCL ER 0.1 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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
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*
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
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
DESOXYN 5 MG TABLET	3	Max. 60 Days Supply
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
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
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
DYANAVEL XR 2.5 MG/ML SUSP	3	Max. 60 Days Supply
EVEKEO 10 MG TABLET	3	Max. 60 Days Supply
EVEKEO 5 MG TABLET	3	Max. 60 Days Supply
EXTAVIA 0.3 MG KIT	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
FOCALIN 10 MG TABLET	3	Max. 60 Days Supply
FOCALIN 2.5 MG TABLET	3	Max. 60 Days Supply

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
GILENYA 0.5 MG CAPSULE	2	Max. 1 per day SPP*: Must use CVS Specialty
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
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	
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*
INTUNIV ER 1 MG TABLET	3	
INTUNIV ER 2 MG TABLET	3	
INTUNIV ER 3 MG TABLET	3	
INTUNIV ER 4 MG TABLET	3	
KAPVAY ER 0.1 MG TABLET	3	
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	
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
METHAMPHETAMINE 5 MG TABLET	1	Max. 60 Days Supply
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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*
NUEDEXTA 20-10 MG CAPSULE	2	
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
PROCENTRA 5 MG/5 ML SOLUTION	3	Max. 60 Days Supply
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
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
RILUTEK 50 MG TABLET	3	
RILUZOLE 50 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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SAVELLA 50 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA TITRATION PACK	2	Step Therapy required STA*: 18 and older
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	
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
TETRABENAZINE 12.5 MG TABLET	1	SPP*: Must use CVS Specialty
TETRABENAZINE 25 MG TABLET	1	SPP*: Must use CVS Specialty
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
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
XENAZINE 12.5 MG TABLET	3	SPP*: Must use CVS Specialty
XENAZINE 25 MG TABLET	3	SPP*: Must use CVS Specialty
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
ZINBRYTA 150 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) in 30 days SPP*: Must use CVS Specialty

CONTRACEPTIVES

CONTRACEPTIVES

AFTERA 1.5 MG TABLET	$0	Max. quantity of 1 per fill ACA*
ALTAVERA-28 TABLET	$0	ACA*
ALYACEN 1-35-28 TABLET	$0	ACA*
ALYACEN 7-7-7-28 TABLET	$0	ACA*
AMETHIA 0.15-0.03-0.01 MG TAB	$0	Max. 91 Days Supply;Max. 1 per day ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AMETHIA LO TABLET	$0	Max. 91 Days Supply;Max. 1 per day ACA*
AMETHYST 90-20 MCG TABLET	3	
APRI 28 DAY TABLET	$0	ACA*
ARANELLE 28 TABLET	$0	ACA*
ASHLYNA 0.15-0.03-0.01 MG TAB	$0	Max. 91 Days Supply;Max. 1 per day ACA*
AUBRA-28 TABLET	$0	ACA*
AVIANE-28 TABLET	$0	ACA*
AZURETTE 28 DAY TABLET	$0	ACA*
BALZIVA 28 TABLET	$0	ACA*
BEKYREE 28 DAY TABLET	$0	ACA*
BEYAZ 28 TABLET	3	
BLISOVI 24 FE TABLET	$0	ACA*
BLISOVI FE 1-20 TABLET	$0	ACA*
BLISOVI FE 1.5-30 TABLET	$0	ACA*
BREVICON 28 TABLET	$0	ACA*
BRIELLYN TABLET	$0	ACA*
CAMILA 0.35 MG TABLET	$0	ACA*
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*
CAYA CONTOURED DIAPHRAGM	$0	ACA*
CAZIANT 28 DAY TABLET	$0	ACA*
CHATEAL-28 TABLET	$0	ACA*
CONCEPTROL GEL	$0	ACA*
CRYSELLE-28 TABLET	$0	ACA*
CYCLAFEM 1-35-28 TABLET	$0	ACA*
CYCLAFEM 7-7-7-28 TABLET	$0	ACA*
CYCLESSA 28 DAY TABLET	3	
CYRED 28 DAY TABLET	$0	ACA*
DASETTA 1-35-28 TABLET	$0	ACA*
DASETTA 7/7/7-28 TABLET	$0	ACA*
DAYSEE 0.15-0.03-0.01 MG TAB	$0	Max. 91 Days Supply;Max. 1 per day ACA*
DEBLITANE 0.35 MG TABLET	$0	ACA*
DELYLA-28 TABLET	$0	ACA*
DEMULEN 1-50-21 TABLET	3	
DESOGEN 28 DAY TABLET	3	
DESOGEST-ETH ESTRA 0.15-0.03MG	$0	ACA*
DESOGESTR-ETH ESTRAD ETH ESTRA	$0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
ECONTRA EZ 1.5 MG TABLET	$0	Max. quantity of 1 per fill ACA*
ELINEST-28 TABLET	$0	ACA*
ELLA 30 MG TABLET	$0	Max. quantity of 1 per fill ACA*
EMOQUETTE 28 DAY TABLET	$0	ACA*
ENPRESSE-28 TABLET	$0	ACA*
ENSKYCE 28 TABLET	$0	ACA*
ERRIN 0.35 MG TABLET	$0	ACA*
ESTARYLLA 0.25-0.035 MG TABLET	$0	ACA*
ESTROSTEP FE-28 TABLET	3	
ETHYNODIOL-ETH ESTRA 1MG-35MCG	$0	ACA*
ETHYNODIOL-ETH ESTRA 1MG-50MCG	$0	ACA*
FALLBACK SOLO 1.5 MG TABLET	$0	Max. quantity of 1 per fill ACA*
FALMINA-28 TABLET	$0	ACA*
FAYOSIM TABLET	$0	Max. 91 Days Supply;Max. 1 per day ACA*
FC2 FEMALE CONDOM	$0	ACA*
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	
FEMYNOR 28 TABLET	$0	ACA*
GENERESS FE CHEWABLE TABLET	3	
GIANVI 3 MG-0.02 MG TABLET	$0	ACA*
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*
GILDESS FE 1-20 TABLET	$0	ACA*
GILDESS FE 1.5-30 TABLET	$0	ACA*
GYNOL II 3% GEL	$0	ACA*
HEATHER TABLET	$0	ACA*
INTROVALE 0.15-0.03 MG TABLET	$0	Max. 91 Days Supply;Max. 1 per day ACA*
ISIBLOOM 28 DAY TABLET	$0	ACA*
JENCYCLA 0.35 MG TABLET	$0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
JOLESSA 0.15 MG-0.03 MG TABLET	$0	Max. 91 Days Supply;Max. 1 per day ACA*
JOLIVETTE TABLET	$0	ACA*
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*
KAITLIB FE CHEWABLE TABLET	$0	ACA*
KARIVA 28 DAY TABLET	$0	ACA*
KELNOR 1-35 28 TABLET	$0	ACA*
KIMIDESS 28 DAY TABLET	$0	ACA*
KURVELO TABLET	$0	ACA*
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*
LAYOLIS FE CHEWABLE TABLET	$0	ACA*
LEENA 28 TABLET	$0	ACA*
LESSINA-28 TABLET	$0	ACA*
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*
LEVONORG 0.15MG-EE 20-25-30MCG	$0	Max. 91 Days Supply;Max. 1 per day 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*
LILLOW-28 TABLET	$0	ACA*
LO LOESTRIN FE 1-10 TABLET	$0	ACA*
LOESTRIN 21 1-20 TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LOESTRIN 21 1.5-30 TABLET	3	
LOESTRIN FE 1-20 TABLET	3	
LOESTRIN FE 1.5-30 TABLET	3	
LOMEDIA 24 FE 1 MG-20 MCG TAB	$0	ACA*
LORYNA 3 MG-0.02 MG TABLET	$0	ACA*
LOSEASONIQUE TABLET	3	Max. 91 Days Supply;Max. 1 per day
LOW-OGESTREL-28 TABLET	$0	ACA*
LUTERA-28 TABLET	$0	ACA*
LYZA 0.35 MG TABLET	$0	ACA*
MARLISSA-28 TABLET	$0	ACA*
MELODETTA 24 FE CHEWABLE TAB	$0	ACA*
MIBELAS 24 FE CHEWABLE TABLET	$0	ACA*
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*
MINASTRIN 24 FE CHEWABLE TAB	3	
MIRCETTE 28 DAY TABLET	3	
MODICON 28 TABLET	3	
MONO-LINYAH 28 TABLET	$0	ACA*
MONONESSA 28 TABLET	$0	ACA*
MY WAY 1.5 MG TABLET	$0	Max. quantity of 1 per fill ACA*
MYZILRA-28 TABLET	$0	ACA*
NATAZIA 28 TABLET	$0	ACA*
NECON 0.5-35-28 TABLET	$0	ACA*
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*
NEXPLANON 68 MG IMPLANT	$0	SPP*: Must use CVS Specialty
NEXT CHOICE ONE DOSE 1.5 MG TB	$0	Max. quantity of 1 per fill ACA*
NIKKI 3 MG-0.02 MG TABLET	$0	ACA*
NOR-Q-D TABLET	3	
NORA-BE TABLET	$0	ACA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NORETHIN-ESTRA-FE 0.8-0.025 MG	$0	ACA*
NORETHIND-ETH ESTRAD 1-0.02 MG	$0	ACA*
NORETHINDRONE 0.35 MG TABLET	$0	ACA*
NORG-EE 0.18-0.215-0.25/0.025	$0	ACA*
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*
NORLYDA 0.35 MG TABLET	$0	ACA*
NORLYROC 0.35 MG TABLET	$0	ACA*
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*
NUVARING VAGINAL RING	$0	ACA*
OCELLA 3 MG-0.03 MG TABLET	$0	ACA*
OGESTREL TABLET	$0	ACA*
OPCICON ONE-STEP 1.5 MG TABLET	$0	Max. quantity of 1 per fill ACA*
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 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	
OVCON-35 28 TABLET	3	
PHILITH 0.4-0.035 MG TABLET	$0	ACA*
PIMTREA 28 DAY TABLET	$0	ACA*
PIRMELLA 1-35-28 TABLET	$0	ACA*
PIRMELLA 7-7-7-28 TABLET	$0	ACA*
PLAN B ONE-STEP 1.5 MG TABLET	$0	Max. quantity of 1 per fill ACA*
PORTIA-28 TABLET	$0	ACA*
PREVIFEM TABLET	$0	ACA*
QUARTETTE TABLET	3	Max. 91 Days Supply;Max. 1 per day

DRUG NAME	TIER	LIMITATIONS/ * NOTES
QUASENSE 0.15-0.03 MG TABLET	$0	Max. 91 Days Supply;Max. 1 per day ACA*
RAJANI 28 TABLET	$0	ACA*
RECLIPSEN 28 DAY TABLET	$0	ACA*
RIVELSA TABLET	$0	Max. 91 Days Supply;Max. 1 per day ACA*
SAFYRAL TABLET	$0	ACA*
SEASONIQUE 0.15-0.03-0.01 TAB	3	Max. 91 Days Supply;Max. 1 per day
SETLAKIN 0.15 MG-0.03 MG TAB	$0	Max. 91 Days Supply;Max. 1 per day ACA*
SHAROBEL 0.35 MG TABLET	$0	ACA*
SPRINTEC 28 DAY TABLET	$0	ACA*
SRONYX 0.10-0.02 MG TABLET	$0	ACA*
SYEDA 28 TABLET	$0	ACA*
TAKE ACTION 1.5 MG TABLET	$0	Max. quantity of 1 per fill ACA*
TARINA FE 1-20 TABLET	$0	ACA*
TAYTULLA 1 MG-20 MCG CAPSULE	$0	ACA*
TILIA FE 28 TABLET	$0	ACA*
TODAY CONTRACEPTIVE SPONGE	$0	ACA*
TRI FEMYNOR 28 TABLET	$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*
TRINESSA LO TABLET	$0	ACA*
TRINESSA TABLET	$0	ACA*
TRIVORA-28 TABLET	$0	ACA*
VCF CONTRACEPTIVE FILM	$0	ACA*
VCF CONTRACEPTIVE FOAM	$0	ACA*
VCF CONTRACEPTIVE GEL	$0	ACA*
VELIVET 28 DAY TABLET	$0	ACA*
VESTURA 3 MG-0.02 MG TABLET	$0	ACA*
VIENVA-28 TABLET	$0	ACA*
VIORELE 28 DAY TABLET	$0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VYFEMLA 28 TABLET	$0	ACA*
WERA 0.5/0.035 MG 28 TABLET	$0	ACA*
WIDE SEAL DIAPHRAGM 70MM	$0	ACA*
WYMZYA FE CHEWABLE TABLET	$0	ACA*
XULANE PATCH	$0	ACA*
YASMIN 28 TABLET	3	
YAZ 28 TABLET	3	
ZARAH TABLET	$0	ACA*
ZENCHENT 0.4 MG-35 MCG TABLET	$0	ACA*
ZENCHENT FE TABLET CHEWABLE	$0	ACA*
ZEOSA CHEWABLE TABLET	$0	ACA*
ZOVIA 1-35E TABLET	$0	ACA*
ZOVIA 1-50E TABLET	$0	ACA*

COUGH AND COLD PRODUCTS

COUGH AND COLD PRODUCTS

AMBITUSSIN AC LIQUID	1
BENZONATATE 100 MG CAPSULE	1
BENZONATATE 150 MG CAPSULE	1
BENZONATATE 200 MG CAPSULE	1
BROMFED DM COUGH SYRUP	1
BROMPHENIR-PSEUDOEPHED-DM SYR	1
CHERATUSSIN AC SYRUP	1
CHERATUSSIN DAC SYRUP	1
CODEINE-GUAIFEN 10-100 MG/5 ML	1
COTABFLU TABLET	3
FLOWTUSS 2.5-200 MG/5 ML SOLN	3
G TUSSIN AC LIQUID	1
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
HYCOFENIX 2.5-30-200 MG/5 ML	3
HYDROCOD-CPM-PSEUDOEP 5-4-60/5	1
HYDROCODONE-CHLORPHEN ER SUSP	1
HYDROCODONE-HOMATROPINE 5-1.5	1
HYDROCODONE-HOMATROPINE SYRUP	1
HYDROMET SYRUP	1
IOPHEN-C NR LIQUID	1
LORTUSS EX LIQUID	1
MAXIFLU CD TABLET	3
MAXIFLU CDX TABLET	3
OBREDON 2.5-200 MG/5 ML SOLN	3
PHENFLU CD TABLET	3
PHENFLU CDX TABLET	3
PHENYLHISTINE DH LIQUID	1
POLY-TUSSIN AC LIQUID	3

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PROMETHAZINE VC-CODEINE SYRUP	1	
PROMETHAZINE-CODEINE SYRUP	1	
PROMETHAZINE-DM SYRUP	1	
REZIRA SOLUTION	3	
TESSALON PERLE 100 MG CAP	3	
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	
TUZISTRA XR 14.7-2.8 MG/5 ML	3	
VIRTUSSIN AC LIQUID	1	
VITUZ SOLUTION	3	
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	
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	
ZONATUSS 150 MG CAPSULE	3	
ZUTRIPRO SOLUTION	3	

