

# Harvard Pilgrim Health Care Prescription Drug List

## PREMIUM FORMULARY THREE-TIER DRUG LIST (2018)

### IN ALPHABETICAL ORDER

This list is subject to change at any time.



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

## About Harvard Pilgrim's formulary

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

## Harvard Pilgrim's 3-Tier Prescription Drug Program

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

## How to use this three-tier prescription drug list

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

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

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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**1**

1ST CHOICE THIN LANCETS	2	HSA*
1ST TIER COMFORTOUCH 28G LANCT	2	HSA*
1ST TIER COMFORTOUCH 30G LANCT	2	HSA*

**8**

8-MOP 10 MG CAPSULE	3	
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**A**

ABACAVIR 20 MG/ML SOLUTION	2	
ABACAVIR 300 MG TABLET	1	
ABACAVIR-LAMIVUDINE 600-300 MG	2	
ABACAVIR-LAMIVUDINE-ZIDOV TAB	1	
ABILIFY 1 MG/ML SOLUTION	NC	
ABILIFY 10 MG TABLET	NC	
ABILIFY 15 MG TABLET	NC	
ABILIFY 2 MG TABLET	NC	
ABILIFY 20 MG TABLET	NC	
ABILIFY 30 MG TABLET	NC	
ABILIFY 5 MG TABLET	NC	
ABILIFY DISCMELT 10 MG TABLET	NC	
ABILIFY DISCMELT 15 MG TABLET	NC	
ABSORICA 10 MG CAPSULE	NC	
ABSORICA 20 MG CAPSULE	NC	
ABSORICA 25 MG CAPSULE	NC	
ABSORICA 30 MG CAPSULE	NC	
ABSORICA 35 MG CAPSULE	NC	
ABSORICA 40 MG CAPSULE	NC	
ABSTRAL 100 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 200 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 300 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 400 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 600 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ABSTRAL 800 MCG TAB SUBLINGUAL	3	Prior Authorization required;Max. 120 per 30 days
ACAMPROSATE CALC DR 333 MG TAB	1	
ACANYA GEL PUMP	NC	
ACARBOSE 100 MG TABLET	1	HSA*
ACARBOSE 25 MG TABLET	1	HSA*
ACARBOSE 50 MG TABLET	1	HSA*
ACCOLATE 10 MG TABLET	NC	
ACCOLATE 20 MG TABLET	NC	
ACCU-CHEK ACTIVE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK AVIVA PLUS TEST STRP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK AVIVA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACCU-CHEK CMFRT CURVE STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
ACCU-PRIL 10 MG TABLET	NC	
ACCU-PRIL 20 MG TABLET	NC	
ACCU-PRIL 40 MG TABLET	NC	
ACCU-PRIL 5 MG TABLET	NC	
ACCURETIC 10-12.5 MG TABLET	NC	
ACCURETIC 20-12.5 MG TABLET	NC	
ACCURETIC 20-25 MG TABLET	NC	
ACCU-TREND GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACE AEROSOL CLOUD ENHANCER	MD	
ACEBUTOLOL 200 MG CAPSULE	1	HSA*
ACEBUTOLOL 400 MG CAPSULE	1	HSA*
ACEON 4 MG TABLET	NC	
ACEON 8 MG TABLET	NC	
ACETAMIN-CAFF-DIHYDROCOD 320.5	1	
ACETAMIN-CAFF-DIHYDROCOD 325	1	
ACETAMINOP-CODEINE 120-12 MG/5	1	
ACETAMINOPH-CAFF-DIHYDROCODEIN	1	
ACETAMINOPHEN-COD #2 TABLET	1	
ACETAMINOPHEN-COD #3 TABLET	1	
ACETAMINOPHEN-COD #4 TABLET	1	
ACETAMINOPHN-COD 360-36 MG SOL	1	
ACETASOL HC EAR DROPS	1	
ACETAZOLAMIDE 125 MG TABLET	1	
ACETAZOLAMIDE 250 MG TABLET	1	
ACETAZOLAMIDE ER 500 MG CAP	1	
ACETIC ACID 2% EAR SOLUTION	1	
ACETYLCYSTEINE 10% VIAL	1	
ACETYLCYSTEINE 20% VIAL	1	
ACID REDUCER 20 MG TABLET	1	
ACIPHEX DR 20 MG TABLET	NC	
ACIPHEX SPRINKLE DR 10 MG CAP	3	
ACIPHEX SPRINKLE DR 5 MG CAP	3	
ACITRETIN 10 MG CAPSULE	1	
ACITRETIN 17.5 MG CAPSULE	1	
ACITRETIN 25 MG CAPSULE	1	
ACTEMRA 162 MG/0.9 ML SYRINGE	3	Prior Authorization required;Max. 3.6 ML(s) in 30 days SPP*: Must use CVS Specialty
ACTI-LANCE LITE 28G LANCETS	2	HSA*
ACTI-LANCE SPECIAL 17G LANCETS	2	HSA*
ACTI-LANCE UNIVERS 23G LANCETS	2	HSA*
ACTICLATE 150 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ACTICLATE 75 MG TABLET	NC	
ACTIGALL 300 MG CAPSULE	NC	
ACTIMMUNE 100 MCG/0.5 ML VIAL	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
ACTIQ 1,200 MCG LOZENGE	NC	
ACTIQ 1,600 MCG LOZENGE	NC	
ACTIQ 200 MCG LOZENGE	NC	
ACTIQ 400 MCG LOZENGE	NC	
ACTIQ 600 MCG LOZENGE	NC	
ACTIQ 800 MCG LOZENGE	NC	
ACTIVELLA 0.5-0.1 MG TABLET	NC	
ACTIVELLA 1 MG-0.5 MG TABLET	NC	
ACTONEL 150 MG TABLET	NC	
ACTONEL 30 MG TABLET	NC	
ACTONEL 35 MG TABLET	NC	
ACTONEL 5 MG TABLET	NC	
ACTOPLUS MET 15 MG-500 MG TAB	NC	
ACTOPLUS MET 15 MG-850 MG TAB	NC	
ACTOPLUS MET XR 15-1,000 MG TB	2	HSA*
ACTOPLUS MET XR 30-1,000 MG TB	2	HSA*
ACTOS 15 MG TABLET	NC	
ACTOS 30 MG TABLET	NC	
ACTOS 45 MG TABLET	NC	
ACUICYN EYELID-EYELASH CLEANSR	3	
ACULAR 0.5% EYE DROPS	NC	
ACULAR LS 0.4% OPHTH SOL	NC	
ACURA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ACUVAIL 0.45% OPHTH SOLUTION	3	Max. 1 per day
ACYCLOVIR 200 MG CAPSULE	1	
ACYCLOVIR 200 MG/5 ML SUSP	1	
ACYCLOVIR 400 MG TABLET	1	
ACYCLOVIR 5% OINTMENT	1	Max. 15 GM(s) in 30 days
ACYCLOVIR 800 MG TABLET	1	
ACZONE 5% GEL	3	
ACZONE 7.5% GEL PUMP	3	
ADALAT CC 30 MG TABLET	NC	
ADALAT CC 60 MG TABLET	NC	
ADALAT CC 90 MG TABLET	NC	
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
ADCIRCA 20 MG TABLET	2	Prior Authorization required;Max. 2 per day SPP*: Must use CVS Specialty
ADDERALL 10 MG TABLET	NC	
ADDERALL 12.5 MG TABLET	NC	
ADDERALL 15 MG TABLET	NC	
ADDERALL 20 MG TABLET	NC	
ADDERALL 30 MG TABLET	NC	
ADDERALL 5 MG TABLET	NC	
ADDERALL 7.5 MG TABLET	NC	
ADDERALL XR 10 MG CAPSULE	NC	
ADDERALL XR 15 MG CAPSULE	NC	
ADDERALL XR 20 MG CAPSULE	NC	
ADDERALL XR 25 MG CAPSULE	NC	
ADDERALL XR 30 MG CAPSULE	NC	
ADDERALL XR 5 MG CAPSULE	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ADDYI 100 MG TABLET	3	Covered for females only;Prior Authorization required;Max. 1 per day
ADEFOVIR DIPIVOXIL 10 MG TAB	1	
ADEMPAS 0.5 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 1 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 1.5 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 2 MG TABLET	2	SPP*: Must use CVS Specialty
ADEMPAS 2.5 MG TABLET	2	SPP*: Must use CVS Specialty
ADENOVIRUS TYPE 4 & 7 EC TABS	3	
ADENOVIRUS TYPE 4 EC TABLET	3	
ADENOVIRUS TYPE 7 EC TABLET	3	
ADLYXIN 10-20 MCG STARTER PACK	3	Max. 4 ML(s) per 28 days;Step Therapy required HSA*
ADLYXIN 20 MCG MAINTENANCE PK	3	Max. 4 ML(s) per 28 days;Step Therapy required HSA*
ADOXA 150 MG CAPSULE	NC	
ADRENALICK 0.15 MG AUTO-INJECT	NC	
ADRENALICK 0.3 MG AUTO-INJECT	NC	
ADRENALIN 1 MG/ML NASAL SOLN	3	
ADVAIR 100-50 DISKUS	2	Max. 60 in 30 days HSA*
ADVAIR 250-50 DISKUS	2	Max. 60 in 30 days HSA*
ADVAIR 500-50 DISKUS	2	Max. 60 in 30 days HSA*
ADVAIR HFA 115-21 MCG INHALER	2	Max. 12 GM(s) in 30 days HSA*
ADVAIR HFA 230-21 MCG INHALER	2	Max. 12 GM(s) in 30 days HSA*
ADVAIR HFA 45-21 MCG INHALER	2	Max. 12 GM(s) in 30 days HSA*
ADVANCED TRAVEL 28G LANCETS	2	HSA*
ADVANCED TRAVEL 30G LANCETS	2	HSA*
ADVATE 2,401-3,600 UNIT VIAL	MD	SPP*: Must use CVS Specialty
ADVICOR 1,000 MG-20 MG TABLET	2	HSA*
ADVICOR 1,000 MG-40 MG TABLET	2	HSA*
ADVICOR 500 MG-20 MG TABLET	2	HSA*
ADVICOR 750 MG-20 MG TABLET	2	HSA*
ADVOCATE 26G LANCETS	2	HSA*
ADVOCATE 26G LANCETS	2	HSA*
ADVOCATE 30G LANCETS	2	HSA*
ADVOCATE REDI-CODE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ADVOCATE REDI-CODE+ TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ADVOCATE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ADYNOVATE 1,251-2,500 UNIT VL	MD	SPP*: Must use CVS Specialty
ADZENYS XR-ODT 12.5 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 15.7 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 18.8 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 3.1 MG TABLET	3	Max. 60 Days Supply