DENTAL AND ORAL AGENTS

DENTAL AND ORAL AGENTS

CAPHOSOL SOLUTION	3	
CEVIMELINE HCL 30 MG CAPSULE	1	
CHLORHEXIDINE 0.12% RINSE	1	
CLINPRO 5000 1.1% TOOTHPASTE	3	
DENTA 5000 PLUS CREAM	1	
DENTAGEL 1.1% GEL	1	
EVOXAC 30 MG CAPSULE	3	
FIRST-MOUTHWASH BLM SUSPENSION	3	
FLUORIDEX DAILY DEFENSE	3	
FLUORIDEX SENSITIVITY RLF GEL	1	
GELX ORAL GEL	3	
NEUTRAL SODIUM FLUORIDE	1	ACA*: Children through age 5; HSA
NEUTRASAL 538 MG POWDER PACKET	3	
ORALONE 0.1% PASTE	1	
PAROEX 0.12% ORAL RINSE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PERIDEX 0.12% ORAL RINSE	3	
PERIOGARD 0.12% ORAL RINSE	1	
PILOCARPINE HCL 5 MG TABLET	1	
PILOCARPINE HCL 7.5 MG TABLET	1	
PREVIDENT 0.2% RINSE	3	
PREVIDENT 5000 BOOSTER PLUS	3	
PREVIDENT 5000 SENSITIVE PASTE	3	
SALAGEN 5 MG TABLET	3	
SALAGEN 7.5 MG TABLET	3	
SALIVAMAX POWDER PACKET	3	
SF 5000 PLUS CREAM	1	
STANNOUS FLUOR 0.63% RINSE	1	
TRIAMCINOLONE 0.1% PASTE	1	

DERMATOLOGICAL AGENTS

DERMATOLOGICAL AGENTS, OTHER

8-MOP 10 MG CAPSULE	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	
ACITRETIN 10 MG CAPSULE	1	
ACITRETIN 17.5 MG CAPSULE	1	
ACITRETIN 25 MG CAPSULE	1	
ACYCLOVIR 5% OINTMENT	1	Max. 15 GM(s) in 30 days
ACZONE 5% GEL	3	
ACZONE 7.5% GEL PUMP	3	
ALDARA 5% CREAM	3	
ALEVICYN ANTIPRURITIC SG GEL	3	
ALUVEA 39% CREAM	3	
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	
ANACAINE OINTMENT	3	
ATOPICLAIR CREAM	3	
AVAR CLEANSER	3	
AVAR LS 10%-2% FOAM	3	
AVAR LS CLEANSER	3	
AVAR-E EMOLLIENT CREAM	3	
AVAR-E LS CREAM	3	
AZELEX 20% CREAM	2	
BENSAL HP 3% OINTMENT	3	
BENZAC AC 5% GEL	3	
BENZAC AC WASH 10% LIQUID	3	
BP CLEANSING WASH	1	
BPO 4% GEL	1	
BPO 8% GEL	1	
CALCIPOTRIENE 0.005% CREAM	1	
CALCIPOTRIENE 0.005% OINTMENT	1	
CALCIPOTRIENE 0.005% SOLUTION	1	
CALCIPOTRIENE-BETAMETH DP OINT	1	
CALCITRENE 0.005% OINTMENT	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CALCITRIOL 3 MCG/G OINTMENT	1	
CARAC 0.5% CREAM	3	
CELACYN GEL	3	
CERACADE SKIN BARRIER EMULSION	3	
CETACAINE ANESTHETIC LIQUID	3	
CETACAINE SPRAY	3	
CLARAVIS 10 MG CAPSULE	1	
CLARAVIS 20 MG CAPSULE	1	
CLARAVIS 30 MG CAPSULE	1	
CLARAVIS 40 MG CAPSULE	1	
CLARIS CLARIFYING WASH	3	
CONDYLOX 0.5% GEL	3	
CONDYLOX 0.5% TOPICAL SOLN	3	
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
DAPSONE 5% GEL	2	
DENAVIR 1% CREAM	3	Max. 5 GM(s) in 30 days
DICLOFENAC SODIUM 3% GEL	1	
DOVONEX 0.005% CREAM	3	
DOXEPIN 5% CREAM	1	
DRITHOCREME HP 1% CREAM	2	
DRYSOL DAB-O-MATIC SOLUTION	2	
DUPIXENT 300 MG/2 ML SAFE SYRG	3	Prior Authorization required;Max. 4 ML(s) per 28 days SPP*: Must use CVS Specialty
EFUDEX 5% CREAM	3	
ENSTILAR 0.005%-0.064% FOAM	3	Max. 2 GM(s) per day Max 60g/28 days supply
ETHYL CHLORIDE SPRAY	1	
EXODERM LOTION	1	
FINACEA 15% FOAM	2	
FINACEA 15% GEL	2	
FLUOROPLEX 1% CREAM	3	
FLUOROURACIL 0.5% CREAM	1	
FLUOROURACIL 2% TOPICAL SOLN	1	
FLUOROURACIL 5% CREAM	1	
FLUOROURACIL 5% TOPICAL SOLN	1	
FORMADON 10% SOLUTION	1	
GORDO-UREA 22% OINTMENT	3	
GORDO-UREA 40% OINTMENT	3	
GRANULEX SPRAY	1	
GUAIACOL LIQUID PURIFIED	3	
HYPERCARE 20% SOLUTION	1	
IMIQUIMOD 5% CREAM PACKET	1	
INOVA 4% EASY PAD	3	
INOVA 4-1 EASY PAD	3	
INOVA 8% EASY PAD	3	
INOVA 8-2 EASY PAD	3	
IODOFLEX PAD	3	
IODOSORB GEL	3	
IV INFUSION CPI KIT	3	
KERAFOAM 30% FOAM	3	
KERALYT 6% GEL	3	
KERALYT SCALP COMPLETE KIT	3	
LAC-HYDRIN 12% CREAM	3	
LAC-HYDRIN 12% LOTION	3	
LACTIC ACID 10% E CREAM	1	
LACTIC ACID 10% LOTION	1	
LATRIX 50% TOPICAL SUSPENSION	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LEVULAN KERASTICK	3	
LUGOL'S STRONG IODINE SOLUTION	1	
MAFENIDE ACETATE 50 GM POWD PK	1	
METHOXSALEN 10 MG CAPSULE	1	
MIRVASO 0.33% GEL PUMP	3	
MYORISAN 10 MG CAPSULE	1	
MYORISAN 20 MG CAPSULE	1	
MYORISAN 30 MG CAPSULE	1	
MYORISAN 40 MG CAPSULE	1	
NIVATOPIC PLUS CREAM	3	
NORMLGEL AG 0.11% WOUND GEL	3	
OVACE PLUS 10% SHAMPOO	3	
OVACE PLUS WASH 10% CLNSNG GEL	3	
OXALIS OINTMENT	3	
OXSORALEN 1% LOTION	2	
OXSORALEN-ULTRA 10 MG CAP	3	
PAIN EASE SPRAY	3	
PANRETIN 0.1% GEL	3	
PICATO 0.015% GEL	2	Max. 30 Days Supply
PICATO 0.05% GEL	2	Max. 30 Days Supply
PLEXION 9.8-4.8% CLEANSER	3	
PODOCON-25 LIQUID	1	
PODOFILOX 0.5% TOPICAL SOLN	1	
POTASSIUM HYDROXIDE 5% SOLN	1	
PR CREAM KIT	1	
PRUCLAIR NONSTEROIDAL CREAM	1	
PRUDOXIN 5% CREAM	3	
PYROGALLIC ACID 25% OINTMENT	3	
RADIAPLEXRX GEL	3	
REA LO 39 CREAM	3	
REA LO 40 CREAM	3	
REA LO 40 LOTION	3	
REGENECARE 2% WOUND GEL	3	
REGRANEX 0.01% GEL	3	Limit fills to 3 in 365 days;Max. 15 GM(s) in 30 days
REMEVEN 50% CREAM	1	
RESTIZAN GEL	3	
RHOFADE 1% CREAM	3	Prior Authorization required
ROSANIL CLEANSER LOTION	2	
ROSULA 10%-5% CLOTHS	3	
SALACYN 6% CREAM	3	
SALACYN 6% LOTION	1	
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	
SALICYLIC ACID 6% GEL	1	
SALICYLIC ACID 6% LOTION KIT	1	
SALICYLIC ACID 6% SHAMPOO	1	
SALIMEZ 6% CREAM	3	Prior Authorization required PA NTM*
SALIMEZ FORTE 10% CREAM	3	Prior Authorization required PA NTM*
SANTYL OINTMENT	2	
SEB-PREV 10% WASH	1	
SILIQ 210 MG/1.5 ML SYRINGE	3	Prior Authorization required SPP*: Must use CVS Specialty; PA NTM*
SILVRSTAT DRESSING GEL	3	
SOD SULFACE-SULF 9.8-4.8% CLSR	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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 SULFACETAMIDE 10% WASH	1	
SOLARAZE 3% GEL	3	
SORIATANE 10 MG CAPSULE	3	
SORIATANE 17.5 MG CAPSULE	3	
SORIATANE 25 MG CAPSULE	3	
SORILUX 0.005% FOAM	3	
SPRAY AND STRETCH SPRAY	3	
SULFACETAMIDE-SULFUR 10-2% CRM	1	
SULFACETAMIDE-SULFUR 10-5% CRM	1	
SULFAMYLON 8.5% CREAM	3	
SULFAMYLON POWDER PACKET	3	
TACLONEX 0.005%-0.064% SUSPENS	3	
TACLONEX OINTMENT	3	
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
TETRIX CREAM	3	
TOLAK 4% CREAM	3	
TREMFYA 100 MG/ML SYRINGE	3	Prior Authorization required PA NTM*; SPP*: Must use CVS Specialty
UMECTA 40% EMULSION	3	
UMECTA PD 40% EMULSION	3	
URE-K 50% CREAM	1	
UREA 39% CREAM	1	
UREA 40% CREAM	1	
UREA 40% GEL	1	
UREA 40% LOTION	1	
UREA 50% NAIL STICK	1	
VALCHLOR 0.016% GEL	3	Max. 60 GM(s) in 30 days LDD*: Dohmen Life Sciences 1-800-305-7881
VANOXIDE-HC LOTION	3	
VASOLEX OINTMENT	1	
VECTICAL 3 MCG/G OINTMENT	3	
VENELEX OINTMENT	3	
VEREGEN 15% OINTMENT	2	
VIRASAL ANTIVIRAL WART REMOVER	3	
X-VIATE 40% CREAM	1	
X-VIATE 40% GEL	3	
X-VIATE 40% LOTION	1	
XERESE 5%-1% CREAM	3	
ZENATANE 10 MG CAPSULE	1	
ZENATANE 20 MG CAPSULE	1	
ZENATANE 30 MG CAPSULE	1	
ZENATANE 40 MG CAPSULE	1	
ZONALON 5% CREAM	3	
ZOVIRAX 5% CREAM	3	Max. 5 GM(s) in 30 days
ZOVIRAX 5% OINTMENT	3	Max. 15 GM(s) in 30 days
ZYCLARA 2.5% CREAM PUMP	3	
ZYCLARA 3.75% CREAM PUMP	3	

DERMATOLOGICAL ANTI-INFLAMMATORY AGENTS

ALA-CORT 1% CREAM	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALA-CORT 2.5% CREAM	1	
ALA-SCALP 2% LOTION	1	
ALCLOMETASONE DIPR 0.05% OINT	1	
ALCLOMETASONE DIPRO 0.05% CRM	1	
AMCINONIDE 0.1% CREAM	1	
AMCINONIDE 0.1% LOTION	1	
AMCINONIDE 0.1% OINTMENT	1	
ANALPRAM HC 1% CREAM	3	
ANALPRAM HC 2.5%-1% CREAM	3	
ANALPRAM HC 2.5%-1% LOTION	2	
ANUCORT-HC 25 MG SUPPOSITORY	1	
ANUSOL-HC 2.5% CREAM	3	
ANUSOL-HC 25 MG SUPPOSITORY	3	
APEXICON E 0.05% CREAM	3	
AQUA GLYCOLIC HC 2% KIT	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	
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	
CAPEX SHAMPOO	2	
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	
CORDRAN 0.05% CREAM	3	
CORDRAN 0.05% LOTION	3	
CORDRAN 0.05% OINTMENT	3	
CORDRAN 4 MCG/SQ CM TAPE LARGE	3	
CORMAX 0.05% SOLUTION	1	
CORTIFOAM 10% AEROSOL	3	
CUTIVATE 0.05% CREAM	3	
CUTIVATE 0.05% LOTION	3	
DERMA-SMOOTHE-FS SCALP OIL	3	
DERMASORB HC 2% COMPLETE KIT	3	
DERMASORB TA 0.1% COMPLETE KIT	3	
DERMATOP 0.1% OINTMENT	3	
DERMATOP EMOLLIENT 0.1% CREAM	3	
DERMAZENE CREAM	1	
DESONATE 0.05% GEL	3	
DESONIDE 0.05% CREAM	1	
DESONIDE 0.05% LOTION	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
DIFLORASONE 0.05% CREAM	1	
DIFLORASONE 0.05% OINTMENT	1	
DIPROLENE 0.05% LOTION	3	
DIPROLENE 0.05% OINTMENT	3	
DIPROLENE AF 0.05% CREAM	3	
ELIDEL 1% CREAM	2	Prior Authorization required
ELOCON 0.1% CREAM	3	
ELOCON 0.1% LOTION	3	
ELOCON 0.1% OINTMENT	3	
EPIFOAM FOAM	3	
EUCRISA 2% OINTMENT	3	Prior Authorization required
FIRST HYDROCORT 10% GEL	3	
FLUOCINOLONE 0.01% BODY OIL	1	
FLUOCINOLONE 0.01% CREAM	1	
FLUOCINOLONE 0.01% SOLUTION	1	
FLUOCINOLONE 0.025% CREAM	1	
FLUOCINOLONE 0.025% OINTMENT	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	
FLURANDRENOLIDE 0.05% CREAM	1	
FLURANDRENOLIDE 0.05% LOTION	1	
FLURANDRENOLIDE 0.05% OINTMENT	2	
FLUTICASONE PROP 0.005% OINT	1	
FLUTICASONE PROP 0.05% CREAM	1	
FLUTICASONE PROP 0.05% LOTION	1	
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	
HEMMOREX-HC 25 MG SUPPOSITORY	3	
HEMMOREX-HC 30 MG SUPPOSITORY	3	
HEMRIL-30 30 MG SUPPOSITORY	1	
HYDROCORT-PRAMOXINE 1%-1% CRM	1	
HYDROCORT-PRAMOXINE 2.5-1% CRM	1	
HYDROCORTISONE 1% CREAM	1	
HYDROCORTISONE 1% OINTMENT	1	
HYDROCORTISONE 2.5% CREAM	1	
HYDROCORTISONE 2.5% LOTION	1	
HYDROCORTISONE 2.5% OINTMENT	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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
HYDROCORTISONE VAL 0.2% CREAM	1	
HYDROCORTISONE VAL 0.2% OINTMT	1	
HYDROCORTISONE-IODOQUINOL CRM	1	
HYDROCORTISONE-PRAMOXINE CREAM	1	
KENALOG 0.147 MG/GRAM SPRAY	3	
LOCOID 0.1% CREAM	3	
LOCOID 0.1% LOTION	3	
LOCOID 0.1% OINTMENT	3	
LOCOID 0.1% SOLUTION	3	
LUXIQ 0.12% FOAM	3	
MEZPAROX-HC 2.5%-1% CREAM	3	Prior Authorization required PA NTM*
MICORT HC 2.5% CREAM	3	
MOMETASONE FUROATE 0.1% CREAM	1	
MOMETASONE FUROATE 0.1% OINT	1	
MOMETASONE FUROATE 0.1% SOLN	1	
MOMEXIN COMBO PACK	3	
NOLIX 0.05% LOTION	3	
OLUX-E 0.05% FOAM	3	
PANDEL 0.1% CREAM	3	
PEDIADERM TA 0.1% KIT	3	
PRAMCORT 1% CREAM	3	
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	
PREDNICARBATE 0.1% CREAM	1	
PREDNICARBATE 0.1% OINTMENT	1	
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	
PROTOPIC 0.03% OINTMENT	3	Prior Authorization required
PROTOPIC 0.1% OINTMENT	3	Prior Authorization required
PSORCON 0.05% CREAM	3	
RECTACORT-HC 25 MG SUPPOSITORY	3	
SCALACORT 2% LOTION	3	
SERNIVO 0.05% SPRAY	3	Max. 4 ML(s) per day
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	
TACROLIMUS 0.03% OINTMENT	1	Prior Authorization required
TACROLIMUS 0.1% OINTMENT	1	Prior Authorization required
TEMOVATE 0.05% CREAM	3	
TEMOVATE 0.05% OINTMENT	3	
TEXACORT 2.5% SOLUTION	3	
TOPICORT 0.05% CREAM	3	
TOPICORT 0.05% GEL	3	
TOPICORT 0.05% OINTMENT	3	
TOPICORT 0.25% CREAM	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TOPICORT 0.25% OINTMENT	3	
TOPICORT 0.25% SPRAY	3	
TRIAMCINOLONE 0.025% CREAM	1	
TRIAMCINOLONE 0.025% LOTION	1	
TRIAMCINOLONE 0.025% OINT	1	
TRIAMCINOLONE 0.1% CREAM	1	
TRIAMCINOLONE 0.1% LOTION	1	
TRIAMCINOLONE 0.1% OINTMENT	1	
TRIAMCINOLONE 0.147 MG/G SPRAY	1	
TRIAMCINOLONE 0.5% CREAM	1	
TRIAMCINOLONE 0.5% OINTMENT	1	
TRIANEX 0.05% OINTMENT	1	
TRIDERM 0.1% CREAM	1	
TRIDERM 0.5% CREAM	1	
TRIDESILON 0.05% CREAM	1	
U-CORT 1% CREAM	1	
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	
VANOS 0.1% CREAM	3	
VERDESO 0.05% FOAM	3	
WESTCORT 0.2% OINTMENT	3	

DERMATOLOGICAL ANTIBACTERIALS

ACANYA GEL PUMP	2	
AKNE-MYCIN 2% OINTMENT	2	
AKTIPAK 3%-5% GEL POUCH	3	Prior Authorization required
ALTABAX 1% OINTMENT	3	
BACTROBAN 2% CREAM	3	
BACTROBAN 2% OINTMENT	3	
BACTROBAN NASAL 2% OINTMENT	3	
BENOXYLDOXY 30 KIT	3	
BENOXYLDOXY 60 KIT	3	
BENZACLIN GEL 50G PUMP	3	
BENZAMYCIN GEL	3	
CENTANY 2% OINTMENT	3	
CENTANY AT 2% OINTMENT KIT	3	
CLEOCIN T 1% GEL	3	
CLEOCIN T 1% LOTION	3	
CLEOCIN T 1% PLEDGETS	3	
CLEOCIN T 1% SOLUTION	3	
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 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	
CORTISPORIN CREAM	3	
CORTISPORIN OINTMENT	3	
DUAC 1.2-5% GEL	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ERY 2% PADS	1	
ERYGEL 2% GEL	3	
ERYTHROMYCIN 2% GEL	1	
ERYTHROMYCIN 2% PLEDGETS	1	
ERYTHROMYCIN 2% SOLUTION	1	
ERYTHROMYCIN-BENZOYL GEL	1	
EVOCLIN 1% FOAM	3	
GENTAMICIN 0.1% CREAM	1	
GENTAMICIN 0.1% OINTMENT	1	
KLARON 10% LOTION	3	
METROCREAM 0.75% CREAM	3	
METROGEL TOPICAL 1% GEL	3	
METROLOTION TOPICAL 0.75%	3	
METRONIDAZOLE 0.75% CREAM	1	
METRONIDAZOLE 0.75% LOTION	1	
METRONIDAZOLE TOPICAL 0.75% GL	1	
METRONIDAZOLE TOPICAL 1% GEL	1	
MUPIROCIN 2% CREAM	1	
MUPIROCIN 2% OINTMENT	1	
NEO-SYNALAR 0.5%-0.025% CREAM	3	
NEO-SYNALAR 0.5-0.025% CRM KIT	3	
NEUAC 1.2-5% KIT	3	
NEUAC GEL	1	
NORITATE 1% CREAM	2	
ONEXTON GEL PUMP	3	
ROSADAN 0.75% CREAM	1	
ROSADAN 0.75% CREAM KIT	3	
ROSADAN 0.75% GEL	3	
SELENIUM SULFIDE 2.25% SHAMPOO	1	
SELENIUM SULFIDE 2.5% LOTION	1	
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	
SSD 1% CREAM	1	
SULFACETAMIDE SOD 10% TOP SUSP	1	
TERSI 2.25% FOAM	3	
THERMAZENE 1% CREAM	3	
VELTIN 1.2%-0.025% GEL	3	Prior Authorization required for members 30 and older
ZIANA GEL	3	Prior Authorization required for members 30 and older

DERMATOLOGICAL RETINOIDS

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
ADAPALENE-BNZYL PEROX 0.1-2.5%	2	Prior Authorization required for members 30 and older
ATRALIN 0.05% GEL	3	Prior Authorization required for members 30 and older
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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DIFFERIN 0.3% GEL PUMP	3	Prior Authorization required for members 30 and older
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
FABIOR 0.1% FOAM	3	Prior Authorization required for members 30 and older
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 0.06% GEL	3	Prior Authorization required for members 31 and older
RETIN-A MICRO PUMP 0.08% GEL	3	Prior Authorization required for members 30 and older
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
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 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

SCABICIDES AND PEDICULICIDES

ELIMITE 5% CREAM	3	
EURAX 10% CREAM	3	
EURAX 10% LOTION	3	
LINDANE 1% LOTION	1	
LINDANE 1% SHAMPOO	1	
MALATHION 0.5% LOTION	1	
NATROBA 0.9% TOPICAL SUSP	3	
OVIDE 0.5% LOTION	3	
PERMETHRIN 5% CREAM	1	
SKLICE 0.5% LOTION	3	
SOOLANTRA 1% CREAM	3	
SPINOSAD 0.9% TOPICAL SUSP	1	

DEVICES

DEVICES

1ST CHOICE THIN LANCETS	2	HSA*
1ST TIER COMFORTOUCH 28G LANCT	2	HSA*
1ST TIER COMFORTOUCH 30G LANCT	2	HSA*
ACCU-CHEK ACTIVE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*
ACCUTREND GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACE AEROSOL CLOUD ENHANCER	MD	
ACTI-LANCE LITE 28G LANCETS	2	HSA*
ACTI-LANCE SPECIAL 17G LANCETS	2	HSA*
ACTI-LANCE UNIVERS 23G LANCETS	2	HSA*
ACUICYN EYELID-EYELASH CLEANSR	3	
ACURA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ADVANCED TRAVEL 28G LANCETS	2	HSA*
ADVANCED TRAVEL 30G LANCETS	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*
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	
AEROTRACH HOLDING CHAMBER	MD	
AEROVENT PLUS HOLDING CHAMBER	MD	
AGAMATRIX AMP TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
AIRZONE PEAK FLOW METER	MD	
ALLERGIST PACK 26GX1/2" 1 ML	3	
ALLERGIST PACK 26GX3/8" 1 ML	3	
ALLERGIST PACK 27GX1/2" 1 ML	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALLERGY SYRINGE 1 ML 27GX1/2"	3	
ALLERGY SYRINGE 1 ML 27GX3/8"	3	
ALTERNATE SITE 26G LANCETS	2	HSA*
ASEPTO BULB SYRINGES GLASS	3	
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*
ASTHMA CHECK PEAK FLOW MTR	MD	
ASTHMAMENTOR PEAK FLOW MTR	MD	
ASTHMAPACK CHILDREN'S CARE KIT	MD	
AURORA SUPER THIN 30G LANCETS	2	HSA*
AURSTAT ANTI-ITCH HYDROGEL KIT	3	
AVENOVA LID-LASH SPRAY	3	
AVO CREAM TOPICAL EMULSION	1	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
BG-STAR GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
BIAFINE EMULSION	3	
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*
BREATHERITE MDI SPACER	MD	
BREATHRITE VALVED MDI CHAMBER	MD	
BREEZE 2 DISC TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
BULLSEYE MINI SAFETY 21G	2	HSA*
BULLSEYE MINI SAFETY 25G LANCT	2	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*
CERAMAX SKIN BARRIER CREAM	3	
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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
COAGUCHEK LANCETS	2	HSA*
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*
COMPACT SPACE CHAMBER	MD	
COMPACT SPACE CHAMBER PLUS	MD	
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*
COOL GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CORNWALL SYRINGES LUER-LOK	3	
CORNWALL SYRINGES LUER-LOK	3	
CORNWALL SYRINGES LUER-LOK	3	
CVS ADVANCED GLUCOSE TEST STR	3	Prior Authorization required;Max. 204 per 30 days HSA*
CVS THIN 26G LANCETS	2	HSA*
CVS ULTRA THIN 30G LANCETS	2	HSA*
DARIO BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
DIATRUE PLUS TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
DOVER BULB SYRINGE 60 ML	3	
DROPLET 30G LANCETS	2	HSA*
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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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*
ELETONE CREAM	3	
ELETONE CREAM TWIN PACK	3	
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*
EMULSION SB TOPICAL EMULSION	1	
EPICERAM SKIN BARRIER EMULSION	3	
EPISIL LIQUID	2	
EQ BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
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*
EVOLUTION TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
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*
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*
FINE 30 UNIVERSAL 30G LANCETS	2	HSA*
FINGERSTIX LANCETS	2	HSA*
FLEXICHAMBER	MD	
FLEXICHAMBER-LG CHILD MASK	MD	
FLEXICHAMBER-SM ADULT MASK	MD	
FLEXICHAMBER-SM CHILD MASK	MD	
FLOW-EZE VENTED NEEDLE	3	
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*
FORA D15G GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
FORTISCARE GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
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*
G-4 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
GE100 BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GELCLAIR ORAL GEL PACKET	2	
GENSTRIP GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GENULTIMATE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days 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*
GLUCOCOM 33G LANCETS	2	HSA*
GLUCOCOM GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GLUCOSOURCE LANCETS	2	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*
HEALTHPRO GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
HEALTHY ACCENTS UNILET 30G	2	HSA*
HPR EMOLLIENT FOAM	3	
HPR PLUS CREAM	3	
HPR PLUS EMOLLIENT FOAM	3	
HPR PLUS HYDROGEL KIT	1	
HPR PLUS-MB HYDROGEL KIT	1	
HYLATOPIC EMOLLIENT FOAM	3	
HYLATOPICPLUS CREAM	3	
HYLATOPICPLUS EMOLLIENT FOAM	3	
HYLATOPICPLUS LOTION	3	
HYPO NEEDLE,POLYPROPYL HUB	3	
HYPODERMIC NEEDLE,ALUM HUB	3	
IGLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
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*
INFINITY TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
INJECT EASE 28G LANCETS	2	HSA*
INJECT EASE 30G LANCETS	2	HSA*
INSPIRACHAMBER	MD	
INSPIRACHAMBER WITH MASK-MED	MD	
INVACARE 30G LANCETS	2	HSA*
IRRIGATION SYRINGE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
KINNEY BRAND 23G LANCETS	2	HSA*
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*
LANCETS 33G	2	HSA*
LANCETS THIN 23G	2	HSA*
LANCETS ULTRA THIN 26G	2	HSA*
LIBERTY TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LITE TOUCH 30G LANCETS	2	HSA*
LITE TOUCH 33G LANCETS	2	HSA*
LITEAIRE MDI CHAMBER	MD	
LITETOUCH MEDIUM MASK	MD	
LONGS THIN LANCETS 26G	2	HSA*
LUER LOCK SYRINGE 30 ML	3	
LUER SLIP TIP SYR TRAY 1 ML	3	
LUER-LOCK SYRINGE 60 ML	3	
LUXAMEND WOUND CREAM	3	
MAGELLAN SAFETY 1 ML 23GX1"	3	
MAGELLAN TUBERCULIN SYR 1 ML	3	
MAXIMA TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
MB HYDROGEL KIT	1	
MEDI-LANCE LANCETS	2	HSA*
MEDLANCE PLUS 21G LANCETS	2	HSA*
MEDLANCE PLUS 30G LANCETS	2	HSA*
MEDLANCE PLUS LITE 25G LANCETS	2	HSA*
MEDLANCE PLUS SPECIAL BLADE	2	HSA*
MICRO THIN 33G LANCETS	2	HSA*
MICROCHAMBER	MD	
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*
MICROLET LANCETS	2	HSA*
MICROLIFE PEAK FLOW METER	MD	
MICROSPACER FOR AEROSOL DEVICE	MD	
MINI WRIGHT PEAK FLOW METER	MD	
MINIMED INFUSION SET	MD	
MINIMED RESERVOIR 3 ML	MD	
MISTASSIST IFCD	MD	
MONAGHAN Z STAT CHAMBER-MD MSK	MD	
MONOJECT 1 ML SYRN 28GX1/2"	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
MONOJECT TUBERCULIN SYR 1 ML	3	
MONOLET 21G LANCETS	2	HSA*
MONOLET THIN 28G LANCETS	2	HSA*
MUGARD ORAL WOUND RINSE	2	
MYGLUCOHEALTH 30G LANCETS	2	HSA*
MYGLUCOHEALTH TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
NEOSALUS CP CREAM	3	
NEOSALUS CREAM	3	
NEOSALUS FOAM	3	
NEOSALUS LOTION	3	
NESSI SPACER	MD	
NEUTEK 2TEK TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
NEUTRASAL POWDER PACKET	3	
NORM-JECT 1 ML SYRINGE	3	
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
NUVAIL NAIL 16% SOLUTION	3	
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*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ONETOUCH ULTRASOFT LANCETS	2	HSA*
ONETOUCH VERIO TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
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*
OPTUMRX TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ORTHO ALL-FLEX FITTING SET	$0	ACA*
PANDA MASK SMALL	MD	
PARADIGM INFUSION 24" SET	MD	
PARADIGM INSULIN PUMP	MD	
PARADIGM RESERVOIR 1.8 ML	MD	
PARADIGM RESERVOIR 3 ML	MD	
PEAK-AIR PEAK FLOW METER	MD	
PEDIATRIC MOUTHPIECE	MD	
PEDIATRIC PANDA MASK	MD	
PEDIATRIC SMALL MASK	MD	
PERSONAL BEST PEAK FLOW MTR	MD	
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*
PIKO 1 FLOW METER	MD	
POCKET CHAMBER	MD	
POCKET PEAK FLOW METER	MD	
POLYFIN QR INFUSION SET	MD	
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*
PREMIUM V10 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRESERA FOAM	3	
PRESSURE ACTIVATED 21G LANCETS	2	HSA*
PRESSURE ACTIVATED 28G LANCETS	2	HSA*
PRIMEAIRE CHAMBER	MD	
PRO COMFORT 30G LANCETS	2	HSA*
PRO COMFORT 31G LANCET	2	HSA*
PROCHAMBER HOLDING CHAMBER	MD	
PRODIGY NO CODING TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRODIGY PRESSURE ACTIVATED 28G	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PRODIGY SAFETY 26G LANCETS	2	HSA*
PRODIGY TWIST TOP 28G LANCET	2	HSA*
PROMISEB COMPLETE KIT	3	
PROMISEB TOPICAL CREAM	3	
PRUMYX CREAM	1	
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*
QUICK RELEASE TEFLN CANNULA	MD	
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*
RA E-ZJECT 26G LANCETS	2	HSA*
RA E-ZJECT 28G LANCETS	2	HSA*
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*
REFUAH PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
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*
RENEW ADVANCED MICRO-LANCETS	2	HSA*
REVEAL TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
RITEFLO SPACER	MD	
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	
SB LANCETS THIN 28G	2	HSA*
SB LANCETS ULTRA THIN 30G	2	HSA*
SIDESTREAM PEDIATRIC FACE MASK	MD	
SILHOUETTE INFUSION SET 43"	MD	
SILICONE MASK-INFANT	MD	
SILICONE MASK-PEDIATRIC	MD	
SINGLE-LET LANCETS	2	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SMARTEST TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SOF-SET MICRO INFUSION SET	MD	
SOF-SET ULTIMATE QR SET	MD	
SOFT TOUCH LANCETS	2	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*
SONAFINE TOPICAL EMULSION	1	
SPACE CHAMBER PLUS	MD	
STERILANCE TL TWIST 30G LANCET	2	HSA*
STERILANCE TL TWIST 32G LANCET	2	HSA*
SUPER THIN 28G LANCETS	2	HSA*
SUPER THIN 33G LANCETS	2	HSA*
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-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*
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	
TD GOLD TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TECHLITE 28G LANCETS	2	HSA*
TECHLITE 30G LANCETS	2	HSA*
TELCARE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TELCARE ULTRA THIN 30G LANCETS	2	HSA*
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	
TEST N'GO GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TETRIX CREAM KIT	3	
THIN LANCETS 28G	2	HSA*
THRESHOLD IMT TRAINER	MD	
THRESHOLD PEP DEVICE	MD	
TOOMEY SYRINGE 70 ML	3	
TOPCARE UNIVERSAL1 33G LANCETS	2	HSA*
TOPCARE UNIVERSAL1 THIN LANCET	2	HSA*
TROPAZONE LOTION	3	
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 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*
TRUZONE PEAK FLOW METER	MD	
TUBERCULIN 1 ML SYRINGE	3	
TUBERCULIN SYRINGE	3	
TUBERCULIN SYRINGES	3	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ULTICARE TB SAFETY 1ML 27GX5/8	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*
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*
ULTRALANCE 26G LANCETS	2	HSA*
ULTRALANCE 28G LANCETS	2	HSA*
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*
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*
UNISTIK 3 COMFORT LANCET	2	HSA*
UNISTIK 3 EXTRA 21G LANCETS	2	HSA*
UNISTIK 3 GENTLE ON-THE-GO 30G	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
UNIVERSAL 1 33G LANCETS	2	HSA*
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	
VGO 40 DISPOSABLE DEVICE	2	Max. 1 per day HSA*
VICTORY GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
VOCAL POINT TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
VORTEX ADULT MASK	MD	
VORTEX FROG CHILD MASK	MD	
VORTEX HOLDING CHAMBER	MD	
VORTEX LADYBUG TODDLER MASK	MD	
VORTEX VHC FROG CHILD MASK	MD	
WALGREENS ULTRA THIN LANCETS	2	HSA*
WATCHHALER SPACER	MD	
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*
WINDMILL TRAINER	MD	
YALE GLASS TB SYR 0.25 ML	3	
YALE GLASS TB SYRINGE 1 ML	3	
YALE GLASS TB SYRINGE 2 ML	3	
YALE NEEDLES 21GX1"	3	
YALE NEEDLES 21GX1.25"	3	
YALE NEEDLES 21GX1.5"	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	