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ADZENYS XR-ODT 6.3 MG TABLET	3	Max. 60 Days Supply
ADZENYS XR-ODT 9.4 MG TABLET	3	Max. 60 Days Supply
AEROCHAMBER MINI	MD	
AEROCHAMBER MV HOLD CHAMBER	MD	
AEROCHAMBER PLUS FLOW-VU	MD	
AEROCHAMBER PLUS FLOW-VU SMALL	MD	
AEROCHAMBER PLUS W-FLOWSIGNAL	MD	
AEROCHAMBER PLUS Z STAT MEDIUM	MD	
AEROCHAMBER Z-STAT PLUS W-FLOW	MD	
AEROGear ASTHMA ACTION KIT	MD	
AEROSPAN 80 MCG INHALER	3	HSA*
AEROTRACH HOLDING CHAMBER	MD	
AEROVENT PLUS HOLDING CHAMBER	MD	
AFEDITAB CR 30 MG TABLET	1	HSA*
AFEDITAB CR 60 MG TABLET	1	HSA*
AFINITOR 10 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR 2.5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR 5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR 7.5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR DISPERZ 2 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR DISPERZ 3 MG TABLET	3	CH*; SPP*: CVS Specialty
AFINITOR DISPERZ 5 MG TABLET	3	CH*; SPP*: CVS Specialty
AFLURIA 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
AFLURIA 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
AFLURIA QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
AFLURIA QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
AFREZZA 12 UNIT CARTRIDGE	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 30-4 UNIT / 60-8 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 4 UNIT CARTRIDGE	3	Prior Authorization required;Max. 6 per day HSA*
AFREZZA 4 UNIT/8 UNIT/12 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 60-8 UNIT / 30-12 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 8 UNIT CARTRIDGE	3	Prior Authorization required;Max. 15 per day HSA*
AFREZZA 90-4 UNIT / 90-8 UNIT	3	Prior Authorization required;Max. 15 per day HSA*
AFSTYLA 500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
AFTERA 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
AGAMATRIX AMP TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
AGGRENOX 25 MG-200 MG CAPSULE	NC	
AGRYLIN 0.5 MG CAPSULE	NC	
AIRDUO RESPICLICK 113-14 MCG	NC	
AIRDUO RESPICLICK 232-14 MCG	NC	
AIRDUO RESPICLICK 55-14 MCG	NC	
AIRZONE PEAK FLOW METER	MD	
AKNE-MYCIN 2% OINTMENT	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AKTIPAK 3%-5% GEL POUCH	NC	
AKYNZEO 300-0.5 MG CAPSULE	3	Max. quantity of 1 per fill;Max. 3 in 30 days MQC*: 1 cap/copay, Max. 3 caps/28 day-supply
ALA-CORT 1% CREAM	1	
ALA-CORT 2.5% CREAM	1	
ALA-QUIN 3-0.5% CREAM	3	
ALA-SCALP 2% LOTION	1	
ALAGESIC LQ ORAL SOLUTION	1	
ALBENZA 200 MG TABLET	3	
ALBUSTIX REAGENT STRIPS	3	
ALBUTEROL 5 MG/ML SOLUTION	1	HSA*
ALBUTEROL SUL 0.63 MG/3 ML SOL	1	HSA*
ALBUTEROL SUL 1.25 MG/3 ML SOL	1	HSA*
ALBUTEROL SUL 2.5 MG/3 ML SOLN	1	HSA*
ALBUTEROL SULF 2 MG/5 ML SYRUP	1	HSA*
ALBUTEROL SULFATE 2 MG TAB	1	HSA*
ALBUTEROL SULFATE 4 MG TAB	1	HSA*
ALBUTEROL SULFATE ER 4 MG TAB	1	HSA*
ALBUTEROL SULFATE ER 8 MG TAB	1	HSA*
ALCAINE 0.5% EYE DROPS	1	
ALCLOMETASONE DIPR 0.05% OINT	1	
ALCLOMETASONE DIPRO 0.05% CRM	1	
ALDACTAZIDE 25-25 TABLET	NC	
ALDACTAZIDE 50-50 TABLET	3	HSA*
ALDACTONE 100 MG TABLET	NC	
ALDACTONE 25 MG TABLET	NC	
ALDACTONE 50 MG TABLET	NC	
ALDARA 5% CREAM	NC	
ALECENSA 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ALENDRONATE SOD 70 MG/75 ML	1	Max. 75 ML(s) per 7 days HSA*
ALENDRONATE SODIUM 10 MG TAB	1	HSA*
ALENDRONATE SODIUM 35 MG TAB	1	Max. 4 per 28 days HSA*
ALENDRONATE SODIUM 40 MG TAB	1	HSA*
ALENDRONATE SODIUM 5 MG TABLET	1	HSA*
ALENDRONATE SODIUM 70 MG TAB	1	Max. 4 per 28 days HSA*
ALEVICYN ANTIPRURITIC GEL	3	
ALEVICYN ANTIPRURITIC SG GEL	3	
ALEVICYN DERMAL SPRAY	3	
ALFENTANIL 500 MCG/ML AMPUL	1	
ALFENTANIL 500 MCG/ML AMPULE	NC	
ALFUZOSIN HCL ER 10 MG TABLET	1	Max. 1 per day
ALINIA 100 MG/5 ML SUSPENSION	3	
ALINIA 500 MG TABLET	3	
ALKERAN 2 MG TABLET	NC	
ALLERGIST PACK 26GX1/2" 1 ML	3	
ALLERGIST PACK 26GX3/8" 1 ML	3	
ALLERGIST PACK 27GX1/2" 1 ML	3	
ALLERGY SYRINGE 1 ML 27GX1/2"	3	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALLERGY SYRINGE 1 ML 27GX3/8"	3	
ALLOPURINOL 100 MG TABLET	1	
ALLOPURINOL 300 MG TABLET	1	
ALLZITAL 25-325 MG TABLET	3	
ALMOTRIPTAN MALATE 12.5 MG TAB	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ALMOTRIPTAN MALATE 6.25 MG TAB	1	Max. quantity of 12 per fill MQC*: 12 tabs/copay
ALOCRIIL 2% EYE DROPS	3	
ALODOX CONVENIENCE KIT	3	
ALOGLIPTIN 12.5 MG TABLET	NC	
ALOGLIPTIN 25 MG TABLET	NC	
ALOGLIPTIN 6.25 MG TABLET	NC	
ALOGLIPTIN-METFORMIN 12.5-1000	NC	
ALOGLIPTIN-METFORMIN 12.5-500	NC	
ALOGLIPTIN-PIOGLIT 12.5-15 MG	NC	
ALOGLIPTIN-PIOGLIT 12.5-30 MG	NC	
ALOGLIPTIN-PIOGLIT 12.5-45 MG	NC	
ALOGLIPTIN-PIOGLIT 25-15 MG TB	NC	
ALOGLIPTIN-PIOGLIT 25-30 MG TB	NC	
ALOGLIPTIN-PIOGLIT 25-45 MG TB	NC	
ALOMIDE 0.1% EYE DROPS	3	
ALORA 0.025 MG PATCH	3	
ALORA 0.05 MG PATCH	3	
ALORA 0.075 MG PATCH	3	
ALORA 0.1 MG PATCH	3	
ALOSETRON HCL 0.5 MG TABLET	1	Covered for females only
ALOSETRON HCL 1 MG TABLET	1	Covered for females only
ALPHAGAN P 0.1% DROPS	2	
ALPHAGAN P 0.15% EYE DROPS	NC	
ALPHANATE 2,000-800 UNIT VIAL	MD	SPP*: Must use CVS Specialty
ALPHANINE SD 1,500 UNITS VIAL	MD	SPP*: Must use CVS Specialty
ALPRAZOLAM 0.25 MG TABLET	1	
ALPRAZOLAM 0.5 MG TABLET	1	
ALPRAZOLAM 1 MG TABLET	1	
ALPRAZOLAM 1 MG/ML ORAL CONC	3	
ALPRAZOLAM 2 MG TABLET	1	
ALPRAZOLAM ER 0.5 MG TABLET	1	
ALPRAZOLAM ER 1 MG TABLET	1	
ALPRAZOLAM ER 2 MG TABLET	1	
ALPRAZOLAM ER 3 MG TABLET	1	
ALPRAZOLAM ODT 0.25 MG TAB	1	
ALPRAZOLAM ODT 0.5 MG TAB	1	
ALPRAZOLAM ODT 1 MG TAB	1	
ALPRAZOLAM ODT 2 MG TAB	1	
ALPROLIX 3,000 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
ALREX 0.2% EYE DROPS	3	
ALSUMA 6 MG/0.5 ML AUTO-INJECT	2	Max. quantity of 3 per fill MQC*: 6 injections/copay
ALTABAX 1% OINTMENT	3	
ALTACAINE 0.5% EYE DROPS	1	
ALTACE 1.25 MG CAPSULE	NC	
ALTACE 10 MG CAPSULE	NC	
ALTACE 2.5 MG CAPSULE	NC	
ALTACE 5 MG CAPSULE	NC	
ALTAFLUOR EYE DROPS	1	
ALTAVERA-28 TABLET	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ALTERNATE SITE 26G LANCETS	2	HSA*
ALTOPREV 20 MG TABLET	NC	
ALTOPREV 40 MG TABLET	NC	
ALTOPREV 60 MG TABLET	NC	
ALUNBRIG 30 MG TABLET	3	Prior Authorization required;Max. 6 per day PA NTM*; CH*; SPP*: CVS Specialty
ALUVEA 39% CREAM	NC	
ALVESCO 160 MCG INHALER	3	HSA*
ALVESCO 80 MCG INHALER	3	HSA*
ALYACEN 1-35-28 TABLET	0	ACA*
ALYACEN 7-7-7-28 TABLET	0	ACA*
AMABELZ 0.5 MG-0.1 MG TABLET	1	
AMABELZ 1 MG-0.5 MG TABLET	1	
AMANTADINE 100 MG CAPSULE	1	
AMANTADINE 100 MG TABLET	1	
AMANTADINE 50 MG/5 ML SOLUTION	1	
AMARYL 1 MG TABLET	NC	
AMARYL 2 MG TABLET	NC	
AMARYL 4 MG TABLET	NC	
AMBIEN 10 MG TABLET	NC	
AMBIEN 5 MG TABLET	NC	
AMBIEN CR 12.5 MG TABLET	NC	
AMBIEN CR 6.25 MG TABLET	NC	
AMBITUSSIN AC LIQUID	1	
AMCINONIDE 0.1% CREAM	1	
AMCINONIDE 0.1% LOTION	1	
AMCINONIDE 0.1% OINTMENT	1	
AMERGE 1 MG TABLET	NC	
AMERGE 2.5 MG TABLET	NC	
AMETHIA 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
AMETHIA LO TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
AMETHYST 90-20 MCG TABLET	NC	
AMICAR 0.25 GRAM/ML ORAL SOLN	2	
AMICAR 1,000 MG TABLET	2	
AMICAR 500 MG TABLET	2	
AMILORIDE HCL 5 MG TABLET	1	HSA*
AMILORIDE HCL-HCTZ 5-50 MG TAB	1	HSA*
AMINOCAPROIC ACID 1,000 MG TAB	1	
AMINOCAPROIC ACID 25% SOLUTION	1	
AMINOCAPROIC ACID 500 MG TAB	1	
AMIODARONE HCL 100 MG TABLET	1	
AMIODARONE HCL 200 MG TABLET	1	
AMIODARONE HCL 400 MG TABLET	1	
AMITIZA 24 MCG CAPSULES	2	
AMITIZA 8 MCG CAPSULE	2	
AMITRIPTYLINE HCL 10 MG TAB	1	
AMITRIPTYLINE HCL 100 MG TAB	1	
AMITRIPTYLINE HCL 150 MG TAB	1	
AMITRIPTYLINE HCL 25 MG TAB	1	
AMITRIPTYLINE HCL 50 MG TAB	1	
AMITRIPTYLINE HCL 75 MG TAB	1	
AMLOD-VALSA-HCTZ 10-160-12.5MG	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AMLOD-VALSA-HCTZ 10-160-25 MG	1	HSA*
AMLOD-VALSA-HCTZ 10-320-25 MG	1	HSA*
AMLOD-VALSA-HCTZ 5-160-12.5 MG	1	HSA*
AMLOD-VALSA-HCTZ 5-160-25 MG	1	HSA*
AMLODIPINE BESYLATE 10 MG TAB	1	HSA*
AMLODIPINE BESYLATE 2.5 MG TAB	1	HSA*
AMLODIPINE BESYLATE 5 MG TAB	1	HSA*
AMLODIPINE-ATORVAST 10-10 MG	1	HSA*
AMLODIPINE-ATORVAST 10-20 MG	1	HSA*
AMLODIPINE-ATORVAST 10-40 MG	1	HSA*
AMLODIPINE-ATORVAST 10-80 MG	1	HSA*
AMLODIPINE-ATORVAST 2.5-10 MG	1	HSA*
AMLODIPINE-ATORVAST 2.5-20 MG	1	HSA*
AMLODIPINE-ATORVAST 2.5-40 MG	1	HSA*
AMLODIPINE-ATORVAST 5-10 MG	1	HSA*
AMLODIPINE-ATORVAST 5-20 MG	1	HSA*
AMLODIPINE-ATORVAST 5-40 MG	1	HSA*
AMLODIPINE-ATORVAST 5-80 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 10-20 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 10-40 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 2.5-10	1	HSA*
AMLODIPINE-BENAZEPRIL 5-10 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 5-20 MG	1	HSA*
AMLODIPINE-BENAZEPRIL 5-40 MG	1	HSA*
AMLODIPINE-OLMESARTAN 10-20 MG	2	HSA*
AMLODIPINE-OLMESARTAN 10-40 MG	2	HSA*
AMLODIPINE-OLMESARTAN 5-20 MG	2	HSA*
AMLODIPINE-OLMESARTAN 5-40 MG	2	HSA*
AMLODIPINE-VALSARTAN 10-160 MG	1	HSA*
AMLODIPINE-VALSARTAN 10-320 MG	1	HSA*
AMLODIPINE-VALSARTAN 5-160 MG	1	HSA*
AMLODIPINE-VALSARTAN 5-320 MG	1	HSA*
AMMONIUM LACTATE 12% CREAM	1	
AMMONIUM LACTATE 12% LOTION	1	
AMNESTEEM 10 MG CAPSULE	1	
AMNESTEEM 20 MG CAPSULE	1	
AMNESTEEM 40 MG CAPSULE	1	
AMOX-CLAV 200-28.5 MG TAB CHEW	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
AMOX-CLAV 200-28.5 MG/5 ML SUS	1	
AMOX-CLAV 250-125 MG TABLET	1	
AMOX-CLAV 250-62.5 MG/5 ML SUS	1	
AMOX-CLAV 400-57 MG TAB CHEW	1	
AMOX-CLAV 400-57 MG/5 ML SUSP	1	
AMOX-CLAV 500-125 MG TABLET	1	
AMOX-CLAV 600-42.9 MG/5 ML SUS	1	
AMOX-CLAV 875-125 MG TABLET	1	
AMOX-CLAV ER 1,000-62.5 MG TAB	1	
AMOXAPINE 100 MG TABLET	1	
AMOXAPINE 150 MG TABLET	1	
AMOXAPINE 25 MG TABLET	1	
AMOXAPINE 50 MG TABLET	1	
AMOXICILLIN 125 MG TAB CHEW	1	
AMOXICILLIN 125 MG/5 ML SUSP	1	
AMOXICILLIN 200 MG/5 ML SUSP	1	
AMOXICILLIN 250 MG CAPSULE	1	
AMOXICILLIN 250 MG TAB CHEW	1	
AMOXICILLIN 250 MG/5 ML SUSP	1	
AMOXICILLIN 400 MG/5 ML SUSP	1	
AMOXICILLIN 500 MG CAPSULE	1	
AMOXICILLIN 500 MG TABLET	1	
AMOXICILLIN 875 MG TABLET	1	
AMOXICILLIN ER 775 MG TABLET	1	
AMPICILLIN 125 MG/5 ML SUSP	1	
AMPICILLIN 250 MG CAPSULE	1	
AMPICILLIN 250 MG/5 ML SUSP	1	
AMPICILLIN 500 MG CAPSULE	1	
AMPYRA ER 10 MG TABLET	3	Max. 2 per day SPP*: Must use CVS Specialty
AMRIX ER 15 MG CAPSULE	3	
AMRIX ER 30 MG CAPSULE	3	
AMTURNIDE 150-5-12.5 MG TAB	2	Max. 1.5 per day HSA*
AMTURNIDE 300-10-12.5 MG TAB	2	Max. 1 per day HSA*
AMTURNIDE 300-10-25 MG TAB	2	Max. 1 per day HSA*
AMTURNIDE 300-5-12.5 MG TAB	2	Max. 1 per day HSA*
AMTURNIDE 300-5-25 MG TAB	2	Max. 1 per day HSA*
AMYL NITRITE AMPUL	1	
ANACAINE OINTMENT	3	
ANADROL-50 TABLET	3	Max. 30 Days Supply
ANAFRANIL 25 MG CAPSULE	NC	
ANAFRANIL 50 MG CAPSULE	NC	
ANAFRANIL 75 MG CAPSULE	NC	
ANAGRELIDE HCL 0.5 MG CAPSULE	1	HSA*
ANAGRELIDE HCL 1 MG CAPSULE	1	HSA*
ANALPRAM HC 1% CREAM	3	
ANALPRAM HC 2.5%-1% CREAM	NC	
ANALPRAM HC 2.5%-1% LOTION	2	
ANAPROX 275 MG TABLET	NC	
ANAPROX DS 550 MG TABLET	NC	
ANASTROZOLE 1 MG TABLET	1	CH*; HSA*
ANCOBON 250 MG CAPSULE	NC	
ANCOBON 500 MG CAPSULE	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
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	NC	
ANDROGEL 1%(2.5G) GEL PACKET	NC	
ANDROGEL 1%(5G) GEL PACKET	NC	
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	NC	
ANDROXY 10 MG TABLET	1	Max. 30 Days Supply
ANGELIQ 0.25 MG-0.5 MG TABLET	3	
ANGELIQ 0.5 MG-1 MG TABLET	3	
ANORO ELLIPTA 62.5-25 MCG INH	2	Max. quantity of 60 per fill;Max. 60 in 30 days HSA*
ANTABUSE 250 MG TABLET	NC	
ANTABUSE 500 MG TABLET	NC	
ANTARA 130 MG CAPSULE	NC	
ANTARA 30 MG CAPSULE	3	HSA*
ANTARA 43 MG CAPSULE	NC	
ANTARA 90 MG CAPSULE	3	HSA*
ANTIPYRINE-BENZOCAINE EAR DROP	3	
ANTIPYRINE-BENZOCAINE OTIC SOL	1	
ANUCORT-HC 25 MG SUPPOSITORY	1	
ANUSOL-HC 2.5% CREAM	NC	
ANUSOL-HC 25 MG SUPPOSITORY	NC	
ANZEMET 100 MG TABLET	3	Max. quantity of 6 per fill MQC*: 3 tabs/copay
ANZEMET 50 MG TABLET	3	Max. quantity of 6 per fill MQC*: 6 tabs/copay
APEXICON E 0.05% CREAM	3	
APIDRA 100 UNITS/ML VIAL	3	HSA*
APIDRA SOLOSTAR 100 UNITS/ML	3	HSA*
APLENZIN ER 174 MG TABLET	NC	
APLENZIN ER 348 MG TABLET	NC	
APLENZIN ER 522 MG TABLET	NC	
APOKYN 30 MG/3 ML CARTRIDGE	3	
APRACLONIDINE HCL 0.5% DROPS	1	
APREPITANT 125 MG CAPSULE	2	Max. 30 Days Supply;Max. quantity of 1 per fill MQC*: 1 cap/copay
APREPITANT 125-80-80 MG PACK	2	Max. 30 Days Supply;Max. quantity of 3 per fill MQC*: 1 pack/copay
APREPITANT 40 MG CAPSULE	2	Max. 30 Days Supply;Max. quantity of 4 per fill MQC*: 4 caps/copay
APREPITANT 80 MG CAPSULE	2	Max. 30 Days Supply;Max. quantity of 2 per fill MQC*: 2 caps/copay
APRI 28 DAY TABLET	0	ACA*
APRISO ER 0.375 GRAM CAPSULE	2	
APTENSIO XR 10 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 15 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 20 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 30 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 40 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 50 MG CAPSULE	3	Max. 60 Days Supply
APTENSIO XR 60 MG CAPSULE	3	Max. 60 Days Supply
APTIOM 200 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
APTIOM 400 MG TABLET	3	
APTIOM 600 MG TABLET	3	
APTIOM 800 MG TABLET	3	
APTIVUS 100 MG/ML SOLUTION	3	
APTIVUS 250 MG CAPSULE	3	
AQUA GLYCOLIC HC 2% KIT	3	
ARALAST NP 1,000 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ARANELLE 28 TABLET	0	ACA*
ARANESP 10 MCG/0.4 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.6 per fill SPP*: CVS Specialty
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 SYRINGE	3	Prior Authorization required;Max. quantity of 1.68 per fill SPP*: CVS Specialty
ARANESP 25 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 300 MCG/0.6 ML SYRINGE	3	Prior Authorization required;Max. quantity of 2.4 per fill SPP*: CVS Specialty
ARANESP 300 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 40 MCG/0.4 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.6 per fill SPP*: CVS Specialty
ARANESP 40 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 500 MCG/1 ML SYRINGE	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARANESP 60 MCG/0.3 ML SYRINGE	3	Prior Authorization required;Max. quantity of 1.2 per fill SPP*: CVS Specialty
ARANESP 60 MCG/ML VIAL	3	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
ARAVA 10 MG TABLET	NC	
ARAVA 20 MG TABLET	NC	
ARBINOXA 4 MG TABLET	1	
ARBINOXA 4 MG/5 ML LIQUID	1	
ARCAPTA NEOHALER 75 MCG CAP	3	Max. 1 per day HSA*
ARICEPT 10 MG TABLET	NC	
ARICEPT 23 MG TABLET	NC	
ARICEPT 5 MG TABLET	NC	
ARICEPT ODT 10 MG TABLET	NC	
ARICEPT ODT 5 MG TABLET	NC	
ARIMIDEX 1 MG TABLET	NC	
ARIPIRAZOLE 1 MG/ML SOLUTION	1	
ARIPIRAZOLE 10 MG TABLET	1	
ARIPIRAZOLE 15 MG TABLET	1	
ARIPIRAZOLE 2 MG TABLET	1	
ARIPIRAZOLE 20 MG TABLET	1	
ARIPIRAZOLE 30 MG TABLET	1	
ARIPIRAZOLE 5 MG TABLET	1	
ARIPIRAZOLE ODT 10 MG TABLET	1	
ARIPIRAZOLE ODT 15 MG TABLET	1	
ARIXTRA 10 MG/0.8 ML SYRINGE	NC	
ARIXTRA 2.5 MG/0.5 ML SYRINGE	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ARIXTRA 5 MG/0.4 ML SYRINGE	NC	
ARIXTRA 7.5 MG/0.6 ML SYRINGE	NC	
ARMODAFINIL 150 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMODAFINIL 200 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMODAFINIL 250 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMODAFINIL 50 MG TABLET	2	Prior Authorization required;Max. 1 per day
ARMONAIR RESPICLICK 113 MCG	3	Prior Authorization required HSA*; PA NTM*
ARMONAIR RESPICLICK 232 MCG	3	Prior Authorization required HSA*; PA NTM*
ARMONAIR RESPICLICK 55 MCG	3	Prior Authorization required HSA*; PA NTM*
ARMOUR THYROID 120 MG TABLET	3	
ARMOUR THYROID 15 MG TABLET	3	
ARMOUR THYROID 180 MG TABLET	3	
ARMOUR THYROID 240 MG TABLET	3	
ARMOUR THYROID 30 MG TABLET	3	
ARMOUR THYROID 300 MG TABLET	3	
ARMOUR THYROID 60 MG TABLET	3	
ARMOUR THYROID 90 MG TABLET	3	
ARNUITY ELLIPTA 100 MCG INH	3	HSA*
ARNUITY ELLIPTA 200 MCG INH	3	HSA*
AROMASIN 25 MG TABLET	NC	
ARTHROTEC 50 MG-200 MCG TAB	NC	
ARTHROTEC 75 MG-200 MCG TAB	NC	
ARYMO ER 15 MG TABLET	3	Max. 3 per day
ARYMO ER 30 MG TABLET	3	Max. 3 per day
ARYMO ER 60 MG TABLET	3	Max. 3 per day
ASACOL HD DR 800 MG TABLET	NC	
ASCOMP WITH CODEINE CAPSULE	1	
ASEPTO BULB SYRINGES GLASS	3	
ASHLYNA 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
ASMANEX HFA 100 MCG INHALER	2	HSA*
ASMANEX HFA 200 MCG INHALER	2	HSA*
ASMANEX TWISTHALER 110 MCG #30	2	HSA*
ASMANEX TWISTHALER 220 MCG #14	2	HSA*
ASMANEX TWISTHALER 220 MCG #30	2	HSA*
ASMANEX TWISTHALER 220 MCG #60	2	HSA*
ASMANEX TWISTHALR 220 MCG #120	2	HSA*
ASPIR-LOW EC 81 MG TABLET	0	ACA*
ASPIR-TRIN EC 325 MG TABLET	0	ACA*
ASPIRIN 300 MG SUPPOSITORY	0	ACA*
ASPIRIN 325 MG TABLET	0	ACA*
ASPIRIN 600 MG SUPPOSITORY	0	ACA*
ASPIRIN 81 MG CHEWABLE TABLET	0	ACA*
ASPIRIN EC 325 MG TABLET	0	ACA*
ASPIRIN EC 500 MG TABLET	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ASPIRIN EC 650 MG TABLET	0	ACA*
ASPIRIN EC 81 MG TABLET	0	ACA*
ASPIRIN EC 975 MG TABLET	0	ACA*
ASPIRIN-CAFF-DIHYDROCODEIN CAP	1	
ASPIRIN-DIPYRIDAM ER 25-200 MG	1	HSA*
ASSESS PEAK FLOW METER	MD	
ASSURE 4 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASSURE COMFORT 30G LANCETS	2	HSA*
ASSURE HAEMOLANCE PLUS 18G	2	HSA*
ASSURE HAEMOLANCE PLUS 21G	2	HSA*
ASSURE HAEMOLANCE PLUS 25G	2	HSA*
ASSURE HAEMOLANCE PLUS 28G	2	HSA*
ASSURE HAEMOLANCE PLUS BLADE	2	HSA*
ASSURE LANCE 25G LANCETS	2	HSA*
ASSURE LANCE 28G LANCETS	2	HSA*
ASSURE LANCE PLUS 21G LANCETS	2	HSA*
ASSURE LANCE PLUS 25G LANCETS	2	HSA*
ASSURE LANCE PLUS 30G LANCETS	2	HSA*
ASSURE PLATINUM TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASSURE PRISM MULTI TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASSURE PRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ASTAGRAF XL 0.5 MG CAPSULE	3	
ASTAGRAF XL 1 MG CAPSULE	3	
ASTAGRAF XL 5 MG CAPSULE	3	
ASTELIN 137 MCG NASAL SPRAY	NC	
ASTEPRO 0.15% NASAL SPRAY	NC	
ASTHMA CHECK PEAK FLOW MTR	MD	
ASTHMAMENTOR PEAK FLOW MTR	MD	
ASTHMAPACK CHILDREN'S CARE KIT	MD	
ATACAND 16 MG TABLET	NC	
ATACAND 32 MG TABLET	NC	
ATACAND 4 MG TABLET	NC	
ATACAND 8 MG TABLET	NC	
ATACAND HCT 16-12.5 MG TAB	NC	
ATACAND HCT 32-12.5 MG TAB	NC	
ATACAND HCT 32-25 MG TABLET	NC	
ATELVIA DR 35 MG TABLET	NC	
ATENOLOL 100 MG TABLET	1	HSA*
ATENOLOL 25 MG TABLET	1	HSA*
ATENOLOL 50 MG TABLET	1	HSA*
ATENOLOL-CHLORTHALIDONE 100-25	1	HSA*
ATENOLOL-CHLORTHALIDONE 50-25	1	HSA*
ATIVAN 0.5 MG TABLET	NC	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
ATIVAN 1 MG TABLET	NC	
ATIVAN 2 MG TABLET	NC	
ATOMOXETINE HCL 10 MG CAPSULE	2	
ATOMOXETINE HCL 100 MG CAPSULE	2	
ATOMOXETINE HCL 18 MG CAPSULE	2	
ATOMOXETINE HCL 25 MG CAPSULE	2	
ATOMOXETINE HCL 40 MG CAPSULE	2	
ATOMOXETINE HCL 60 MG CAPSULE	2	
ATOMOXETINE HCL 80 MG CAPSULE	2	
ATOPICLAIR CREAM	NC	
ATORVASTATIN 10 MG TABLET	0	ACA*
ATORVASTATIN 20 MG TABLET	0	ACA*
ATORVASTATIN 40 MG TABLET	1	HSA*
ATORVASTATIN 80 MG TABLET	1	HSA*
ATOVAQUONE 750 MG/5 ML SUSP	1	
ATOVAQUONE-PROGUANIL 250-100	1	
ATOVAQUONE-PROGUANIL 62.5-25	1	
ATRALIN 0.05% GEL	NC	
ATRAPRO DERMAL SPRAY	3	
ATRAPRO HYDROGEL	3	
ATRIPLA TABLET	2	
ATROPINE 0.01%-NS EYE DROPS	1	
ATROPINE 1% EYE DROPS	1	
ATROPINE 1% EYE OINTMENT	1	
ATROPINE CARE 1% EYE DROPS	1	
ATROVENT 0.03% SPRAY	NC	
ATROVENT 0.06% SPRAY	NC	
ATROVENT HFA INHALER	2	HSA*
AUBAGIO 14 MG TABLET	3	Max. 1 per day SPP*: Must use CVS Specialty
AUBAGIO 7 MG TABLET	3	Max. 1 per day SPP*: Must use CVS Specialty
AUBRA-28 TABLET	0	ACA*
AUGMENTIN 125-31.25 MG/5 ML	2	
AUGMENTIN 250-62.5 MG/5 ML	NC	
AUGMENTIN 500-125 TABLET	NC	
AUGMENTIN 875-125 TABLET	NC	
AUGMENTIN ES-600 SUSPENSION	NC	
AUGMENTIN XR 1,000-62.5 TAB	NC	
AURODEX OTIC SOLUTION	1	
AUROGUARD OTIC SOLUTION	3	
AURORA SUPER THIN 30G LANCETS	2	HSA*
AURSTAT ANTI-ITCH HYDROGEL KIT	NC	
AURYXIA 210 MG TABLET	3	
AUSTEDO 12 MG TABLET	3	Prior Authorization required;Max. 2 per day LDD*: Cardinal Health Specialty (888) 662-9779; PA NTM*
AUSTEDO 6 MG TABLET	3	Prior Authorization required;Max. 2 per day LDD*: Cardinal Health Specialty (888) 662-9779; PA NTM*
AUSTEDO 9 MG TABLET	3	Prior Authorization required;Max. 2 per day LDD*: Cardinal Health Specialty (888) 662-9779; PA NTM*
AUVI-Q 0.15 MG AUTO-INJECTOR	NC	
AUVI-Q 0.3 MG AUTO-INJECTOR	NC	
AVALIDE 150-12.5 MG TABLET	NC	
AVALIDE 300-12.5 MG TABLET	NC	

AVANDAMET 2 MG-1,000 MG TAB	2	HSA*
AVANDAMET 2 MG-500 MG TABLET	2	HSA*
AVANDAMET 4 MG-1,000 MG TABLET	2	HSA*
AVANDAMET 4 MG-500 MG TABLET	2	HSA*
AVANDARYL 4 MG-1 MG TABLET	2	HSA*
AVANDARYL 4 MG-2 MG TABLET	2	HSA*
AVANDARYL 4 MG-4 MG TABLET	2	HSA*
AVANDARYL 8 MG-2 MG TABLET	2	HSA*
AVANDARYL 8 MG-4 MG TABLET	2	HSA*
AVANDIA 2 MG TABLET	2	HSA*
AVANDIA 4 MG TABLET	2	HSA*
AVANDIA 8 MG TABLET	2	HSA*
AVAPRO 150 MG TABLET	NC	
AVAPRO 300 MG TABLET	NC	
AVAPRO 75 MG TABLET	NC	
AVAR CLEANSER	NC	
AVAR LS 10%-2% FOAM	3	
AVAR LS CLEANSER	NC	
AVAR-E EMOLLIENT CREAM	NC	
AVAR-E LS CREAM	NC	
AVC 15% CREAM	2	
AVELOX 400 MG TABLET	NC	
AVELOX ABC PACK 400 MG TAB	NC	
AVENOVA LID-LASH SPRAY	3	
AVIANE-28 TABLET	0	ACA*
AVIDOXY 100 MG TABLET	NC	
AVINZA 120 MG CAPSULE	NC	
AVINZA 30 MG CAPSULE	NC	
AVINZA 45 MG CAPSULE	NC	
AVINZA 60 MG CAPSULE	NC	
AVINZA 75 MG CAPSULE	NC	
AVINZA 90 MG CAPSULE	NC	
AVITA 0.025% CREAM	1	Prior Authorization required for members 30 and older
AVITA 0.025% GEL	1	Prior Authorization required for members 30 and older
AVITENE FLOUR	3	
AVITENE SHEET 35MMX35MM	3	
AVITENE SHEET 70MMX35MM	3	
AVITENE SHEET 70MMX70MM	3	
AVO CREAM TOPICAL EMULSION	1	
AVODART 0.5 MG SOFTGEL	NC	
AVONEX 30 MCG VIAL KIT	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
AVONEX PEN 30 MCG/0.5 ML KIT	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
AVONEX PREFILLED SYR 30 MCG KT	2	Max. 30 Days Supply SPP*: Must use CVS Specialty
AXERT 12.5 MG TABLET	NC	
AXERT 6.25 MG TABLET	NC	
AXID 15 MG/ML ORAL SOLUTION	NC	
AXIRON 30 MG/ACTUATION SOLN	3	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 180 ML(s) in 30 days
AYGESTIN 5 MG TABLET	NC	
AZASAN 100 MG TABLET	2	
AZASAN 75 MG TABLET	2	