ENZYME REPLACEMENT/MODIFIERS

ENZYME REPLACEMENT/MODIFIERS

CHENODAL 250 MG TABLET	3	LDD*: Dohmen Life Sciences (800) 305-7881
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	
CYSTAGON 150 MG CAPSULE	3	
CYSTAGON 50 MG CAPSULE	3	
KRYSTEXXA 8 MG/ML VIAL	MD	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
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
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
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.
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	
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	
PULMOZYME 1 MG/ML AMPUL	2	SPP*: Must use CVS Specialty
STRENSIQ 18 MG/0.45 ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
SUCRAID 8,500 UNITS/ML SOLN	3	LDD*: Accredo (866) 815-4717
ULTRESA DR 13,800 UNIT CAPSULE	3	
ULTRESA DR 20,700 UNIT CAPSULE	3	
ULTRESA DR 23,000 UNIT CAPSULE	3	
VIOKACE 10,440-39,150 UNITS TB	3	
VIOKACE 20,880-78,300 UNITS TB	3	
XIAFLEX 0.9 MG VIAL	MD	
ZAVESCA 100 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
ZENPEP DR 10,000 UNIT CAPSULE	2	
ZENPEP DR 15,000 UNIT CAPSULE	2	
ZENPEP DR 20,000 UNIT CAPSULE	2	
ZENPEP DR 25,000 UNIT CAPSULE	2	
ZENPEP DR 3,000 UNIT CAPSULE	2	
ZENPEP DR 40,000 UNIT CAPSULE	2	
ZENPEP DR 5,000 UNIT CAPSULE	2	

EYE, EAR, NOSE, THROAT AGENTS

EYE, EAR, NOSE, THROAT AGENTS, MISCELLANEOUS

ADRENALIN 1 MG/ML NASAL SOLN	3	
ALCAINE 0.5% EYE DROPS	1	
ALOMIDE 0.1% EYE DROPS	3	
ALTACAINE 0.5% EYE DROPS	1	
APRACLONIDINE HCL 0.5% DROPS	1	
ASTELIN 137 MCG NASAL SPRAY	3	
ASTEPRO 0.15% NASAL SPRAY	3	
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	
AZELASTINE 0.1% (137 MCG) SPRY	1	
AZELASTINE 0.15% NASAL SPRAY	1	
AZELASTINE HCL 0.05% DROPS	1	
BEPREVE 1.5% EYE DROPS	3	
CARTEOLOL HCL 1% EYE DROPS	1	
CROMOLYN 4% EYE DROPS	1	HSA*
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	
CYSTARAN 0.44% EYE DROPS	3	LDD*: Walgreens Specialty.CYSTARAN Hotline: 1-877-534-9627.
DYMISTA NASAL SPRAY	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ELESTAT 0.05% EYE DROPS	3	
EMADINE 0.05% EYE DROPS	3	
EPINASTINE HCL 0.05% EYE DROPS	1	
EYLEA 2 MG/0.05 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
FLUCAINE EYE DROPS	1	
GELFILM OPHTHALMIC 25X50MM	3	
HOMATROPAIRE 5% EYE DROPS	1	
HOMATROPINE 5% EYE DROPS	1	
IOPIDINE 0.5% EYE DROPS	3	
IOPIDINE 1% EYE DROPS	3	
IPRATROPIUM 0.03% SPRAY	1	
IPRATROPIUM 0.06% SPRAY	1	
ISOPTO ATROPINE 1% EYE DROPS	3	
ISOPTO HOMATROPINE 5% DROPS	3	
ISOPTO HYOSCINE 0.25% DROPS	3	
LACRISERT 5 MG EYE INSERT	2	
LASTACAFT 0.25% EYE DROPS	3	
MYDFRIN 2.5% EYE DROPS	3	
MYDRIACYL 1% EYE DROPS	3	
NAPHAZOLINE 0.1% EYE DROPS	1	
OLOPATADINE 665 MCG NASAL SPRY	1	
OLOPATADINE HCL 0.1% EYE DROPS	1	
OLOPATADINE HCL 0.2% EYE DROP	1	
OPTIVAR 0.05% DROPS	3	
OTICIN DROPS	1	
OTOVEL 0.3%-0.025% EAR DROPS	3	Max. quantity of 2 per fill
OZURDEX 0.7 MG IMPLANT	MD	SPP*: Must use CVS Specialty
PAREMYD EYE DROPS	3	
PATADAY 0.2% EYE DROPS	3	
PATANASE 665 MCG NASAL SPRAY	3	
PATANOL 0.1% EYE DROPS	3	
PAZEO 0.7% EYE DROPS	3	
PHENYLEPHRINE 10% EYE DROPS	1	
PHENYLEPHRINE 2.5% EYE DROP	1	
PRED 1%-GATI 0.5%-NEPAF 0.1%	2	
PREDNISOLONE 1%-GATIFLOX 0.5%	2	
PROPARACAINE 0.5% EYE DROPS	1	
TETCAINE 0.5% EYE DROPS	1	
TETRACAINE 0.5% EYE DROPS	1	
TETRAVISC 0.5% EYE DROPS	3	
TROPICAMIDE 0.5% EYE DROPS	1	
TROPICAMIDE 1% EYE DROPS	1	
TYZINE 0.1% NOSE DROPS	3	
TYZINE 0.1% NOSE SPRAY	3	

EYE, EAR, NOSE, THROAT ANTI-INFECTIVES AGENTS

ACETASOL HC EAR DROPS	1	
ACETIC ACID 2% EAR SOLUTION	1	
ANTIPYRINE-BENZOCAINE EAR DROP	3	
ANTIPYRINE-BENZOCAINE OTIC SOL	1	
AURODEX OTIC SOLUTION	1	
AUROGUARD OTIC SOLUTION	3	
AZASITE 1% EYE DROPS	3	
BACITRACIN 500 UNIT/GM OPHTH	1	
BACITRACIN-POLYMYXIN EYE OINT	1	
BESIVANCE 0.6% SUSP	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BETADINE 5% EYE SOLUTION	3	
BLEPH-10 10% EYE DROPS	1	
BLEPHAMIDE EYE DROPS	2	
BLEPHAMIDE EYE OINTMENT	2	
CETRAXAL 0.2% EAR SOLUTION	3	
CILOXAN 0.3% EYE DROPS	3	
CILOXAN 0.3% OINTMENT	2	
CIPRO HC OTIC SUSPENSION	3	
CIPRODEX OTIC SUSPENSION	2	
CIPROFLOXACIN 0.2% OTIC SOLN	1	
CIPROFLOXACIN 0.3% EYE DROP	1	
COLY-MYCIN S OTIC SUSP DROP	3	
CORTISPORIN-TC EAR SUSPENSION	3	
CRESYLATE EAR DROPS	1	
ERYTHROMYCIN 0.5% EYE OINTMENT	1	
FLOXIN 0.3% EAR DROPS	3	
GARAMYCIN 0.3% EYE DROPS	3	
GARAMYCIN 3 MG/GM EYE OINTMENT	3	
GATIFLOXACIN 0.5% EYE DROPS	1	
GENTAK 0.3 % EYE OINTMENT	1	
GENTAMICIN 3 MG/GM EYE OINT	1	
GENTAMICIN 3 MG/ML EYE DROPS	1	
HYDROCORTISON-ACETIC ACID SOLN	1	
ILOTYCIN 0.5% EYE OINTMENT	3	
LEVOFLOXACIN 0.5% EYE DROPS	1	
MAXITROL EYE DROPS	3	
MAXITROL EYE OINTMENT	3	
MOXEZA 0.5% EYE DROPS	3	
MOXIFLOXACIN 0.5% EYE DROPS	2	
NATACYN EYE DROPS	2	
NEO-BACIT-POLY-HC EYE OINTMENT	1	
NEO-POLYCIN EYE OINTMENT	1	
NEO-POLYCIN HC EYE OINTMENT	1	
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-POLY-HC EYE DROPS	1	
NEOMYCIN-POLYMYXIN-HC EAR SOLN	1	
NEOMYCIN-POLYMYXIN-HC EAR SUSP	1	
NEOSPORIN EYE DROPS	3	
OCUFLOX 0.3% EYE DROPS	3	
OFLOXACIN 0.3% EAR DROPS	1	
OFLOXACIN 0.3% EYE DROPS	1	
OTIC CARE OTIC SOLUTION	3	
POLYCIN EYE OINTMENT	1	
POLYMYXIN B-TMP EYE DROPS	1	
POLYTRIM EYE DROPS	3	
PRED-G 1% EYE DROPS	3	
PRED-G S.O.P. EYE OINTMENT	3	
SULF-PRED 10-0.23% EYE DROPS	1	
SULFACETAMIDE 10% EYE DROPS	1	
SULFACETAMIDE 10% EYE OINTMENT	1	
TOBRADEX EYE DROPS	3	
TOBRADEX EYE OINTMENT	2	
TOBRADEX ST EYE DROPS	3	
TOBRAMYCIN 0.3% EYE DROPS	1	
TOBRAMYCIN-DEXAMETH OPHTH SUSP	1	
TOBREX 0.3% EYE DROPS	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TOBREX 0.3% EYE OINTMENT	2	
TRIFLURIDINE 1% EYE DROPS	1	
VIGAMOX 0.5% EYE DROPS	3	
VIROPTIC 1% EYE DROPS	3	
VOSOL HC EAR DROPS	3	
ZIRGAN 0.15% OPHTHALMIC GEL	3	
ZYLET EYE DROPS	2	
ZYMAXID 0.5% EYE DROPS	3	