AZASITE 1% EYE DROPS	3	
AZATHIOPRINE 50 MG TABLET	1	
AZELASTINE 0.1% (137 MCG) SPRY	1	
AZELASTINE 0.15% NASAL SPRAY	1	
AZELASTINE HCL 0.05% DROPS	1	
AZELEX 20% CREAM	2	
AZILECT 0.5 MG TABLET	NC	
AZILECT 1 MG TABLET	NC	
AZITHROMYCIN 1 GM PWD PACKET	1	
AZITHROMYCIN 100 MG/5 ML SUSP	1	
AZITHROMYCIN 200 MG/5 ML SUSP	1	
AZITHROMYCIN 250 MG TABLET	1	
AZITHROMYCIN 500 MG TABLET	1	
AZITHROMYCIN 600 MG TABLET	1	
AZOPT 1% EYE DROPS	2	
AZOR 10-20 MG TABLET	NC	
AZOR 10-40 MG TABLET	NC	
AZOR 5-20 MG TABLET	NC	
AZOR 5-40 MG TABLET	NC	
AZULFIDINE 500 MG TABLET	NC	
AZULFIDINE ENTAB 500 MG	NC	
AZURETTE 28 DAY TABLET	0	ACA*

## B

B-12 KIT	1	
B-PLEX TABLET	1	
BACITRACIN 500 UNIT/GM OPHTH	1	
BACITRACIN-POLYMYXIN EYE OINT	1	
BACLOFEN 10 MG TABLET	1	
BACLOFEN 20 MG TABLET	1	
BACMIN CAPLET	1	
BACTRIM 400-80 MG TABLET	NC	
BACTRIM DS TABLET	NC	
BACTROBAN 2% CREAM	NC	
BACTROBAN 2% OINTMENT	NC	
BACTROBAN NASAL 2% OINTMENT	3	
BALSALAZIDE DISODIUM 750 MG CP	1	
BALZIVA 28 TABLET	0	ACA*
BANZEL 200 MG TABLET	2	
BANZEL 40 MG/ML SUSPENSION	2	
BANZEL 400 MG TABLET	2	
BARACLUDE 0.05 MG/ML SOLUTION	2	
BARACLUDE 0.5 MG TABLET	NC	
BARACLUDE 1 MG TABLET	NC	
BASAGLAR 100 UNIT/ML KWIKPEN	3	Prior Authorization required HSA*
BAXDELA 450 MG TABLET	3	Prior Authorization required;Max. 2 per day
BAYER ADVANCED 500 MG TABLET	0	ACA*
BAYER PLUS 500 MG CAPLET	0	ACA*
BD 1 ML SYRINGE WITH NEEDLE	3	
BD 1 ML SYRINGE-NEEDLE 25GX5/8	3	
BD 10 ML SYRINGE	3	
BD 10 ML SYRINGE 20GX1"	3	
BD 10 ML SYRINGE 20GX1-1/2"	3	
BD 10 ML SYRINGE 21GX1"	3	
BD 10 ML SYRINGE 21GX1-1/2"	3	
BD 10 ML SYRINGE 22GX1"	3	

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

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BD SAFETYGLIDE SYR 22GX1.5"	3	
BD SAFETYGLIDE TB 1 ML SYR	3	
BD SLIP TIP 5 ML SYRINGE	3	
BD SLIP TIP 60 ML SYRINGE	3	
BD SLIP-TIP SYRINGE 20 ML	3	
BD SYR 0.3 ML 6MMX31G (1/2)	2	HSA*
BD SYRINGE 10 ML	3	
BD SYRINGE 2 ML	3	
BD SYRINGE 20 ML	3	
BD SYRINGE 3 ML	3	
BD SYRINGE 3 ML	3	
BD SYRINGE 30 ML	3	
BD SYRINGE 30 ML	3	
BD SYRINGE 5 ML	3	
BD SYRINGE 50 ML	3	
BD SYRINGE GLASS 3 ML	3	
BD SYRINGE WITH CANNULA	3	
BD SYRINGE-SAFETY GLIDE	3	
BD SYRINGE-SAFETY GLIDE	3	
BD TB SYRINGE 21GX1"	3	
BD TB SYRINGE 22GX1"	3	
BD TB SYRINGE 25GX5/8"	3	
BD TB SYRINGE 26GX3/8"	3	
BD TB SYRINGE 27GX1/2"	3	
BD TB SYRNGE 27GX1/2"	3	
BD TUBERCULIN 1 ML SYRINGE	3	
BD ULTRA-FINE 33G LANCETS	2	HSA*
BD ULTRA-FINE II 30G LANCETS	2	HSA*
BD ULTRA-FINE PEN NDL 4MMX32G	2	HSA*
BEAU RX SCAR CARE GEL	3	
BEBULIN 200-1,200 UNITS VIAL	MD	SPP*: Must use CVS Specialty
BECONASE AQ 0.042% SPRAY	NC	
BEKYREE 28 DAY TABLET	0	ACA*
BELBUCA 150 MCG FILM	3	Max. 2 per day
BELBUCA 300 MCG FILM	3	Max. 2 per day
BELBUCA 450 MCG FILM	3	Max. 2 per day
BELBUCA 600 MCG FILM	3	Max. 2 per day
BELBUCA 75 MCG FILM	3	Max. 2 per day
BELBUCA 750 MCG FILM	3	Max. 2 per day
BELBUCA 900 MCG FILM	3	Max. 2 per day
BELLADONNA-OPIUM 16.2-30 SUPP	1	
BELLADONNA-OPIUM 16.2-60 SUPP	1	
BELSOMRA 10 MG TABLET	3	Max. 1 per day;Step Therapy required STA*: 18 and older
BELSOMRA 15 MG TABLET	3	Max. 1 per day;Step Therapy required STA*: 18 and older
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
BENZAEPRIIL HCL 10 MG TABLET	1	HSA*
BENZAEPRIIL HCL 20 MG TABLET	1	HSA*
BENZAEPRIIL HCL 40 MG TABLET	1	HSA*
BENZAEPRIIL HCL 5 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BENAZEPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
BENAZEPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
BENAZEPRIL-HCTZ 20-25 MG TAB	1	HSA*
BENAZEPRIL-HCTZ 5-6.25 MG TAB	1	HSA*
BENEFIX 2,000 UNIT RANGE	MD	SPP*: Must use CVS Specialty
BENICAR 20 MG TABLET	NC	
BENICAR 40 MG TABLET	NC	
BENICAR 5 MG TABLET	NC	
BENICAR HCT 20-12.5 MG TABLET	NC	
BENICAR HCT 40-12.5 MG TABLET	NC	
BENICAR HCT 40-25 MG TABLET	NC	
BENLYSTA 200 MG/ML AUTOINJECT	3	Prior Authorization required;Max. 4 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
BENLYSTA 200 MG/ML SYRINGE	3	Prior Authorization required;Max. 4 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
BENOXYLDOXY 30 KIT	3	
BENOXYLDOXY 60 KIT	3	
BENSAL HP 3% OINTMENT	3	
BENTYL 10 MG CAPSULE	NC	
BENTYL 20 MG TABLET	NC	
BENZAC AC 5% GEL	NC	
BENZAC AC WASH 10% LIQUID	NC	
BENZACLIN GEL 50G PUMP	NC	
BENZAMYCIN GEL	NC	
BENZODOX 30 KIT	3	
BENZODOX 60 KIT	3	
BENZONATATE 100 MG CAPSULE	1	
BENZONATATE 150 MG CAPSULE	1	
BENZONATATE 200 MG CAPSULE	1	
BENZTROPINE MES 0.5 MG TAB	1	
BENZTROPINE MES 1 MG TABLET	1	
BENZTROPINE MES 2 MG TABLET	1	
BEPREVE 1.5% EYE DROPS	NC	
BESIVANCE 0.6% SUSP	3	
BETADINE 5% EYE SOLUTION	NC	
BETAGAN 0.5% EYE DROPS	NC	
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	
BETAPACE 160 MG TABLET	NC	
BETAPACE 240 MG TABLET	NC	
BETAPACE 80 MG TABLET	NC	
BETAPACE AF 120 MG TABLET	NC	
BETASERON 0.3 MG KIT	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
BETAXOLOL 10 MG TABLET	1	HSA*
BETAXOLOL 20 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BETAXOLOL HCL 0.5% EYE DROP	1	
BETHANECHOL 10 MG TABLET	1	
BETHANECHOL 25 MG TABLET	1	
BETHANECHOL 5 MG TABLET	1	
BETHANECHOL 50 MG TABLET	1	
BETHKIS 300 MG/4 ML AMPULE	2	SPP*: Must use CVS Specialty
BETIMOL 0.25% EYE DROPS	2	
BETIMOL 0.5% EYE DROPS	2	
BETOPTIC S 0.25% EYE DROPS	2	
BEVESPI AEROSPHERE INHALER	3	
BEVYXXA 40 MG CAPSULE	3	Prior Authorization required;Max. 1 per day HSA*; PA NTM*
BEVYXXA 80 MG CAPSULE	3	Prior Authorization required;Max. 1 per day HSA*; PA NTM*
BEXAROTENE 75 MG CAPSULE	1	CH*
BEYAZ 28 TABLET	NC	
BG-STAR GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
BHT POWDER	3	
BIAFINE EMULSION	NC	
BIAXIN 250 MG TABLET	NC	
BIAXIN 250 MG/5 ML SUSPENSION	NC	
BIAXIN 500 MG TABLET	NC	
BIAXIN XL 500 MG TABLET	NC	
BICALUTAMIDE 50 MG TABLET	1	CH*
BIDIL TABLET	2	
BILTRICIDE 600 MG TABLET	3	
BIMATOPROST 0.03% EYE DROPS	1	
BINOSTO 70 MG TABLET EFF	3	Max. 4 per 28 days HSA*
BIONECT 0.2% CREAM	3	
BIONECT 0.2% FOAM	3	
BIONECT 0.2% GEL	3	
BIONECT 0.2% SPRAY	3	
BISOPROLOL FUMARATE 10 MG TAB	1	HSA*
BISOPROLOL FUMARATE 5 MG TAB	1	HSA*
BISOPROLOL-HCTZ 10-6.25 MG TAB	1	HSA*
BISOPROLOL-HCTZ 2.5-6.25 MG TB	1	HSA*
BISOPROLOL-HCTZ 5-6.25 MG TAB	1	HSA*
BLEPH-10 10% EYE DROPS	1	
BLEPHAMIDE EYE DROPS	2	
BLEPHAMIDE EYE OINTMENT	2	
BLISOVI 24 FE TABLET	0	ACA*
BLISOVI FE 1-20 TABLET	0	ACA*
BLISOVI FE 1.5-30 TABLET	0	ACA*
BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
BLOOD GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
BLOOD LANCETS 30G	2	HSA*
BONIVA 150 MG TABLET	NC	
BONIVA 3 MG/3 ML SYRINGE	MD	HSA*; SPP*: Must use CVS Specialty



DRUG NAME	TIER	LIMITATIONS/ * NOTES
BOSULIF 100 MG TABLET	3	CH*; SPP*: CVS Specialty
BOSULIF 500 MG TABLET	3	CH*; SPP*: CVS Specialty
BOTOX 100 UNITS VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
BOTOX 200 UNITS VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
BP CLEANSING WASH	1	
BPO 4% GEL	1	
BPO 8% GEL	1	
BRAVELLE 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
BREATHERITE MDI SPACER	MD	
BREATHRITE VALVED MDI CHAMBER	MD	
BREEZE 2 DISC TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
BREO ELLIPTA 100-25 MCG INH	2	Max. 2 per day HSA*
BREO ELLIPTA 200-25 MCG INH	2	Max. 2 per day HSA*
BREVICON 28 TABLET	0	ACA*
BRIELLYN TABLET	0	ACA*
BRILINTA 60 MG TABLET	2	HSA*
BRILINTA 90 MG TABLET	2	HSA*
BRIMONIDINE 0.2% EYE DROP	1	
BRIMONIDINE TARTRATE 0.15% DRP	1	
BRINTELLIX 10 MG TABLET	3	Step Therapy required STA*: 18 and older
BRINTELLIX 20 MG TABLET	3	Step Therapy required STA*: 18 and older
BRINTELLIX 5 MG TABLET	3	Step Therapy required STA*: 18 and older
BRISDELLE 7.5 MG CAPSULE	3	Step Therapy required
BRIVIACT 10 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 10 MG/ML ORAL SOLN	3	Prior Authorization required
BRIVIACT 100 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 25 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 50 MG TABLET	3	Prior Authorization required;Max. 2 per day
BRIVIACT 75 MG TABLET	3	Prior Authorization required;Max. 2 per day
BROMFED DM COUGH SYRUP	1	
BROMFENAC SODIUM 0.09% EYE DRP	1	
BROMOCRIPTINE 2.5 MG TABLET	1	
BROMOCRIPTINE 5 MG CAPSULE	1	
BROMPHENIR-PSEUDOEPHED-DM SYR	1	
BROMSITE 0.075% EYE DROPS	3	
BROVANA 15 MCG/2 ML SOLUTION	3	HSA*
BUCALSEP SOLUTION	3	
BUDEPRION SR 100 MG TABLET	1	
BUDEPRION SR 150 MG TABLET	1	
BUDESONIDE 0.25 MG/2 ML SUSP	1	HSA*
BUDESONIDE 0.5 MG/2 ML SUSP	1	HSA*
BUDESONIDE 1 MG/2 ML INH SUSP	1	HSA*
BUDESONIDE 32 MCG NASAL SPRAY	NC	
BUDESONIDE EC 3 MG CAPSULE	1	
BULLSEYE MINI SAFETY 21G	2	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BULLSEYE MINI SAFETY 25G LANCT	2	HSA*
BUMETANIDE 0.5 MG TABLET	1	HSA*
BUMETANIDE 1 MG TABLET	1	HSA*
BUMETANIDE 2 MG TABLET	1	HSA*
BUNAVAIL 2.1-0.3 MG FILM	3	Max. 3 per day
BUNAVAIL 4.2-0.7 MG FILM	3	Max. 3 per day
BUNAVAIL 6.3-1 MG FILM	3	Max. 2 per day
BUPAP 50 MG-300 MG TABLET	NC	
BUPHENYL 500 MG TABLET	3	
BUPHENYL POWDER	NC	
BUPRENORPHIN-NALOXON 8-2 MG SL	1	
BUPRENORPHINE 10 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 15 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 2 MG TABLET SL	1	
BUPRENORPHINE 20 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 5 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 7.5 MCG/HR PATCH	2	Max. 4 per 28 days
BUPRENORPHINE 8 MG TABLET SL	1	
BUPRENORPHN-NALOXN 2-0.5 MG SL	1	
BUPROBAN 150 MG TABLET	0	Max. 180 Days Supply ACA*
BUPROPION HCL 100 MG TABLET	1	
BUPROPION HCL 75 MG TABLET	1	
BUPROPION HCL SR 100 MG TABLET	1	
BUPROPION HCL SR 150 MG TABLET	0	Max. 180 Days Supply ACA*
BUPROPION HCL SR 150 MG TABLET	0	Max. 180 Days Supply;Max. 180 in 365 days ACA*
BUPROPION HCL SR 150 MG TABLET	1	
BUPROPION HCL SR 200 MG TABLET	1	
BUPROPION HCL XL 150 MG TABLET	1	
BUPROPION HCL XL 300 MG TABLET	1	
BUSPIRONE HCL 10 MG TABLET	1	
BUSPIRONE HCL 15 MG TABLET	1	
BUSPIRONE HCL 30 MG TABLET	1	
BUSPIRONE HCL 5 MG TABLET	1	
BUSPIRONE HCL 7.5 MG TABLET	1	
BUTALB-ACETAMIN-CAFF 50-300-40	1	
BUTALB-ACETAMIN-CAFF 50-325-40	1	
BUTALB-ACETAMIN-CAFF 50-500-40	1	
BUTALB-ACETAMINOPH-CAFF-CODEIN	1	
BUTALB-ASPIRIN-CAFFE 50-325-40	1	
BUTALB-CAFF-ACETAMINOPH-CODEIN	1	
BUTALBIT-ACETAMINOPHEN-CAFF CP	1	
BUTALBITAL COMP-CODEINE #3 CAP	1	
BUTALBITAL-ACETAMINOPHN 50-300	1	
BUTALBITAL-ACETAMINOPHN 50-325	1	
BUTALBITAL-ASA-CAFFEINE CAP	1	
BUTISOL SODIUM 30 MG TABLET	3	
BUTISOL SODIUM 30 MG/5 ML ELX	3	
BUTISOL SODIUM 50 MG TABLET	3	
BUTORPHANOL 10 MG/ML SPRAY	1	
BUTRANS 10 MCG/HR PATCH	NC	
BUTRANS 15 MCG/HR PATCH	NC	
BUTRANS 20 MCG/HR PATCH	NC	
BUTRANS 5 MCG/HR PATCH	NC	
BUTRANS 7.5 MCG/HR PATCH	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
BYDUREON 2 MG PEN INJECT	2	Max. 4 per 28 days;Step Therapy required HSA*
BYDUREON 2 MG VIAL	2	Max. 4 per 28 days;Step Therapy required HSA*
BYETTA 10 MCG DOSE PEN INJ	2	Max. 2.4 ML(s) per 30 days;Step Therapy required HSA*
BYETTA 5 MCG DOSE PEN INJ	2	Max. 1.2 ML(s) per 30 days;Step Therapy required HSA*
BYSTOLIC 10 MG TABLET	2	HSA*
BYSTOLIC 2.5 MG TABLET	2	HSA*
BYSTOLIC 20 MG TABLET	2	HSA*
BYSTOLIC 5 MG TABLET	2	HSA*
BYVALSON 5 MG-80 MG TABLET	2	HSA*