EYE, EAR, NOSE, THROAT ANTI-INFLAMMATORY AGENTS

ACULAR 0.5% EYE DROPS	3	
ACULAR LS 0.4% OPHTH SOL	3	
ACUVAIL 0.45% OPHTH SOLUTION	3	Max. 1 per day
ALOCRIL 2% EYE DROPS	3	
ALREX 0.2% EYE DROPS	3	
BECONASE AQ 0.042% SPRAY	3	
BROMFENAC SODIUM 0.09% EYE DRP	1	
BROMSITE 0.075% EYE DROPS	3	
BUDESONIDE 32 MCG NASAL SPRAY	1	HSA*
CORTANE-B LOTION	3	
CORTANE-B OTIC DROPS	1	
DERMOTIC OIL 0.01% EAR DROPS	3	
DEXAMETHASONE 0.1% EYE DROP	1	
DICLOFENAC 0.1% EYE DROPS	1	
DUREZOL 0.05% EYE DROPS	3	
EXOTIC-HC EAR DROP	1	
FLAREX 0.1% EYE DROPS	3	
FLONASE 0.05% NASAL SPRAY	3	
FLUNISOLIDE 0.025% SPRAY	1	
FLUOCINOLONE OIL 0.01% EAR DRP	1	
FLUOROMETHOLONE 0.1% DROPS	1	
FLURBIPROFEN 0.03% EYE DROP	1	
FLUTICASONE PROP 50 MCG SPRAY	1	
FML FORTE 0.25% EYE DROPS	2	
FML LIQUIFILM 0.1% EYE DROP	3	
FML S.O.P. 0.1% OINTMENT	2	
ILEVRO 0.3% OPHTH DROPS	3	
KETOROLAC 0.4% OPHTH SOLUTION	1	
KETOROLAC 0.5% OPHTH SOLUTION	1	
LOTEMAX 0.5% EYE DROPS	2	
LOTEMAX 0.5% EYE OINTMENT	2	
LOTEMAX 0.5% OPHTHALMIC GEL	2	
MAXIDEX 0.1% EYE DROPS	3	
MOMETASONE FUROATE 50 MCG SPRY	1	
NASACORT AQ NASAL SPRAY	3	
NASONEX 50 MCG NASAL SPRAY	3	
NEVANAC 0.1% DROPTAINER	3	
OCUFEN 0.03% EYE DROPS	3	
OMNARIS 50 MCG NASAL SPRAY	3	
OMNIPRED 1% EYE DROPS	3	
OTICIN HC DROPS	3	
OTO-END 10 EAR DROPS	3	
OTOMAX-HC EAR DROPS	1	
PRAMOXINE-HC OTIC DROPS	3	
PRED FORTE 1% EYE DROPS	3	
PRED MILD 0.12% EYE DROPS	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PREDNISOLONE 1%-NEPAFENAC 0.1%	2	
PREDNISOLONE AC 1% EYE DROP	1	
PREDNISOLONE SOD 1% EYE DROP	1	
PROLENSA 0.07% EYE DROPS	3	
QNASL 80 MCG NASAL SPRAY	3	
QNASL CHILDREN'S 40 MCG SPRAY	3	
RESTASIS 0.05% EYE EMULSION	2	Max. 2 per day
RHINOCORT AQUA NASAL SPRAY	3	
TRIAMCINOLONE 55 MCG NASAL SPR	1	
VERAMYST 27.5 MCG NASAL SPRAY	2	
VEXOL 1% EYE DROPS	3	
XHANCE 93 MCG NASAL SPRAY	3	Prior Authorization required
XIIDRA 5% EYE DROPS	2	Max. 2 per day
ZETONNA 37 MCG NASAL SPRAY	3	

GASTROINTESTINAL AGENTS

ANTIULCER AGENTS AND ACID SUPPRESSANTS

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	
CARAFATE 1 GM TABLET	3	
CARAFATE 1 GM/10 ML SUSP	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	
CYTOTEC 100 MCG TABLET	3	
CYTOTEC 200 MCG TABLET	3	
DEPRIZINE ORAL SUSPENSION	3	
DEXILANT DR 30 MG CAPSULE	3	
DEXILANT DR 60 MG CAPSULE	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
FAMOTIDINE 20 MG TABLET	1	
FAMOTIDINE 40 MG TABLET	1	
FAMOTIDINE 40 MG/5 ML SUSP	1	
FIRST-LANSOPRAZOLE 3 MG/ML	3	
FIRST-OMEPRAZOLE 2 MG/ML SUSP	3	
LANSOPRAZOL-AMOXICIL-CLARITHRO	1	
LANSOPRAZOLE DR 15 MG CAPSULE	2	
LANSOPRAZOLE DR 30 MG CAPSULE	2	
MISOPROSTOL 100 MCG TABLET	1	
MISOPROSTOL 200 MCG TABLET	1	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NEXIUM DR 40 MG PACKET	2	
NEXIUM DR 5 MG PACKET	2	
NIZATIDINE 15 MG/ML SOLUTION	1	
NIZATIDINE 150 MG CAPSULE	1	
NIZATIDINE 300 MG CAPSULE	1	
OMECLAMOX-PAK COMBO PACK	3	
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	
PANTOPRAZOLE SOD DR 20 MG TAB	1	
PANTOPRAZOLE SOD DR 40 MG TAB	1	
PEPCID 20 MG TABLET	3	
PEPCID 40 MG TABLET	3	
PEPCID 40 MG/5 ML ORAL SUSP	3	
PREVACID 15 MG SOLUTAB	3	
PREVACID 30 MG SOLUTAB	3	
PREVACID DR 15 MG CAPSULE	3	
PREVACID DR 30 MG CAPSULE	3	
PREVPAC PATIENT PACK	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	
PROTONIX 40 MG SUSPENSION	3	
PROTONIX DR 20 MG TABLET	3	
PROTONIX DR 40 MG TABLET	3	
RABEPRAZOLE SOD DR 20 MG TAB	2	
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	
SUCRALFATE 1 GM TABLET	1	
ZANTAC 150 MG TABLET	3	
ZANTAC 300 MG TABLET	3	
ZEGERID 20 MG CAPSULE	3	
ZEGERID 20 MG PACKET	3	
ZEGERID 40 MG CAPSULE	3	
ZEGERID 40 MG PACKET	3	

GASTROINTESTINAL AGENTS, OTHER

ACTIGALL 300 MG CAPSULE	3	
AMITIZA 24 MCG CAPSULES	2	
AMITIZA 8 MCG CAPSULE	2	
BENTYL 10 MG CAPSULE	3	
BENTYL 20 MG TABLET	3	
BUPHENYL 500 MG TABLET	3	
BUPHENYL POWDER	3	
CANTIL 25 MG TABLET	3	
CARBAGLU 200 MG DISPER TABLET	3	LDD*: Accredo (866) 815-4717

CHOLBAM 250 MG CAPSULE	3	
CHOLBAM 50 MG CAPSULE	3	
CONSTULOSE 10 GM/15 ML SOLN	1	
CROMOLYN 100 MG/5 ML ORAL CONC	1	HSA*
CUVPOSA 1 MG/5 ML SOLUTION	3	SPP*: Must use CVS Specialty
DICYCLOMINE 10 MG CAPSULE	1	
DICYCLOMINE 10 MG/5 ML SOLN	1	
DICYCLOMINE 20 MG TABLET	1	
DIPHENOXYLAT-ATROP 2.5-0.025/5	1	
DIPHENOXYLATE-ATROP 2.5-0.025	1	
ENTEREG 12 MG CAPSULE	3	
ENULOSE 10 GM/15 ML SOLUTION	1	
FULYZAQ 125 MG DR TABLET	3	Step Therapy required
GASTROCROM 100 MG/5 ML CONC	3	
GATTEX 5 MG 30-VIAL KIT	3	Prior Authorization required SPP*: Must use CVS Specialty
GENERLAC 10 GM/15 ML SOLUTION	1	
GLYCATE 1.5 MG TABLET	3	
GLYCOPYRROLATE 1 MG TABLET	1	
GLYCOPYRROLATE 1.5 MG TABLET	2	
GLYCOPYRROLATE 2 MG TABLET	1	
HELIDAC THERAPY	3	
KAYEXALATE POWDER	3	
KIONEX 15 GM/60 ML SUSPENSION	1	
KRISTALOSE 10 GM PACKET	2	
KRISTALOSE 20 GM PACKET	2	
LACTULOSE 10 GM/15 ML SOLUTION	1	
LINZESS 145 MCG CAPSULE	2	
LINZESS 290 MCG CAPSULE	2	
LINZESS 72 MCG CAPSULE	2	
LOMOTIL 2.5-0.025 MG TABLET	3	
LOPERAMIDE 2 MG CAPSULE	1	
METHSCOPOLAMINE BROM 2.5 MG TB	1	
METHSCOPOLAMINE BROM 5 MG TAB	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	
METOZOLV ODT 5 MG TABLET	3	
MOTOFEN 1-0.025 MG TABLET	3	
MOVANTIK 12.5 MG TABLET	2	
MOVANTIK 25 MG TABLET	2	
MYTESI 125 MG DR TABLET	3	Step Therapy required
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
OPIUM TINCTURE 10 MG/ML	1	
PAMINE 2.5 MG TABLET	3	
PAREGORIC LIQUID	1	
PYLERA CAPSULE	3	
RAVICTI 1.1 GRAM/ML LIQUID	3	SPP*: Must use CVS Specialty
REGLAN 10 MG TABLET	3	
REGLAN 5 MG TABLET	3	
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	
ROBINUL 1 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ROBINUL FORTE 2 MG TABLET	3	
SOD POLYSTYREN SULF 15 G/60 ML	1	
SODIUM PHENYLBUTYRATE 500MG TB	2	
SODIUM PHENYLBUTYRATE POWDER	1	
SPS 15 GM/60 ML SUSPENSION	1	
SYMPROIC 0.2 MG TABLET	3	Prior Authorization required PA NTM*
TRULANCE 3 MG TABLET	3	Prior Authorization required
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	
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
VIBERZI 100 MG TABLET	2	
VIBERZI 75 MG TABLET	2	
XERMELO 250 MG TABLET	3	Prior Authorization required;Max. 3 per day LDD*: Diplomat Pharmacy (877) 977-9118

LAXATIVES

COLYTE WITH FLAVOR PACKETS	3	
GAVILYTE-C SOLUTION	$0	ACA*
GAVILYTE-G SOLUTION	$0	ACA*
GAVILYTE-H AND BISACODYL KIT	$0	ACA*
GAVILYTE-N SOLUTION	$0	ACA*
GOLYTELY PACKET	3	
GOLYTELY SOLUTION	3	
MOVIPREP POWDER PACKET	2	
NULYTELY WITH FLAVOR PACKS SOL	3	
OSMOPREP TABLET	3	
PEG 3350 ELECTROLYTE SOLN	$0	ACA*
PEG 3350-ELECTROLYTE SOLUTION	$0	ACA*
PEG-3350 AND ELECTROLYTES SOLN	$0	ACA*
PEG-PREP KIT	$0	ACA*
POLYETHYLENE GLYCOL 3350 POWD	1	
PREPOPIK POWDER PACKET	2	
SORBITOL 70% SOLUTION	3	
SUCLEAR BOWEL PREP KIT	3	
SUPREP BOWEL PREP KIT	3	
TRILYTE WITH FLAVOR PACKETS	$0	ACA*

PHOSPHATE BINDERS

AURYXIA 210 MG TABLET	3	
CALCIUM ACETATE 667 MG GELCAP	1	
CALCIUM ACETATE 667 MG TABLET	1	
ELIPHOS 667 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
LANTHANUM CARB 1,000 MG TB CHW	2	
LANTHANUM CARB 500 MG TAB CHEW	2	
LANTHANUM CARB 750 MG TAB CHEW	2	
MAGNEBIND 400 RX TABLET	1	
PHOSLO 667 MG GELCAP	3	
PHOSLYRA 667 MG/5 ML SOLUTION	2	
RENAGEL 400 MG TABLET	2	
RENAGEL 800 MG TABLET	2	
RENVELA 0.8 GM POWDER PACKET	2	
RENVELA 2.4 GM POWDER PACKET	2	
RENVELA 800 MG TABLET	2	
SEVELAMER 0.8 GM POWDER PACKET	2	
SEVELAMER 2.4 GM POWDER PACKET	2	
SEVELAMER CARBONATE 800 MG TAB	1	
VELPHORO 500 MG CHEWABLE TAB	3	

GENERAL ANESTHETICS

GENERAL ANESTHETICS, MISCELLANEOUS

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	

GENITOURINARY AGENTS

ANTISPASMODICS, URINARY

BETHANECHOL 10 MG TABLET	1	
BETHANECHOL 25 MG TABLET	1	
BETHANECHOL 5 MG TABLET	1	
BETHANECHOL 50 MG TABLET	1	
DARIFENACIN ER 15 MG TABLET	1	
DARIFENACIN ER 7.5 MG TABLET	1	
DETROL 1 MG TABLET	3	
DETROL 2 MG TABLET	3	
DETROL LA 2 MG CAPSULE	3	
DETROL LA 4 MG CAPSULE	3	
DITROPAN XL 10 MG TABLET	3	
DITROPAN XL 15 MG TABLET	3	
DITROPAN XL 5 MG TABLET	3	
ENABLEX 15 MG TABLET	3	
ENABLEX 7.5 MG TABLET	3	
FLAVOXATE HCL 100 MG TABLET	1	
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
MYRBETRIQ ER 25 MG TABLET	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MYRBETRIQ ER 50 MG TABLET	2	
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	
OXYTROL 3.9 MG/24HR PATCH	3	
SANCTURA 20 MG TABLET	3	
SANCTURA XR 60 MG CAPSULE	3	
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	
TOVIAZ ER 4 MG TABLET	2	
TOVIAZ ER 8 MG TABLET	2	
TROSPIUM CHLORIDE 20 MG TABLET	1	
TROSPIUM CHLORIDE ER 60 MG CAP	1	
URECHOLINE 10 MG TABLET	3	
URECHOLINE 25 MG TABLET	3	
URECHOLINE 5 MG TABLET	3	
URECHOLINE 50 MG TABLET	3	
VESICARE 10 MG TABLET	2	
VESICARE 5 MG TABLET	2	

GENITOURINARY AGENTS, MISCELLANEOUS

ALFUZOSIN HCL ER 10 MG TABLET	1	Max. 1 per day
AVODART 0.5 MG SOFTGEL	3	
DUTASTERIDE 0.5 MG CAPSULE	1	
DUTASTERIDE-TAMSULOSIN 0.5-0.4	1	
FINASTERIDE 5 MG TABLET	1	
FLOMAX 0.4 MG CAPSULE	3	
JALYN 0.5-0.4 MG CAPSULE	3	
PHENAZOPYRIDINE 100 MG TAB	1	
PHENAZOPYRIDINE 200 MG TAB	1	
PROSCAR 5 MG TABLET	3	
PYRIDIUM 100 MG TABLET	3	
PYRIDIUM 200 MG TABLET	3	
RAPAFLO 4 MG CAPSULE	3	
RAPAFLO 8 MG CAPSULE	3	
TAMSULOSIN HCL 0.4 MG CAPSULE	1	
TERAZOSIN 1 MG CAPSULE	1	HSA*
TERAZOSIN 10 MG CAPSULE	1	HSA*
TERAZOSIN 2 MG CAPSULE	1	HSA*
TERAZOSIN 5 MG CAPSULE	1	HSA*
UROXATRAL 10 MG TABLET	3	Max. 1 per day

HEAVY METAL ANTAGONISTS

HEAVY METAL ANTAGONISTS

CHEMET 100 MG CAPSULE	2	
CUPRIMINE 250 MG CAPSULE	2	Prior Authorization required
DEPEN 250 MG TITRATAB	2	Prior Authorization required

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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.
GALZIN 25 MG CAPSULE	3	
GALZIN 50 MG CAPSULE	3	
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
SYPRINE 250 MG CAPSULE	3	Prior Authorization required

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING

ANDROGENS

ANADROL-50 TABLET	3	Max. 30 Days Supply
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
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
COVARYX H.S. TABLET	1	Max. 30 Days Supply
COVARYX TABLET	1	Max. 30 Days Supply
DANAZOL 100 MG CAPSULE	1	
DANAZOL 200 MG CAPSULE	1	
DANAZOL 50 MG CAPSULE	1	
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
ESTROGEN-METHYLTESTOS F.S. TAB	1	Max. 30 Days Supply
ESTROGEN-METHYLTESTOS H.S. TAB	1	Max. 30 Days Supply
FIRST 2% TESTOSTERONE OINT	3	Max. 30 Days Supply
FIRST-TESTOSTERONE MC 2% CR	3	Max. 30 Days Supply