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CABERGOLINE 0.5 MG TABLET	1	
CABOMETYX 20 MG TABLET	3	Max. 1 per day CH*; SPP*: CVS Specialty
CABOMETYX 40 MG TABLET	3	Max. 1 per day CH*; SPP*: CVS Specialty
CABOMETYX 60 MG TABLET	3	Max. 1 per day CH*; SPP*: CVS Specialty
CADUET 10 MG-10 MG TABLET	NC	
CADUET 10 MG-20 MG TABLET	NC	
CADUET 10 MG-40 MG TABLET	NC	
CADUET 10 MG-80 MG TABLET	NC	
CADUET 2.5 MG-10 MG TABLET	NC	
CADUET 2.5 MG-20 MG TABLET	NC	
CADUET 2.5 MG-40 MG TABLET	NC	
CADUET 5 MG-10 MG TABLET	NC	
CADUET 5 MG-20 MG TABLET	NC	
CADUET 5 MG-40 MG TABLET	NC	
CADUET 5 MG-80 MG TABLET	NC	
CAFICIT 20 MG/ML ORAL SOLN	NC	
CAFERGOT TABLET	NC	
CAFFEINE CIT 60 MG/3 ML ORAL	1	
CALAN 120 MG TABLET	NC	
CALAN 80 MG TABLET	NC	
CALAN SR 120 MG CAPLET	NC	
CALAN SR 180 MG CAPLET	NC	
CALAN SR 240 MG CAPLET	NC	
CALCIPOTRIENE 0.005% CREAM	1	
CALCIPOTRIENE 0.005% OINTMENT	1	
CALCIPOTRIENE 0.005% SOLUTION	1	
CALCIPOTRIENE-BETAMETH DP OINT	1	
CALCITONIN-SALMON 200 UNITS SP	1	
CALCITRENE 0.005% OINTMENT	1	
CALCITRIOL 0.25 MCG CAPSULE	1	
CALCITRIOL 0.5 MCG CAPSULE	1	
CALCITRIOL 1 MCG/ML SOLUTION	1	
CALCITRIOL 3 MCG/G OINTMENT	1	
CALCIUM ACETATE 667 MG GELCAP	1	
CALCIUM ACETATE 667 MG TABLET	1	
CAMBIA 50 MG POWDER PACKET	3	
CAMILA 0.35 MG TABLET	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CAMPRAL DR 333 MG TABLET	NC	
CAMRESE 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
CAMRESE LO TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
CANASA 1,000 MG SUPPOSITORY	2	
CANDESARTAN CILEXETIL 16 MG TB	1	HSA*
CANDESARTAN CILEXETIL 32 MG TB	1	HSA*
CANDESARTAN CILEXETIL 4 MG TAB	1	HSA*
CANDESARTAN CILEXETIL 8 MG TAB	1	HSA*
CANDESARTAN-HCTZ 16-12.5 MG TB	1	HSA*
CANDESARTAN-HCTZ 32-12.5 MG TB	1	HSA*
CANDESARTAN-HCTZ 32-25 MG TAB	1	HSA*
CANTIL 25 MG TABLET	3	
CAPACET CAPSULE	1	
CAPECITABINE 150 MG TABLET	1	CH*; SPP*: CVS Specialty
CAPECITABINE 500 MG TABLET	1	CH*; SPP*: CVS Specialty
CAPEX SHAMPOO	2	
CAPHOSOL SOLUTION	3	
CAPITAL WITH CODEINE SUSP	3	
CAPRELSA 100 MG TABLET	3	CH*
CAPRELSA 300 MG TABLET	3	CH*
CAPTOPRIL 100 MG TABLET	1	HSA*
CAPTOPRIL 12.5 MG TABLET	1	HSA*
CAPTOPRIL 25 MG TABLET	1	HSA*
CAPTOPRIL 50 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 25-15 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 25-25 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 50-15 MG TABLET	1	HSA*
CAPTOPRIL-HCTZ 50-25 MG TABLET	1	HSA*
CARAC 0.5% CREAM	NC	
CARAFATE 1 GM TABLET	NC	
CARAFATE 1 GM/10 ML SUSP	2	
CARBAGLU 200 MG DISPER TABLET	3	LDD*: Accredo (866) 815-4717
CARBAMAZEPINE 100 MG TAB CHEW	1	
CARBAMAZEPINE 100 MG/5 ML SUSP	1	
CARBAMAZEPINE 200 MG TABLET	1	
CARBAMAZEPINE ER 100 MG CAP	1	
CARBAMAZEPINE ER 100 MG TABLET	1	
CARBAMAZEPINE ER 200 MG CAP	1	
CARBAMAZEPINE ER 200 MG TABLET	1	
CARBAMAZEPINE ER 300 MG CAP	1	
CARBAMAZEPINE ER 400 MG TABLET	1	
CARBATROL ER 100 MG CAPSULE	3	
CARBATROL ER 200 MG CAPSULE	3	
CARBATROL ER 300 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CARBIDOPA 25 MG TABLET	1	
CARBIDOPA-LEVO 10-100 MG ODT	1	
CARBIDOPA-LEVO 25-100 MG ODT	1	
CARBIDOPA-LEVO 25-250 MG ODT	1	
CARBIDOPA-LEVO ER 25-100 TAB	1	
CARBIDOPA-LEVO ER 50-200 TAB	1	
CARBIDOPA-LEVODOPA 10-100 TAB	1	
CARBIDOPA-LEVODOPA 25-100 TAB	1	
CARBIDOPA-LEVODOPA 25-250 TAB	1	
CARBIDOPA-LEVODOPA-ENTA 100 MG	1	
CARBIDOPA-LEVODOPA-ENTA 125 MG	1	
CARBIDOPA-LEVODOPA-ENTA 150 MG	1	
CARBIDOPA-LEVODOPA-ENTA 200 MG	1	
CARBIDOPA-LEVODOPA-ENTA 50 MG	1	
CARBIDOPA-LEVODOPA-ENTA 75 MG	1	
CARBINOXAMINE 4 MG/5 ML LIQUID	1	
CARBINOXAMINE MALEATE 4 MG TAB	1	
CARDENE SR 30 MG CAPSULE	3	
		HSA*
CARDENE SR 60 MG CAPSULE	3	
		HSA*
CARDIOVID PLUS SOFTGEL	1	
CARDIZEM 120 MG TABLET	NC	
CARDIZEM 30 MG TABLET	NC	
CARDIZEM 60 MG TABLET	NC	
CARDIZEM 90 MG TABLET	NC	
CARDIZEM CD 120 MG CAPSULE	NC	
CARDIZEM CD 180 MG CAPSULE	NC	
CARDIZEM CD 240 MG CAPSULE	NC	
CARDIZEM CD 300 MG CAPSULE	NC	
CARDIZEM CD 360 MG CAPSULE	NC	
CARDIZEM LA 120 MG TABLET	3	
		HSA*
CARDIZEM LA 180 MG TABLET	NC	
CARDIZEM LA 240 MG TABLET	NC	
CARDIZEM LA 300 MG TABLET	NC	
CARDIZEM LA 360 MG TABLET	NC	
CARDIZEM LA 420 MG TABLET	NC	
CARDURA 1 MG TABLET	NC	
CARDURA 2 MG TABLET	NC	
CARDURA 4 MG TABLET	NC	
CARDURA 8 MG TABLET	NC	
CARDURA XL 4 MG TABLET	3	
		HSA*
CARDURA XL 8 MG TABLET	3	
		HSA*
CAREONE ULTRA THIN LANCET	2	
		HSA*
CAREPOINT LUER SLIP 1 ML SYRNG	3	
CARESENS N TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CARESENS ULTRA THIN 30G LANCET	2	
		HSA*
CARETOUCH TWIST 28G LANCET	2	
		HSA*
CARETOUCH TWIST 30G LANCET	2	
		HSA*
CARISOPRODL-ASPIRIN 200-325 MG	1	
CARISOPRODOL 250 MG TABLET	1	
CARISOPRODOL 350 MG TABLET	1	
CARISOPRODOL-ASPIRIN-CODEIN TB	1	
CARNITOR 330 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CARNITOR SF 100 MG/ML ORAL SOL	3	
CAROSPIR 25 MG/5 ML SUSPENSION	3	Prior Authorization required HSA*; PA NTM*
CARTEOLOL HCL 1% EYE DROPS	1	
CARTIA XT 120 MG CAPSULE	1	HSA*
CARTIA XT 180 MG CAPSULE	1	HSA*
CARTIA XT 240 MG CAPSULE	1	HSA*
CARTIA XT 300 MG CAPSULE	1	HSA*
CARVEDILOL 12.5 MG TABLET	1	HSA*
CARVEDILOL 25 MG TABLET	1	HSA*
CARVEDILOL 3.125 MG TABLET	1	HSA*
CARVEDILOL 6.25 MG TABLET	1	HSA*
CASODEX 50 MG TABLET	NC	
CATAFLAM 50 MG TABLET	NC	
CATAPRES 0.1 MG TABLET	NC	
CATAPRES 0.2 MG TABLET	NC	
CATAPRES 0.3 MG TABLET	NC	
CATAPRES-TTS 1 PATCH	NC	
CATAPRES-TTS 2 PATCH	NC	
CATAPRES-TTS 3 PATCH	NC	
CAVERJECT 20 MCG VIAL	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
CAVERJECT 40 MCG VIAL	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
CAVERJECT IMPULSE 10 MCG KIT	2	Not covered for members 17 and younger; Max. 6 in 30 days
CAVERJECT IMPULSE 20 MCG KIT	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
CAYA CONTOURED DIAPHRAGM	0	ACA*
CAYSTON 75 MG INHAL SOLUTION	3	LDD*: IV Solutions. 1-800-658-6046.
CAZIAN 28 DAY TABLET	0	ACA*
CEDAX 180 MG/5 ML SUSPENSION	NC	
CEDAX 400 MG CAPSULE	NC	
CEFACTOR 125 MG/5 ML SUSP	1	
CEFACTOR 250 MG CAPSULE	1	
CEFACTOR 250 MG/5 ML SUSP	1	
CEFACTOR 375 MG/5 ML SUSPEN	1	
CEFACTOR 500 MG CAPSULE	1	
CEFACTOR 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	