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
METHITEST 10 MG TABLET	3	Max. 30 Days Supply;Prior Authorization required
METHYLTESTOSTERONE 10 MG CAP	1	Max. 30 Days Supply;Prior Authorization required
NATESTO NASAL 5.5 MG/0.122 GM	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older
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
STRIANT 30 MG MUCOADHESIVE	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 2 per day
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 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
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

ESTROGENS AND ANTIESTROGENS

ACTIVELLA 0.5-0.1 MG TABLET	3	
ACTIVELLA 1 MG-0.5 MG TABLET	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	
AMABELZ 0.5 MG-0.1 MG TABLET	1	
AMABELZ 1 MG-0.5 MG TABLET	1	
ANGELIQ 0.25 MG-0.5 MG TABLET	3	
ANGELIQ 0.5 MG-1 MG TABLET	3	
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	
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	
CLOMIPHENE CITRATE 50 MG TAB	1	
COMBIPATCH 0.05-0.14 MG PTCH	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
COMBIPATCH 0.05-0.25 MG PTCH	2	
DIVIGEL 1 MG GEL PACKET	2	
DUAVEE 0.45-20 MG TABLET	3	HSA*
ELESTRIN 0.06% GEL	3	
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	
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	
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	
ESTROPIPATE 0.625(0.75 MG) TAB	1	
ESTROPIPATE 1.25(1.5 MG) TAB	1	
ESTROPIPATE 2.5(3 MG) TAB	1	
EVAMIST 1.53 MG/SPRAY	3	Max. quantity of 1 per fill MQC*: 1 bottle/copay
EVISTA 60 MG TABLET	3	HSA*
FEMHRT 0.5 MG-2.5 MCG TABLET	3	
FEMRING 0.05 MG/DAY VAG RING	3	Max. 90 Days Supply;Max. 1 in 90 days
FEMRING 0.10 MG/DAY VAG RING	3	Max. 90 Days Supply;Max. 1 in 90 days
FYAVOLV 0.5 MG-2.5 MCG TABLET	1	
FYAVOLV 1 MG-5 MCG TABLET	1	
JEVANTIQUE LO 0.5 MG-2.5 MCG	3	
JINTELI 1 MG-5 MCG TABLET	1	
LOPREEZA 0.5 MG-0.1 MG TABLET	1	
LOPREEZA 1 MG-0.5 MG TABLET	1	
MENEST 0.3 MG TABLET	2	
MENEST 0.625 MG TABLET	2	
MENEST 1.25 MG TABLET	2	
MENEST 2.5 MG TABLET	2	
MENOSTAR 14 MCG/DAY PATCH	3	
MIMVEY 1-0.5 MG TABLET	1	
MIMVEY LO 0.5-0.1 MG TABLET	1	
MINIVELLE 0.025 MG PATCH	3	
MINIVELLE 0.0375 MG PATCH	3	
MINIVELLE 0.05 MG PATCH	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MINIVELLE 0.075 MG PATCH	3	
MINIVELLE 0.1 MG PATCH	3	
NORETHIN-ETH ESTRAD 1 MG-5 MCG	1	
NORETHIND-ETH ESTRAD 0.5-2.5	1	
OSPHENA 60 MG TABLET	3	
PREFEST TABLET	3	
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	
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	
RALOXIFENE HCL 60 MG TABLET	1	HSA*; ACA*
SEROPHENE 50 MG TABLET	3	
VAGIFEM 10 MCG VAGINAL TAB	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	
YUVAFEM 10 MCG VAGINAL INSERT	2	

GLUCOCORTICOIDS/MINERALOCORTICOIDS

CORTEF 10 MG TABLET	3	
CORTEF 20 MG TABLET	3	
CORTEF 5 MG TABLET	3	
CORTISONE 25 MG TABLET	1	
DELTASONE 20 MG TABLET	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	
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	
DEXPAK 10 DAY 1.5 MG TABLET	3	
DEXPAK 13 DAY 1.5 MG TABLET	2	
DEXPAK 6 DAY 1.5 MG TABLET	3	
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
FLO-PRED 16.7(15) MG/5 ML SUSP	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FLUDROCORTISONE 0.1 MG TABLET	1	
HYDROCORTISONE 10 MG TABLET	1	
HYDROCORTISONE 20 MG TABLET	1	
HYDROCORTISONE 5 MG TABLET	1	
INTRAROSA 6.5 MG VAG INSERT	3	Prior Authorization required;Max. 28 per 28 days PA NTM*
LOCORT 11 DAY 1.5 MG TABLET	3	
LOCORT 7 DAY 1.5 MG TABLET	3	
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	
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	
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	
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	
PEDIAPRED 5 MG/5 ML SOLN	3	
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 ODT 10 MG TABLET	1	
PREDNISOLONE ODT 15 MG TABLET	1	
PREDNISOLONE ODT 30 MG TABLET	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	
PRELONE 15 MG/5 ML SYRUP	1	
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
VERIPRED 20 20 MG/5 ML SOLN	3	
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*
ZONACORT 11 DAY 1.5 MG TABLET	3	
ZONACORT 7 DAY 1.5 MG TABLET	3	

PITUITARY

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BRAVELLE 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
CETROTIDE 0.25 MG KIT	2	Max. 30 Days Supply IVF*
CHORIONIC GONAD 10,000 UNIT VL	2	Max. 30 Days Supply IVF*
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	
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	
EGRIFTA 1 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty 1-844-EGRIFTA (1-844-347-4382)
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*
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
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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
INCRELEX 40 MG/4 ML VIAL	2	Prior Authorization required SPP*: Must use 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
MENOPUR 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
METOPIRONE 250 MG CAPSULE	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
NOVAREL 10,000 UNITS VIAL	2	Max. 30 Days Supply IVF*
NOVAREL 5,000 UNIT VIAL	2	Max. 30 Days Supply IVF*
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
OCTREOTIDE 1,000 MCG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
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
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
OVIDREL 250 MCG/0.5 ML SYRG	2	Max. 30 Days Supply IVF*
PREGNYL 10,000 UNITS VIAL	2	Max. 30 Days Supply IVF*
REPRONEX 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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
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
STIMATE 1.5 MG/ML NASAL SPRAY	2	
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
ZORBTIVE 8.8 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty

PROGESTINS

AYGESTIN 5 MG TABLET	3	
CRINONE 4% GEL	2	Max. 30 Days Supply IVF*
CRINONE 8% GEL	2	Max. 30 Days Supply IVF*
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*
ENDOMETRIN 100 MG SUPPOSITORY	2	Max. 30 Days Supply IVF*
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
MAKENA 250 MG/ML VIAL	MD	Prior Authorization required;Max. 4 ML(s) per 28 days IVF*
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MEDROXYPROGESTERONE 2.5 MG TAB	1	
MEDROXYPROGESTERONE 5 MG TAB	1	
MEGACE 40 MG/ML ORAL SUSP	3	CH*
MEGACE ES 625 MG/5 ML SUSP	3	CH*
MEGESTROL 625 MG/5 ML SUSP	1	CH*
MEGESTROL ACET 40 MG/ML SUSP	1	CH*
NORETHINDRONE 5 MG TABLET	1	
PROGESTERONE 100 MG CAPSULE	1	HSA*
PROGESTERONE 200 MG CAPSULE	1	HSA*
PROGESTERONE OIL 50 MG/ML VL	1	Max. 30 Days Supply IVF*
PROMETRIUM 100 MG CAPSULE	3	
PROMETRIUM 200 MG CAPSULE	3	
PROVERA 10 MG TABLET	3	
PROVERA 2.5 MG TABLET	3	
PROVERA 5 MG TABLET	3	

THYROID AND ANTITHYROID AGENTS

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	
CYTOMEL 25 MCG TABLET	3	
CYTOMEL 5 MCG TABLET	3	
CYTOMEL 50 MCG TABLET	3	
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	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
LIOTHYRONINE SOD 25 MCG TAB	1	
LIOTHYRONINE SOD 5 MCG TAB	1	
LIOTHYRONINE SOD 50 MCG TAB	1	
METHIMAZOLE 10 MG TABLET	1	
METHIMAZOLE 5 MG TABLET	1	
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	
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	
PROPYLTHIOURACIL 50 MG TABLET	1	
SSKI 1 GM/ML SOLUTION	1	
STRONG IODINE SOLUTION	1	
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	
TAPAZOLE 10 MG TABLET	3	
TAPAZOLE 5 MG TABLET	3	
THYROGEN 1.1 MG VIAL	MD	SPP*: Must use CVS Specialty
THYROID 120 MG TABLET	1	
THYROID 15 MG TABLET	1	
THYROID 30 MG TABLET	1	
THYROID 60 MG TABLET	1	
THYROID 90 MG TABLET	1	
THYROLAR-1 STRENGTH TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
THYROLAR-1/2 STRENGTH TAB	3	
THYROLAR-1/4 STRENGTH TAB	3	
THYROLAR-2 STRENGTH TABLET	3	
THYROLAR-3 STRENGTH TABLET	3	
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	
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	
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	
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	

IMMUNOLOGICAL AGENTS

IMMUNOLOGICAL AGENTS

ACTEMRA 162 MG/0.9 ML SYRINGE	3	Prior Authorization required;Max. 3.6 ML(s) in 30 days SPP*: Must use CVS Specialty
ARAVA 10 MG TABLET	3	
ARAVA 20 MG TABLET	3	
ASTAGRAF XL 0.5 MG CAPSULE	3	
ASTAGRAF XL 1 MG CAPSULE	3	
ASTAGRAF XL 5 MG CAPSULE	3	
AZASAN 100 MG TABLET	2	
AZASAN 75 MG TABLET	2	
AZATHIOPRINE 50 MG TABLET	1	
CELLCEPT 200 MG/ML ORAL SUSP	3	
CELLCEPT 250 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CELLCEPT 500 MG TABLET	3	
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
CYCLOSPORINE 100 MG CAPSULE	1	
CYCLOSPORINE 100 MG/ML SOLN	1	
CYCLOSPORINE 25 MG CAPSULE	1	
CYCLOSPORINE MODIFIED 100 MG	1	
CYCLOSPORINE MODIFIED 25 MG	1	
CYCLOSPORINE MODIFIED 50 MG	1	
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 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
ENVARSUS XR 0.75 MG TABLET	3	
ENVARSUS XR 1 MG TABLET	3	
ENVARSUS XR 4 MG TABLET	3	
GENGRAF 100 MG CAPSULE	1	
GENGRAF 100 MG/ML SOLUTION	1	
GENGRAF 25 MG CAPSULE	1	
GENGRAF 50 MG CAPSULE	1	
HECORIA 0.5 MG CAPSULE	2	
HECORIA 1 MG CAPSULE	2	
HECORIA 5 MG CAPSULE	2	
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
HYPERRAB S-D 150 UNITS/ML VIAL	MD	
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
IMOGAM RABIES-HT 150 UNIT/ML	MD	
IMURAN 50 MG TABLET	3	
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
KINERET 100 MG/0.67 ML SYRINGE	3	Prior Authorization required LDD*: Omnicare/RX Crossroads. 866-547-0644.
LEFLUNOMIDE 10 MG TABLET	1	
LEFLUNOMIDE 20 MG TABLET	1	
MICRHOGAM ULTRA-FILTD PLUS SYR	MD	SPP*: Must use CVS Specialty
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MYFORTIC 180 MG TABLET	3	
MYFORTIC 360 MG TABLET	3	
NEORAL 100 MG GELATIN CAPSULE	3	
NEORAL 100 MG/ML SOLUTION	3	
NEORAL 25 MG GELATIN CAPSULE	3	
NULOJIX 250 MG VIAL	MD	SPP*: Must use CVS Specialty
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
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
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	
PROGRAF 0.5 MG CAPSULE	2	
PROGRAF 1 MG CAPSULE	2	
PROGRAF 5 MG CAPSULE	2	
RAPAMUNE 0.5 MG TABLET	3	
RAPAMUNE 1 MG TABLET	3	
RAPAMUNE 1 MG/ML ORAL SOLN	3	
RAPAMUNE 2 MG TABLET	3	
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
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
RHOGAM ULTRA-FILTERED PLUS SYR	MD	SPP*: Must use CVS Specialty
RIDAURA 3 MG CAPSULE	3	
SANDIMMUNE 100 MG CAPSULE	3	
SANDIMMUNE 100 MG/ML SOLN	2	
SANDIMMUNE 25 MG CAPSULE	3	
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
SIROLIMUS 0.5 MG TABLET	1	
SIROLIMUS 1 MG TABLET	1	
SIROLIMUS 2 MG TABLET	1	
STELARA 45 MG/0.5 ML SYRINGE	MD	Prior Authorization required SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
STELARA 90 MG/ML SYRINGE	MD	Prior Authorization required SPP*: Must use CVS Specialty
TACROLIMUS 0.5 MG CAPSULE	1	
TACROLIMUS 1 MG CAPSULE	1	
TACROLIMUS 5 MG CAPSULE	1	
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
ZORTRESS 0.25 MG TABLET	3	
ZORTRESS 0.5 MG TABLET	3	
ZORTRESS 0.75 MG TABLET	3	

VACCINES

ADENOVIRUS TYPE 4 & 7 EC TABS	3	
ADENOVIRUS TYPE 4 EC TABLET	3	
ADENOVIRUS TYPE 7 EC TABLET	3	
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*
CERVARIX VACCINE SYRINGE	$0	Covered for females only;Not covered for members 27 and older ACA*
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
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*
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*
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*
FLUVIRIN 2017-2018 SYRINGE	$0	Not covered for members 18 and younger ACA*
FLUVIRIN 2017-2018 VIAL	$0	Not covered for members 18 and younger ACA*
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*
GARDASIL 9 SYRINGE	$0	Not covered for members 27 and older ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
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
HEPLISAV-B 20 MCG/0.5 ML VIAL	MD	Not covered for members 17 and younger
IMOVAX RABIES VACCINE+DILUENT	MD	
MENACTRA VIAL	MD	
MENOMUNE-A-C-Y-W-135 VIAL	MD	
MENOMUNE-A-C-Y-W-135 W-DILUENT	MD	
RABAVERT RABIES VACC W-DILUENT	MD	
RECOMBIVAX HB 10 MCG/ML SYR	MD	Not covered for members 17 and younger
RECOMBIVAX HB 10 MCG/ML VIAL	MD	Not covered for members 17 and younger
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
SHINGRIX VIAL KIT	$0	Not covered for members 49 and younger
TWINRIX VACCINE SYRINGE	MD	Not covered for members 17 and younger
TWINRIX VACCINE VIAL	MD	Not covered for members 17 and younger
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
VIVOTIF EC CAPSULE	3	
ZOSTAVAX VIAL	$0	Not covered for members 49 and younger ACA*, SPP*: CVS/Specialty, Covered ages 50 and older