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CETROTIDE 3 MG KIT	2	Max. 30 Days Supply IVF*
CETYLEV 2.5 GM EFF TABLET	3	Max. quantity of 20 per fill
CETYLEV 500 MG EFF TABLET	3	Max. quantity of 20 per fill
CEVIMELINE HCL 30 MG CAPSULE	1	
CHANTIX 0.5 MG TABLET	0	Max. 182 Days Supply ACA*
CHANTIX 1 MG CONT MONTH BOX	0	Max. 182 Days Supply
CHANTIX 1 MG TABLET	0	Max. 182 Days Supply ACA*
CHANTIX STARTING MONTH BOX	0	Max. 182 Days Supply ACA*
CHATEAL-28 TABLET	0	ACA*
CHEK-STIX STRIPS	2	
CHEMET 100 MG CAPSULE	2	
CHEMSTRIP 10 MD	2	
CHEMSTRIP 10 WITH SG	2	
CHEMSTRIP 2 GP	2	
CHEMSTRIP 50B	2	
CHEMSTRIP 7	2	
CHEMSTRIP K	2	
CHEMSTRIP MICRAL TEST STRIP	3	
CHEMSTRIP UGK	2	HSA*
CHEMSTRIP-9	2	
CHENODAL 250 MG TABLET	3	LDD*: Dohmen Life Sciences (800) 305-7881
CHERATUSSIN AC SYRUP	1	
CHERATUSSIN DAC SYRUP	1	
CHLORDIAZEPO-AMITRIPTYL 5-12.5	1	
CHLORDIAZEPOX-AMITRIPTYL 10-25	1	
CHLORDIAZEPOXIDE 10 MG CAPSULE	1	
CHLORDIAZEPOXIDE 25 MG CAPSULE	1	
CHLORDIAZEPOXIDE 5 MG CAPSULE	1	
CHLORDIAZEPOXIDE-CLIDINIUM CAP	1	
CHLORHEXIDINE 0.12% RINSE	1	
CHLOROQUINE PH 250 MG TABLET	1	
CHLOROQUINE PH 500 MG TABLET	1	
CHLOROTHIAZIDE 250 MG TABLET	1	HSA*
CHLOROTHIAZIDE 500 MG TABLET	1	HSA*
CHLORPROMAZINE 10 MG TABLET	1	
CHLORPROMAZINE 100 MG TABLET	1	
CHLORPROMAZINE 200 MG TABLET	1	
CHLORPROMAZINE 25 MG TABLET	1	
CHLORPROMAZINE 50 MG TABLET	1	
CHLORPROPAMIDE 100 MG TABLET	1	HSA*
CHLORPROPAMIDE 250 MG TABLET	1	HSA*
CHLORTHALIDONE 25 MG TABLET	1	HSA*
CHLORTHALIDONE 50 MG TABLET	1	HSA*
CHLORZOAZONE 250 MG TABLET	1	
CHLORZOAZONE 500 MG TABLET	1	
CHOICE-TABS TABLET	1	
CHOICEDM CLARUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CHOICEDM G20 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CHOLBAM 250 MG CAPSULE	3	



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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CIPROFLOXACIN HCL 250 MG TAB	1	
CIPROFLOXACIN HCL 500 MG TAB	1	
CIPROFLOXACIN HCL 750 MG TAB	1	
CITALOPRAM HBR 10 MG TABLET	1	
CITALOPRAM HBR 10 MG/5 ML SOLN	1	
CITALOPRAM HBR 20 MG TABLET	1	
CITALOPRAM HBR 40 MG TABLET	1	
CLARAVIS 10 MG CAPSULE	1	
CLARAVIS 20 MG CAPSULE	1	
CLARAVIS 30 MG CAPSULE	1	
CLARAVIS 40 MG CAPSULE	1	
CLARINEX 0.5 MG/ML (2.5 MG/5)	3	
CLARINEX 5 MG TABLET	NC	
CLARINEX-D 12 HOUR TABLET	3	
CLARINEX-D 24 HOUR TABLET	3	
CLARIS CLARIFYING WASH	NC	
CLARITHROMYCIN 125 MG/5 ML SUS	1	
CLARITHROMYCIN 250 MG TABLET	1	
CLARITHROMYCIN 250 MG/5 ML SUS	1	
CLARITHROMYCIN 500 MG TABLET	1	
CLARITHROMYCIN ER 500 MG TAB	1	
CLEMASTINE 0.5 MG/5 ML SYRUP	1	
CLEMASTINE FUM 2.68 MG TAB	1	
CLEOCIN 100 MG VAGINAL OVULE	3	
CLEOCIN 2% VAGINAL CREAM	NC	
CLEOCIN 75 MG/5 ML GRANULES	NC	
CLEOCIN HCL 150 MG CAPSULE	NC	
CLEOCIN HCL 300 MG CAPSULE	NC	
CLEOCIN HCL 75 MG CAPSULE	NC	
CLEOCIN T 1% GEL	NC	
CLEOCIN T 1% LOTION	NC	
CLEOCIN T 1% PLEDGETS	NC	
CLEOCIN T 1% SOLUTION	NC	
CLEVER CHEK ULTRA THIN 30G	2	HSA*
CLEVER CHOICE CHAMBER-LRG MASK	MD	
CLEVER CHOICE MICRO TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE PRO TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE TALK TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLEVER CHOICE VOICE+ TST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
CLIMARA 0.025 MG/DAY PATCH	NC	
CLIMARA 0.0375 MG/DAY PATCH	NC	
CLIMARA 0.05 MG/DAY PATCH	NC	
CLIMARA 0.06 MG/DAY PATCH	NC	
CLIMARA 0.075 MG/DAY PATCH	NC	
CLIMARA 0.1 MG/DAY PATCH	NC	
CLIMARA PRO PATCH	2	
CLIND PH-BENZOYL PEROX 1.2-5%	1	
CLINDA-TRETINOIN 1.2%-0.025%	2	Prior Authorization required for members 30 and older
CLINDACIN ETZ 1% PLEDGET	NC	
CLINDACIN PAC KIT	NC	
CLINDAGEL 1% GEL	NC	
CLINDAMYCIN 2% VAGINAL CREAM	1	
CLINDAMYCIN 75 MG/5 ML SOLN	1	
CLINDAMYCIN HCL 150 MG CAPSULE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLINDAMYCIN HCL 300 MG CAPSULE	1	
CLINDAMYCIN HCL 75 MG CAPSULE	1	
CLINDAMYCIN PH 1% GEL	1	
CLINDAMYCIN PH 1% SOLUTION	1	
CLINDAMYCIN PHOS 1% PLEDGET	1	
CLINDAMYCIN PHOSP 1% LOTION	1	
CLINDAMYCIN PHOSPHATE 1% FOAM	1	
CLINDAMYCIN-BENZOYL PEROX 1-5%	1	
CLINDESSE 2% VAGINAL CREAM	3	
CLINPRO 5000 1.1% TOOTHPASTE	3	
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	NC	
CLOBEX 0.05% SPRAY	NC	
CLOBEX 0.05% TOPICAL LOTION	NC	
CLOCORTOLONE PIVALATE 0.1% CRM	1	
CLODAN 0.05% KIT	3	
CLODAN 0.05% SHAMPOO	NC	
CLODERM 0.1% CREAM	NC	
CLOMIPHENE CITRATE 50 MG TAB	1	
CLOMIPRAMINE 25 MG CAPSULE	1	
CLOMIPRAMINE 50 MG CAPSULE	1	
CLOMIPRAMINE 75 MG CAPSULE	1	
CLONAZEPAM 0.125 MG DIS TAB	1	
CLONAZEPAM 0.25 MG ODT	1	
CLONAZEPAM 0.5 MG DIS TABLET	1	
CLONAZEPAM 0.5 MG TABLET	1	
CLONAZEPAM 1 MG DIS TABLET	1	
CLONAZEPAM 1 MG TABLET	1	
CLONAZEPAM 2 MG ODT	1	
CLONAZEPAM 2 MG TABLET	1	
CLONIDINE 0.1 MG/DAY PATCH	1	HSA*
CLONIDINE 0.2 MG/DAY PATCH	1	HSA*
CLONIDINE 0.3 MG/DAY PATCH	1	HSA*
CLONIDINE HCL 0.1 MG TABLET	1	HSA*
CLONIDINE HCL 0.2 MG TABLET	1	HSA*
CLONIDINE HCL 0.3 MG TABLET	1	HSA*
CLONIDINE HCL ER 0.1 MG TABLET	1	
CLOPIDOGREL 300 MG TABLET	1	HSA*
CLOPIDOGREL 75 MG TABLET	1	HSA*
CLORAZEPATE 15 MG TABLET	1	
CLORAZEPATE 3.75 MG TABLET	1	
CLORAZEPATE 7.5 MG TABLET	1	
CLORPRES 0.1-15 TABLET	1	HSA*
CLORPRES 0.2-15 TABLET	1	HSA*
CLORPRES 0.3-15 TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CLOTRIMAZOLE 1% CREAM	1	
CLOTRIMAZOLE 1% SOLUTION	1	
CLOTRIMAZOLE 10 MG TROCHE	1	
CLOTRIMAZOLE-BETAMETHASONE CRM	1	
CLOTRIMAZOLE-BETAMETHASONE LOT	1	
CLOZAPINE 100 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE 200 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE 25 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE 50 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 100 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 12.5 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 150 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 200 MG TABLET	1	Max. 28 Days Supply
CLOZAPINE ODT 25 MG TABLET	1	Max. 28 Days Supply
CLOZARIL 100 MG TABLET	NC	
CLOZARIL 25 MG TABLET	NC	
COAGUCHEK LANCETS	2	HSA*
COARTEM TABLETS	3	Max. quantity of 24 per fill MQC*: 24 tabs/copay
CODEINE SULFATE 15 MG TABLET	1	
CODEINE SULFATE 30 MG TABLET	1	
CODEINE SULFATE 30 MG/5 ML SOL	NC	
CODEINE SULFATE 60 MG TABLET	1	
CODEINE-GUAIFEN 10-100 MG/5 ML	1	
COLAZAL 750 MG CAPSULE	NC	
COLCHICINE 0.6 MG CAPSULE	1	
COLCHICINE 0.6 MG TABLET	1	
COLCRYS 0.6 MG TABLET	NC	
COLESTID 1 GM TABLET	NC	
COLESTID FLAVORED GRANULES	3	HSA*
COLESTIPOL HCL GRANULES PACKET	1	HSA*
COLESTIPOL MICRONIZED 1 GM TAB	1	HSA*
COLOCORT 100 MG ENEMA	1	
COLY-MYCIN S OTIC SUSP DROP	3	
COLYTE WITH FLAVOR PACKETS	NC	
COMBIGAN 0.2%-0.5% EYE DROPS	2	
COMBIPATCH 0.05-0.14 MG PTCH	2	
COMBIPATCH 0.05-0.25 MG PTCH	2	
COMBISTIX REAGENT STRIPS	2	
COMBIVENT INHALER	2	HSA*
COMBIVENT RESPIMAT INHAL SPRAY	2	HSA*
COMBIVIR TABLET	NC	
COMETRIQ 100 MG DAILY-DOSE PK	3	CH*; LDD*: Diplomat Pharmacy. 1-877-977-9118.
COMETRIQ 140 MG DAILY-DOSE PK	3	CH*; LDD*: Diplomat Pharmacy. 1-877-977-9118.
COMETRIQ 60 MG DAILY-DOSE PACK	3	CH*; LDD*: Diplomat Pharmacy. 1-877-977-9118.
COMFORT EZ SAFETY 21G LANCETS	2	HSA*
COMFORT EZ SAFETY 23G LANCETS	2	HSA*
COMFORT EZ SAFETY 28G LANCETS	2	HSA*
COMFORT LANCETS	2	HSA*
COMFORT PAC-CYCLOBENZAPRINE KT	3	
COMFORT PAC-IBUPROFEN KIT	3	

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

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

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
CYCLOSPORINE MODIFIED 25 MG	1	
CYCLOSPORINE MODIFIED 50 MG	1	
CYMBALTA 20 MG CAPSULE	NC	
CYMBALTA 30 MG CAPSULE	NC	
CYMBALTA 60 MG CAPSULE	NC	
CYPROHEPTADINE 2 MG/5 ML SYRUP	1	
CYPROHEPTADINE 4 MG TABLET	1	
CYRED 28 DAY TABLET	0	ACA*
CYSTADANE 1 GRAM/1.7 ML POWDER	3	LDD*: Accredo (866) 815-4717
CYSTAGON 150 MG CAPSULE	3	
CYSTAGON 50 MG CAPSULE	3	
CYSTARAN 0.44% EYE DROPS	3	LDD*: Walgreens Specialty.CYSTARAN Hotline: 1-877-534-9627.
CYTOMEL 25 MCG TABLET	3	
CYTOMEL 5 MCG TABLET	3	
CYTOMEL 50 MCG TABLET	3	
CYTOTEC 100 MCG TABLET	NC	
CYTOTEC 200 MCG TABLET	NC	
CYTRA-2 ORAL SOLUTION	1	
CYTRA-3 SYRUP	1	
CYTRA-K CRYSTALS PACKET	1	
CYTRA-K ORAL SOLUTION	1	