INFLAMMATORY BOWEL DISEASE AGENTS

INFLAMMATORY BOWEL DISEASE AGENTS

ALOSETRON HCL 0.5 MG TABLET	1	Covered for females only
ALOSETRON HCL 1 MG TABLET	1	Covered for females only
APRISO ER 0.375 GRAM CAPSULE	2	
ASACOL HD DR 800 MG TABLET	3	
BALSALAZIDE DISODIUM 750 MG CP	1	
BUDESONIDE EC 3 MG CAPSULE	1	
CANASA 1,000 MG SUPPOSITORY	2	
COLAZAL 750 MG CAPSULE	3	
COLOCORT 100 MG ENEMA	1	
CORTENEMA 100 MG/60 ML ENEMA	3	
DELZICOL DR 400 MG CAPSULE	2	
DIPENTUM 250 MG CAPSULE	3	
ENTOCORT EC 3 MG CAPSULE	3	
GIAZO 1.1 GM TABLET	3	
HYDROCORTISONE 100 MG/60 ML	1	
LIALDA DR 1.2 GM TABLET	3	
LOTRONEX 0.5 MG TABLET	3	Covered for females only
LOTRONEX 1 MG TABLET	3	Covered for females only
MESALAMINE 4 GM/60 ML ENEMA	1	
MESALAMINE 800 MG DR TABLET	2	
MESALAMINE DR 1.2 GM TABLET	2	
PENTASA 250 MG CAPSULE	2	
PENTASA 500 MG CAPSULE	2	
ROWASA 4 GM/60 ML ENEMA KIT	3	
UCERIS 2 MG RECTAL FOAM	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
UCERIS 9 MG ER TABLET	3	

IRRIGATING SOLUTIONS

IRRIGATING SOLUTIONS

GLYCINE 1.5% IRRIGATION	1	
RENACIDIN IRRIGATION SOLUTION	3	
SODIUM CHLORIDE 0.9% IRRIG.	1	

METABOLIC BONE DISEASE AGENTS

METABOLIC BONE DISEASE AGENTS

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*
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*
ATELVIA DR 35 MG TABLET	3	Max. 4 per 28 days HSA*
BINOSTO 70 MG TABLET EFF	3	Max. 4 per 28 days 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
CALCITONIN-SALMON 200 UNITS SP	1	
CALCITRIOL 0.25 MCG CAPSULE	1	
CALCITRIOL 0.5 MCG CAPSULE	1	
CALCITRIOL 1 MCG/ML SOLUTION	1	
DOXERCALCIFEROL 0.5 MCG CAP	1	
DOXERCALCIFEROL 1 MCG CAPSULE	1	
DOXERCALCIFEROL 2.5 MCG CAP	1	
ETIDRONATE DISODIUM 200 MG TAB	1	HSA*
ETIDRONATE DISODIUM 400 MG TAB	1	HSA*
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
FORTICAL 200 UNITS NASAL SPRAY	2	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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
HECTOROL 0.5 MCG CAPSULE	3	
HECTOROL 1 MCG CAPSULE	3	
HECTOROL 2.5 MCG CAPSULE	3	
IBANDRONATE 3 MG/3 ML SYRINGE	MD	SPP*: Must use CVS Specialty
IBANDRONATE SODIUM 150 MG TAB	1	Max. 1 per 30 days HSA*
MIACALCIN 200 UNIT NASAL SPRAY	3	HSA*
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
PARICALCITOL 1 MCG CAPSULE	1	
PARICALCITOL 2 MCG CAPSULE	1	
PARICALCITOL 4 MCG CAPSULE	1	
PROLIA 60 MG/ML SYRINGE	MD	Prior Authorization required;Max. 1 ML(s) in 180 days SPP*: Must use CVS Specialty
RAYALDEE ER 30 MCG CAPSULE	3	Prior Authorization required;Max. 2 per day
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*
ROCALTROL 0.25 MCG CAPSULE	3	
ROCALTROL 0.5 MCG CAPSULE	3	
ROCALTROL 1 MCG/ML ORAL SOLN	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
XGEVA 120 MG/1.7 ML VIAL	MD	Prior Authorization required;Max. 1.7 ML(s) in 28 days SPP*: Must use CVS Specialty
ZEMPLAR 1 MCG CAPSULE	3	
ZEMPLAR 2 MCG CAPSULE	3	
ZEMPLAR 4 MCG CAPSULE	3	
ZOLEDRONIC ACID 5 MG/100 ML	MD	Prior Authorization required;Max. 100 ML(s) in 365 days SPP*: Must use CVS Specialty

MISCELLANEOUS THERAPEUTIC AGENTS

MISCELLANEOUS THERAPEUTIC AGENTS

ACTIMMUNE 100 MCG/0.5 ML VIAL	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
ALEVICYN ANTIPRURITIC GEL	3	
ALEVICYN DERMAL SPRAY	3	
ATRAPRO DERMAL SPRAY	3	
ATRAPRO HYDROGEL	3	
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
BHT POWDER	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BIONECT 0.2% CREAM	3	
BIONECT 0.2% FOAM	3	
BIONECT 0.2% GEL	3	
BIONECT 0.2% SPRAY	3	
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
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	
CARDIOVID PLUS SOFTGEL	1	
CARNITOR 330 MG TABLET	3	
CARNITOR SF 100 MG/ML ORAL SOL	3	
CERDELGA 84 MG CAPSULE	2	SPP*: Must use CVS Specialty
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
CYSTADANE 1 GRAM/1.7 ML POWDER	3	LDD*: AnovoRx (888) 487-4703
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
ELMIRON 100 MG CAPSULE	3	
ERGOLOID MESYLATES 1 MG TAB	1	
ETHYL ACETATE LIQUID	3	
FORMA-RAY 20% SOLUTION	2	
FORMALDEHYDE 10% SOLUTION	1	
GANIRELIX ACET 250 MCG/0.5 ML	2	Max. 30 Days Supply IVF*
GLUCAGEN 1 MG HYPOKIT	2	
GLUCAGON 1 MG EMERGENCY KIT	2	HSA*
GRASTEK 2,800 BAU SL TABLET	3	Max. 1 per day
GUANIDINE HCL 125 MG TABLET	1	
HP ACTHAR GEL 80 UNIT/ML VIAL	MD	Prior Authorization required SPP*: CVS Specialty
HYDROXYZINE PAM 100 MG CAP	1	
HYDROXYZINE PAM 25 MG CAP	1	
HYDROXYZINE PAM 50 MG CAP	1	
HYGEL 2.5% GEL	3	
KEVEYIS 50 MG TABLET	3	Prior Authorization required LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
LEUCOVORIN CALCIUM 10 MG TAB	1	
LEUCOVORIN CALCIUM 15 MG TAB	1	
LEUCOVORIN CALCIUM 25 MG TAB	1	
LEUCOVORIN CALCIUM 5 MG TAB	1	
LEVOCARNITINE 1 G/10 ML SOLN	1	
LEVOCARNITINE 330 MG TABLET	1	
LITHOSTAT 250 MG TABLET	3	
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
LYCELLE HEAD LICE REMOVAL KIT	3	
MEPROBAMATE 200 MG TABLET	1	
MEPROBAMATE 400 MG TABLET	1	
MESNEX 400 MG TABLET	3	
MESTINON 180 MG TIMESPAN	3	
MESTINON 60 MG TABLET	3	
MESTINON 60 MG/5 ML SYRUP	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
METHERGINE 0.2 MG TABLET	3	
METHYLERGONOVINE 0.2 MG TABLET	1	
MICROCRYSTAL CELLULOSE POWDER	3	
MICROCYN SKIN-WOUND CARE SPRAY	3	
MYALEPT 11.3 MG (5 MG/ML) VIAL	3	LDD*: Accredo (866) 815-4717
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
MYOBLOC 5,000 UNITS/1 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ODACTRA 12 SQ-HDM SL TABLET	3	Prior Authorization required;Max. 1 per day
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
ORENCIA CLICKJECT 125 MG/ML	3	Prior Authorization required;Max. 1 ML(s) per 7 days SPP*: Must use CVS Specialty
POTABA 500 MG CAPSULE	3	
PROCYSBI DR 25 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
PROCYSBI DR 75 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
PROSTIGMIN 15 MG TABLET	3	
PROTHELIAL 1 GM/10 ML PASTE	3	
PRUTECT TOPICAL EMULSION	1	
PYRIDOSTIGMINE BR 60 MG TABLET	1	
PYRIDOSTIGMINE ER 180 MG TAB	1	
RADIAGEL	3	
RAGWITEK SUBLINGUAL TABLET	3	Max. 1 per day
RECTIV 0.4% OINTMENT	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
SHINGRIX ADJUVANT COMPONENT	$0	Not covered for members 49 and younger ACA*; Covered ages 50 and older
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
SODIUM SUCCINATE POWDER	3	
SYNAREL 2 MG/ML NASAL SPRAY	2	Max. 30 Days Supply IVF*
THALOMID 100 MG CAPSULE	2	CH*; SPP*: CVS Specialty
THALOMID 150 MG CAPSULE	2	CH*; SPP*: CVS Specialty
THALOMID 200 MG CAPSULE	2	CH*; SPP*: CVS Specialty
THALOMID 50 MG CAPSULE	2	CH*; SPP*: CVS Specialty
THIOLA 100 MG TABLET	3	Prior Authorization required LDD*: Dohmen Life Sciences (800) 305-7881
TYBOST 150 MG TABLET	3	
ULESFIA 5% LOTION	3	
VEHICLE-N MILD SOLUTION	3	
VEHICLE-N SOLUTION	3	
VISTARIL 25 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VISTARIL 50 MG CAPSULE	3	
VISTOGARD 10 GRAM PACKET	3	
WATER FOR INJECTION VIAL	1	
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
XURIDEN GRANULE PACKET	3	
ZANABIN ANTIPRURITIC HYDROGEL	3	

MOUTHWASHES AND GARGLES

MOUTHWASHES AND GARGLES

ORAMAGICRX ORAL RINSE	3	

OPHTHALMIC AGENTS

ANTIGLAUCOMA AGENTS

ACETAZOLAMIDE 125 MG TABLET	1	
ACETAZOLAMIDE 250 MG TABLET	1	
ACETAZOLAMIDE ER 500 MG CAP	1	
ALPHAGAN P 0.1% DROPS	2	
ALPHAGAN P 0.15% EYE DROPS	3	
AZOPT 1% EYE DROPS	2	
BETAGAN 0.5% EYE DROPS	3	
BETAXOLOL HCL 0.5% EYE DROP	1	
BETIMOL 0.25% EYE DROPS	2	
BETIMOL 0.5% EYE DROPS	2	
BETOPTIC S 0.25% EYE DROPS	2	
BIMATOPROST 0.03% EYE DROPS	1	
BRIMONIDINE 0.2% EYE DROP	1	
BRIMONIDINE TARTRATE 0.15% DRP	1	
COMBIGAN 0.2%-0.5% EYE DROPS	2	
COSOPT EYE DROPS	3	
COSOPT PF EYE DROPS	3	
DIAMOX SEQUELS ER 500 MG CAP	3	
DORZOLAMIDE HCL 2% EYE DROPS	1	
DORZOLAMIDE-TIMOLOL EYE DROPS	1	
ISOPTO CARBACHOL 3% DROPS	3	
ISOPTO CARPINE 1% EYE DROPS	3	
ISOPTO CARPINE 2% EYE DROPS	3	
ISOPTO CARPINE 4% EYE DROPS	3	
ISTALOL 0.5% EYE DROPS	3	
LATANOPROST 0.005% EYE DROPS	1	
LEVOBUNOLOL 0.5% EYE DROPS	1	
LUMIGAN 0.01% EYE DROPS	2	
METHAZOLAMIDE 25 MG TABLET	1	
METHAZOLAMIDE 50 MG TABLET	1	
METIPRANOLOL 0.3% EYE DROPS	1	
NEPTAZANE 25 MG TABLET	3	
NEPTAZANE 50 MG TABLET	3	
PHOSPHOLINE IODIDE 0.125%	2	
PILOCARPINE 1% EYE DROPS	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PILOCARPINE 2% EYE DROPS	1	
PILOCARPINE 4% EYE DROPS	1	
SIMBRINZA 1%-0.2% EYE DROPS	2	
TIMOLOL 0.25% GFS GEL-SOLUTION	1	
TIMOLOL 0.5% GFS GEL-SOLUTION	1	
TIMOLOL MALEATE 0.25% EYE DROP	1	
TIMOLOL MALEATE 0.5% EYE DROPS	1	
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	
TRAVATAN Z 0.004% EYE DROP	2	
TRAVOPROST 0.004% EYE DROP	1	
TRUSOPT 2% EYE DROPS	3	
VYZULTA 0.024% OPHTH SOLUTION	3	Prior Authorization required
XALATAN 0.005% EYE DROPS	3	
ZIOPTAN 0.0015% EYE DROPS	3	

REPLACEMENT PREPARATIONS

REPLACEMENT PREPARATIONS

CYTRA-2 ORAL SOLUTION	1	
CYTRA-3 SYRUP	1	
CYTRA-K CRYSTALS PACKET	1	
CYTRA-K ORAL SOLUTION	1	
EFFER-K 10 MEQ TABLET EFF	3	
EFFER-K 20 MEQ TABLET EFF	3	
EFFER-K 25 MEQ TABLET EFF	1	
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	
K-TAB ER 10 MEQ TABLET	3	
K-TAB ER 20 MEQ TABLET	3	
K-TAB ER 8 MEQ TABLET	3	
KAOCHLOR-EFF 20 MEQ 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	
ORACIT ORAL SOLUTION	2	
PHOSPHA 250 NEUTRAL TABLET	1	
POT CITRATE-CITRIC ACID PACKET	1	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	
SHOHL'S MODIFIED SOLUTION	3	
SOD CITRATE-CITRIC ACID SOLN	1	
TRICITRATES ORAL SOLUTION	1	
UROCIT-K ER 15 MEQ TABLET	3	
UROCIT-K SR 10 MEQ TABLET	3	
UROCIT-K SR 5 MEQ TABLET	3	
VIRT-PHOS 250 NEUTRAL TABLET	1	
ZINC SULFATE 220 MG CAPSULE	1	

RESPIRATORY TRACT AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

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*
AEROSPAN 80 MCG INHALER	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*
ALVESCO 160 MCG INHALER	3	HSA*
ALVESCO 80 MCG INHALER	3	HSA*
ARMONAIR RESPICLICK 113 MCG	3	Prior Authorization required HSA*; PA NTM*
ARMONAIR RESPICLICK 232 MCG	3	Prior Authorization required HSA*; PA NTM*
ARMONAIR RESPICLICK 55 MCG	3	Prior Authorization required HSA*; PA NTM*
ARNUITY ELLIPTA 100 MCG INH	3	HSA*
ARNUITY ELLIPTA 200 MCG INH	3	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ASMANEX TWISTHALER 220 MCG #60	2	HSA*
ASMANEX TWISTHALR 220 MCG #120	2	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*
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*
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*
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*
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*
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*
QVAR 40 MCG ORAL INHALER	2	HSA*
QVAR 80 MCG ORAL INHALER	2	HSA*
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*

ANTILEUKOTRIENES

ACCOLATE 10 MG TABLET	3	HSA*
ACCOLATE 20 MG TABLET	3	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SINGULAIR 10 MG TABLET	3	HSA*
SINGULAIR 4 MG GRANULES	3	HSA*
SINGULAIR 4 MG TABLET CHEW	3	HSA*
SINGULAIR 5 MG TABLET CHEW	3	HSA*
ZAFIRLUKAST 10 MG TABLET	1	HSA*
ZAFIRLUKAST 20 MG TABLET	1	HSA*
ZILEUTON ER 600 MG TABLET	2	HSA*
ZYFLO 600 MG FILMTAB	3	HSA*
ZYFLO CR 600 MG TABLET	3	HSA*

BRONCHODILATORS

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*
ANORO ELLIPTA 62.5-25 MCG INH	2	Max. quantity of 60 per fill;Max. 60 in 30 days HSA*
ARCAPTA NEOHALER 75 MCG CAP	3	Max. 1 per day HSA*
ATROVENT HFA INHALER	2	HSA*
BROVANA 15 MCG/2 ML SOLUTION	3	HSA*
COMBIVENT INHALER	2	HSA*
COMBIVENT RESPIMAT INHAL SPRAY	2	HSA*
DUONEB 0.5 MG-3 MG/3 ML SOLN	3	HSA*
ELIXOPHYLLIN 80 MG/15 ML ELIX	1	HSA*
FORADIL AEROLIZER 12 MCG CAP	2	Max. 2 per day HSA*
INCRUSE ELLIPTA 62.5 MCG INH	2	Max. quantity of 30 per fill;Max. 30 in 30 days HSA*
IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	1	HSA*
IPRATROPIUM BR 0.02% SOLN	1	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LEVALBUTEROL CONC 1.25 MG/0.5	1	HSA*
LEVALBUTEROL TAR HFA 45MCG INH	2	HSA*
LUFYLLIN 200 MG TABLET	2	HSA*
LUFYLLIN-400 TABLET	3	HSA*
MAXAIR AUTOHALER 0.2 MG AERO	2	HSA*
METAPROTERENOL 10 MG TABLET	1	HSA*
METAPROTERENOL 10 MG/5 ML SYR	1	HSA*
METAPROTERENOL 20 MG TABLET	1	HSA*
PERFOROMIST 20 MCG/2 ML SOLN	2	HSA*
PROAIR HFA 90 MCG INHALER	2	HSA*
PROAIR RESPICLICK INHAL POWDER	2	HSA*
PROVENTIL HFA 90 MCG INHALER	3	HSA*
SEEBRI NEOHALER 15.6 MCG INHAL	3	Max. 2 per day HSA*
SEREVENT DISKUS 50 MCG	2	Max. 60 in 30 days HSA*
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
STIOLTO RESPIMAT INHAL SPRAY	3	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
STRIVERDI RESPIMAT INHAL SPRAY	3	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
TERBUTALINE SULFATE 2.5 MG TAB	1	HSA*
TERBUTALINE SULFATE 5 MG TAB	1	HSA*
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRELEGY ELLIPTA 100-62.5-25	3	Prior Authorization required;Max. 60 in 30 days HSA*; PA NTM*
TUDORZA PRESSAIR 400 MCG INH	2	Max. 1 in 30 days HSA*
UTIBRON NEOHALER 27.5-15.6 MCG	3	Max. 2 per day HSA*
VENTOLIN HFA 90 MCG INHALER	2	HSA*
VOSPIRE ER 4 MG TABLET	3	HSA*
VOSPIRE ER 8 MG TABLET	3	HSA*
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*

RESPIRATORY TRACT AGENTS, OTHER

ACETYLCYSTEINE 10% VIAL	1	
ACETYLCYSTEINE 20% VIAL	1	
ARALAST NP 1,000 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
CROMOLYN 20 MG/2 ML NEB SOLN	1	HSA*
CUROSURF 120 MG/1.5 ML VIAL	3	
DALIRESP 500 MCG TABLET	2	HSA*
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
HYPER-SAL 3.5% VIAL	3	
HYPER-SAL 7% VIAL	3	
INFASURF 35 MG/ML VIAL	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
NEBUSAL 3% VIAL	1	
NEBUSAL 6% VIAL	3	
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
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
PROLASTIN C 1,000 MG VIAL	MD	Prior Authorization required LDD*: Dohmen Life Sciences. 1-800-305-7881.
PULMOSAL 7% VIAL	3	
SODIUM CHLORIDE 0.9% INHAL VL	1	
SODIUM CHLORIDE 10% VIAL	1	
SODIUM CHLORIDE 3% VIAL	1	
SODIUM CHLORIDE 7% VIAL	1	
SURVANTA 25 MG/ML VIAL	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
XOLAIR 150 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ZEMAIRA 1,000 MG VIAL	MD	Prior Authorization required LDD*: Accredo (866) 815-4717

SALT AND SUGAR SUBSTITUTES

SALT AND SUGAR SUBSTITUTES

SACCHARIN POWDER	3

SKELETAL MUSCLE RELAXANTS

SKELETAL MUSCLE RELAXANTS

AMRIX ER 15 MG CAPSULE	3
AMRIX ER 30 MG CAPSULE	3
BACLOFEN 10 MG TABLET	1
BACLOFEN 20 MG TABLET	1
CARISOPRODL-ASPIRIN 200-325 MG	1
CARISOPRODOL 250 MG TABLET	1
CARISOPRODOL 350 MG TABLET	1
CARISOPRODOL-ASPIRIN-CODEIN TB	1
CHLORZOXAZONE 250 MG TABLET	1
CHLORZOXAZONE 500 MG TABLET	1
COMFORT PAC-CYCLOBENZAPRINE KT	3
CYCLOBENZAPRINE 10 MG TABLET	1
CYCLOBENZAPRINE 5 MG TABLET	1
CYCLOBENZAPRINE 7.5 MG TABLET	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
FEXMID 7.5 MG TABLET	3
LORZONE 375 MG TABLET	3
LORZONE 750 MG TABLET	3
METAXALL 800 MG TABLET	1
METAXALONE 400 MG TABLET	1
METAXALONE 800 MG TABLET	1
METHOCARBAMOL 500 MG TABLET	1
METHOCARBAMOL 750 MG TABLET	1
ORPHENADRINE COMP FORTE TAB	1
ORPHENADRINE ER 100 MG TABLET	1
PARAFON FORTE DSC 500 MG CAPLT	3
ROBAXIN 500 MG TABLET	3
ROBAXIN-750 TABLET	3
SKELAXIN 800 MG TABLET	3
SOMA 250 MG TABLET	3
SOMA 350 MG TABLET	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
ZANAFLEX 2 MG CAPSULE	3

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZANAFLEX 4 MG CAPSULE	3	
ZANAFLEX 4 MG TABLET	3	
ZANAFLEX 6 MG CAPSULE	3	

SLEEP DISORDER AGENTS

SLEEP DISORDER AGENTS

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
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
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
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
BUTISOL SODIUM 30 MG TABLET	3	
BUTISOL SODIUM 30 MG/5 ML ELX	3	
BUTISOL SODIUM 50 MG TABLET	3	
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
ESZOPICLONE 1 MG TABLET	1	
ESZOPICLONE 2 MG TABLET	1	
ESZOPICLONE 3 MG TABLET	1	
HETLIOZ 20 MG CAPSULE	3	Prior Authorization required;Max. 1 per day LDD*: Diplomat Pharmacy (877) 977-9118
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
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
MODAFINIL 100 MG TABLET	2	Prior Authorization required;Max. 1 per day
MODAFINIL 200 MG TABLET	2	Prior Authorization required;Max. 1 per day
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
PROVIGIL 100 MG TABLET	3	Prior Authorization required;Max. 1 per day
PROVIGIL 200 MG TABLET	3	Prior Authorization required;Max. 1 per day
ROZEREM 8 MG TABLET	3	Step Therapy required STA*: 18 and older
SECONAL SODIUM 100 MG CAPSULE	3	
SILENOR 3 MG TABLET	3	Step Therapy required STA*: 18 and older

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SILENOR 6 MG TABLET	3	Step Therapy required STA*: 18 and older
SONATA 10 MG CAPSULE	3	Step Therapy required STA*: 18 and older
SONATA 5 MG CAPSULE	3	Step Therapy required STA*: 18 and older
XYREM 500 MG/ML ORAL SOLUTION	3	Prior Authorization required;Max. 18 ML(s) per day LDD*: Express Scripts. 866-997-3688 x66247.
ZALEPLON 10 MG CAPSULE	1	
ZALEPLON 5 MG CAPSULE	1	
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

URINE AND FECES CONTENTS

KETONES

CHEMSTRIP K	2	
CVS KETONE CARE TEST STRIPS	2	
DIASCREEN 1K REAGENT STRIPS	2	
KETONE TEST STRIPS	2	
KETOSTIX REAGENT STRIPS	2	
TRUEPLUS KETONE TEST STRIPS	2	

PROTEIN

ALBUSTIX REAGENT STRIPS	3	
CHEMSTRIP MICRAL TEST STRIP	3	

SUGAR

DIASCREEN 1G REAGENT STRIPS	2	HSA*
DIASTIX REAGENT STRIPS	2	HSA*
NO-STICK GLUCOSE TEST STRIPS	2	HSA*

URINE AND FECES CONTENTS

CHEK-STIX STRIPS	2	
CHEMSTRIP 10 MD	2	
CHEMSTRIP 10 WITH SG	2	
CHEMSTRIP 2 GP	2	
CHEMSTRIP 50B	2	
CHEMSTRIP 7	2	
CHEMSTRIP UGK	2	HSA*
CHEMSTRIP-9	2	
COMBISTIX REAGENT STRIPS	2	
DIASCREEN 10 REAGENT STRIPS	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DIASCREEN 1B REAGENT STRIPS	2	
DIASCREEN 2GK REAGENT STRIPS	2	HSA*
DIASCREEN 2GP STRIPS	2	
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*
HEMA-COMBISTIX REAGENT STRIPS	2	
KETO-DIASTIX REAGENT STRIPS	2	HSA*
LABSTIX REAGENT STRIPS	2	
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	
URISTIX 4 REAGENT STRIPS	2	
URISTIX REAGENT STRIPS	2	

VASODILATING AGENTS

VASODILATING AGENTS

ADCIRCA 20 MG TABLET	2	Prior Authorization required;Max. 2 per day SPP*: Must use CVS Specialty
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
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
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
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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
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
LETAIRIS 10 MG TABLET	2	SPP*: Must Use CVS Specialty
LETAIRIS 5 MG TABLET	2	SPP*: Must Use CVS Specialty
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
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
OPSUMIT 10 MG TABLET	2	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
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
SILDENAFIL 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
SILDENAFIL 20 MG TABLET	1	Prior Authorization required SPP*: Must use CVS Specialty
SILDENAFIL 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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SILDENAFIL 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
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
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
TRACLEER 125 MG TABLET	2	SPP*: Must use CVS Specialty
TRACLEER 32 MG TABLET FOR SUSP	2	SPP*: Must use CVS Specialty
TRACLEER 62.5 MG TABLET	2	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
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
VENTAVIS 10 MCG/1 ML SOLUTION	3	SPP*: Must use CVS Specialty
VENTAVIS 20 MCG/1 ML SOLUTION	3	SPP*: Must use CVS Specialty
VIAGRA 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
VIAGRA 25 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
VIAGRA 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

VITAMINS AND MINERALS

VITAMINS AND MINERALS

DRUG NAME	TIER	LIMITATIONS/ * NOTES
B-12 KIT	1	
BACMIN CAPLET	1	
CHOICE-TABS TABLET	1	
CORVITA TABLET	3	
CORVITE TABLET	3	
CVS CHILDREN'S VIT D 400 UNIT	$0	Not covered for members 64 and younger ACA*
CYANOCOBALAMIN 1,000 MCG/ML	1	
DELTA D3 400 UNIT TABLET	$0	Not covered for members 64 and younger ACA*
DIALYVITE TABLET	1	
DIALYVITE WITH ZINC TABLET	1	
DRISDOL 50,000 UNITS CAPSULE	3	HSA*
ELDERCAPS CAPSULE	3	
FEROCON CAPSULE	1	
FERREX 150 FORTE CAPSULE	1	
FERREX 150 FORTE PLUS CAPSULE	1	
FERROCITE PLUS TABLET	1	
FERROGELS FORTE SOFTGEL	1	
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	
FOLPLEX 2.2 TABLET	1	
FOLTRATE TABLET	3	
FORTAVIT SOFTGEL	3	
FUSION SPRINKLES POWDER PACKET	3	
HEMATINIC-FOLIC ACID TABLET	1	
HEMATINIC-VITAMIN-MINERAL TAB	1	
HEMATOGEN FA SOFTGEL	1	
HEMATOGEN FORTE SOFTGEL	1	
HEMATRON LIQUID	3	
HEMOCYTE PLUS CAPSULE	3	
HEMOCYTE-F TABLET	3	
HYDROXOCOBALAMIN 1,000 MCG/ML	1	
IFEREX 150 FORTE CAPSULE	1	
IRON AG-PS-ASC-B12-FA-THRE-SUC	1	
KIDS VITAMIN D3 TAB CHEW	3	
LYSIPLEX PLUS TABLET	3	
MEPHYTON 5 MG TABLET	2	HSA*
MULTICHEW CHEWABLE TABLET	3	
MULTIVITAMINS CHEWABLES TABLET	1	
MULTIVITAMINS PEDIATRIC DROPS	1	
MYFERON-150 FORTE CAPSULE	1	
MYNEPHROCAPS SOFTGEL	1	
MYNEPHRON CAPSULE	2	
NASCOBAL 500 MCG NASAL SPRAY	3	
NEPHRO-VITE RX TABLET	1	
NEPHROCAPS QT TABLET	3	
NEPHROCAPS SOFTGEL	1	
NEPHRON FA TABLET	1	
NEURIN-SL TABLET SL	1	
NOXIFOL-D3 2,500 UNIT-1 MG TAB	3	
NUTRICAP CAPLET	3	
PHYSICIANS EZ USE B-12 KIT	1	
PNV PRENATAL PLUS MULTIVIT TAB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
POLY-IRON 150 FORTE CAPSULE	1	
POLY-VI-FLOR FS 0.25 MG FILM	3	
PRENA1 PEARL SOFTGEL	1	HSA*
PROFERRIN-FORTE TABLET	3	
RENA-VITE RX TABLET	1	
RENAL CAPS SOFTGEL	1	
RENO CAPS SOFTGEL	1	
SIDEROL LIQUID	1	
SODIUM FLUORIDE 0.5 MG/ML DROP	1	ACA*: Children through age 5; HSA
STROVITE FORTE CAPLET	1	
STROVITE ONE CAPLET	3	
STROVITE PLUS CAPLET	1	
SUPERVITE LIQUID	3	
TEXAVITE LQ DROPS	3	
THERAPEUTIC HEMATINIC TAB	1	
TL G-FOL OS TABLET	1	
TL GARD RX TABLET	1	
TL ICON CAPSULE	1	
TRICON CAPSULE	1	
TRIGELS-F FORTE SOFTGEL	1	
TRIPHROCAPS SOFTGEL	1	
V-C FORTE CAPSULE	1	
VIC-FORTE CAPSULE	1	
VINATE DHA GELCAP	1	HSA*
VIRT-CAPS SOFTGEL	1	
VIRT-GARD TABLET	1	
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	Not covered for members 64 and younger ACA*
VITAMIN D-400 TABLET	$0	Not covered for members 64 and younger ACA*
VITAMIN D2 400 UNIT TABLET	$0	Not covered for members 64 and younger 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*
VOL-CARE RX TABLET	1	
VP-VITE RX TABLET	1	

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.