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D-AMPHETAMINE ER 10 MG CAPSULE	1	Max. 60 Days Supply
D-AMPHETAMINE ER 15 MG CAPSULE	1	Max. 60 Days Supply
D-AMPHETAMINE ER 5 MG CAPSULE	1	Max. 60 Days Supply
D.H.E.45 1 MG/ML AMPUL	NC	
DAKLINZA 30 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
DAKLINZA 60 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
DAKLINZA 90 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
DALIRESP 500 MCG TABLET	2	HSA*
DANAZOL 100 MG CAPSULE	1	
DANAZOL 200 MG CAPSULE	1	
DANAZOL 50 MG CAPSULE	1	
DANTRIUM 100 MG CAPSULE	NC	
DANTRIUM 25 MG CAPSULE	NC	
DANTRIUM 50 MG CAPSULE	NC	
DANTROLENE SODIUM 100 MG CAP	1	
DANTROLENE SODIUM 25 MG CAP	1	
DANTROLENE SODIUM 50 MG CAP	1	
DAPSONE 100 MG TABLET	1	
DAPSONE 25 MG TABLET	1	
DARAPRIM 25 MG TABLET	2	Prior Authorization required
DARIFENACIN ER 15 MG TABLET	1	
DARIFENACIN ER 7.5 MG TABLET	1	
DARIO BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
DASETTA 1-35-28 TABLET	0	ACA*
DASETTA 7/7/7-28 TABLET	0	ACA*
DAXBIA 333 MG CAPSULE	NC	
DAYPRO 600 MG CAPLET	NC	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
DAYSEE 0.15-0.03-0.01 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
DAYTRANA 10 MG/9 HR PATCH	3	Max. 60 Days Supply
DAYTRANA 15 MG/9 HR PATCH	3	Max. 60 Days Supply
DAYTRANA 20 MG/9 HOUR PATCH	3	Max. 60 Days Supply
DAYTRANA 30 MG/9 HOUR PATCH	3	Max. 60 Days Supply
DDAVP 0.01% NASAL SPRAY	NC	
DDAVP 0.1 MG TABLET	NC	
DDAVP 0.2 MG TABLET	NC	
DDAVP 10 MCG/0.1 ML SOLUTION	NC	
DDAVP 4 MCG/ML AMPUL	NC	
DDAVP 4 MCG/ML VIAL	NC	
DEBLITANE 0.35 MG TABLET	0	ACA*
DELTA D3 400 UNIT TABLET	0	Not covered for members 64 and younger ACA*
DELTASONE 20 MG TABLET	1	
DELYLA-28 TABLET	0	ACA*
DELZICOL DR 400 MG CAPSULE	2	
DEMADEX 10 MG TABLET	NC	
DEMADEX 100 MG TABLET	NC	
DEMADEX 20 MG TABLET	NC	
DEMADEX 5 MG TABLET	NC	
DEMECLOXYCLINE 150 MG TABLET	1	
DEMECLOXYCLINE 300 MG TABLET	1	
DEMEROL 100 MG TABLET	NC	
DEMEROL 50 MG TABLET	NC	
DEMSER 250 MG CAPSULE	3	HSA*
DEMULEN 1-50-21 TABLET	NC	
DENAVIR 1% CREAM	3	Max. 5 GM(s) in 30 days
DENTA 5000 PLUS CREAM	1	
DENTAGEL 1.1% GEL	1	
DEPAKENE 250 MG CAPSULE	3	
DEPAKENE 250 MG/5 ML SOLUTION	3	
DEPAKOTE DR 125 MG SPRINKLE CP	3	
DEPAKOTE DR 125 MG TABLET	3	
DEPAKOTE DR 250 MG TABLET	3	
DEPAKOTE DR 500 MG TABLET	3	
DEPAKOTE ER 250 MG TABLET	3	
DEPAKOTE ER 500 MG TABLET	3	
DEPEN 250 MG TITRATAB	2	Prior Authorization required
DEPO-PROVERA 150 MG/ML SYRINGE	0	Max. 90 Days Supply;Max. 1 ML(s) in 90 days ACA*
DEPO-PROVERA 150 MG/ML VIAL	0	Max. 90 Days Supply;Max. 1 ML(s) in 90 days ACA*
DEPO-PROVERA 400 MG/ML VIAL	MD	
DEPO-SUBQ PROVERA 104 SYRINGE	0	Max. 1 ML(s) in 60 days ACA*
DEPO-TESTOSTERONE 100 MG/ML VL	NC	
DEPO-TESTOSTERONE 200 MG/ML	NC	
DEPRIZINE ORAL SUSPENSION	3	
DERMA-SMOOTHIE-FS SCALP OIL	NC	
DERMASORB HC 2% COMPLETE KIT	3	
DERMASORB TA 0.1% COMPLETE KIT	3	
DERMATOP 0.1% OINTMENT	NC	
DERMATOP EMOLLIENT 0.1% CREAM	NC	
DERMAZENE CREAM	1	
DERMOTIC OIL 0.01% EAR DROPS	NC	
DESCOVY 200-25 MG TABLET	3	
DESIPRAMINE 10 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DESIPRAMINE 100 MG TABLET	1	
DESIPRAMINE 150 MG TABLET	1	
DESIPRAMINE 25 MG TABLET	1	
DESIPRAMINE 50 MG TABLET	1	
DESIPRAMINE 75 MG TABLET	1	
DESLORATADINE 2.5 MG ODT	1	
DESLORATADINE 5 MG ODT	1	
DESLORATADINE 5 MG TABLET	1	
DESMOPRESSIN 0.1 MG/ML SOL	1	
DESMOPRESSIN 10 MCG/0.1 ML SPR	1	
DESMOPRESSIN AC 4 MCG/ML VIAL	1	
DESMOPRESSIN ACETATE 0.1 MG TB	1	
DESMOPRESSIN ACETATE 0.2 MG TB	1	
DESOGEN 28 DAY TABLET	NC	
DESOGEST-ETH ESTRA 0.15-0.03MG	0	ACA*
DESOGESTR-ETH ESTRAD ETH ESTRA	0	ACA*
DESONATE 0.05% GEL	3	
DESONIDE 0.05% CREAM	1	
DESONIDE 0.05% LOTION	1	
DESONIDE 0.05% OINTMENT	1	
DESOWEN 0.05% CREAM	NC	
DESOWEN 0.05% LOTION	NC	
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	
DESOPYN 5 MG TABLET	NC	
DESVENLAFAXINE ER 100 MG TAB	2	
DESVENLAFAXINE ER 100 MG TAB	1	(generic)
DESVENLAFAXINE ER 50 MG TAB	2	
DESVENLAFAXINE ER 50 MG TABLET	1	(generic)
DESVENLAFAXINE FUM ER 100 MG	3	Step Therapy required STA*: 18 and older
DESVENLAFAXINE FUM ER 50 MG	3	Step Therapy required STA*: 18 and older
DESVENLAFAXINE SUC ER 100 MG	2	
DESVENLAFAXINE SUC ER 25 MG TB	2	
DESVENLAFAXINE SUC ER 50 MG TB	2	
DETROL 1 MG TABLET	NC	
DETROL 2 MG TABLET	NC	
DETROL LA 2 MG CAPSULE	NC	
DETROL LA 4 MG CAPSULE	NC	
DEXAMETHASONE 0.1% EYE DROP	1	
DEXAMETHASONE 0.5 MG TABLET	1	
DEXAMETHASONE 0.5 MG/5 ML ELX	1	
DEXAMETHASONE 0.75 MG TABLET	1	
DEXAMETHASONE 1 MG TABLET	1	
DEXAMETHASONE 1.5 MG TABLET	1	
DEXAMETHASONE 10 MG/ML VIAL	MD	
DEXAMETHASONE 2 MG TABLET	1	
DEXAMETHASONE 4 MG TABLET	1	
DEXAMETHASONE 4 MG/ML VIAL	MD	
DEXAMETHASONE 6 MG TABLET	1	
DEXAMETHASONE INTENSOL 1MG/1ML	2	
DEXEDRINE 10 MG TABLET	NC	
DEXEDRINE 5 MG TABLET	NC	

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DIASCREEN 7 REAGENT STRIPS	2	HSA*
DIASCREEN 8 REAGENT STRIPS	2	HSA*
DIASCREEN 9 REAGENT STRIPS	2	HSA*
DIASTAT 2.5 MG PEDI SYSTEM	NC	
DIASTAT ACUDIAL 12.5-15-20 MG	NC	
DIASTAT ACUDIAL 5-7.5-10 MG KT	NC	
DIASTIX REAGENT STRIPS	2	HSA*
DIATRUE PLUS TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
DIAZEPAM 10 MG RECTAL GEL SYST	1	
DIAZEPAM 10 MG TABLET	1	
DIAZEPAM 2 MG TABLET	1	
DIAZEPAM 2.5 MG RECTAL GEL SYS	1	
DIAZEPAM 20 MG RECTAL GEL SYST	1	
DIAZEPAM 5 MG TABLET	1	
DIAZEPAM 5 MG/5 ML SOLUTION	1	
DIAZEPAM 5 MG/ML ORAL CONC	1	
DIAZEPAM 5 MG/ML VIAL	1	
DIBENZYLINE 10 MG CAPSULE	NC	
DICLEGIS DR 10-10 MG TABLET	3	
DICLOFENAC 0.1% EYE DROPS	1	
DICLOFENAC 1.5% TOPICAL SOLN	1	
DICLOFENAC POT 50 MG TABLET	1	
DICLOFENAC SOD EC 25 MG TAB	1	
DICLOFENAC SOD EC 50 MG TAB	1	
DICLOFENAC SOD EC 75 MG TAB	1	
DICLOFENAC SOD ER 100 MG TAB	1	
DICLOFENAC SODIUM 1% GEL	1	
DICLOFENAC SODIUM 3% GEL	1	
DICLOFENAC-MISOPROST 50-200 TB	1	
DICLOFENAC-MISOPROST 75-200 TB	1	
DICLOTRAL PAK	NC	
DICLOXACILLIN 250 MG CAPSULE	1	
DICLOXACILLIN 500 MG CAPSULE	1	
DICOPANOL ORAL SUSPENSION	3	
DICYCLOMINE 10 MG CAPSULE	1	
DICYCLOMINE 10 MG/5 ML SOLN	1	
DICYCLOMINE 20 MG TABLET	1	
DIDANOSINE DR 125 MG CAPSULE	1	
DIDANOSINE DR 200 MG CAPSULE	1	
DIDANOSINE DR 250 MG CAPSULE	1	
DIDANOSINE DR 400 MG CAPSULE	1	
DIFFERIN 0.1% CREAM	NC	
DIFFERIN 0.1% GEL	NC	
DIFFERIN 0.1% LOTION	NC	
DIFFERIN 0.3% GEL PUMP	NC	
DIFICID 200 MG TABLET	2	Limit fills to 1 in 30 days;Max. 20 per 10 days
DIFLORASONE 0.05% CREAM	1	
DIFLORASONE 0.05% OINTMENT	1	
DIFLUCAN 10 MG/ML SUSPENSION	NC	
DIFLUCAN 100 MG TABLET	NC	
DIFLUCAN 150 MG TABLET	NC	
DIFLUCAN 200 MG TABLET	NC	
DIFLUCAN 40 MG/ML SUSPENSION	NC	
DIFLUCAN 50 MG TABLET	NC	
DIFLUNISAL 500 MG TABLET	1	

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DILTIAZEM 90 MG TABLET	1	HSA*
DILTZAC ER 120 MG CAPSULE	1	HSA*
DILTZAC ER 180 MG CAPSULE	1	HSA*
DILTZAC ER 240 MG CAPSULE	1	HSA*
DILTZAC ER 300 MG CAPSULE	1	HSA*
DILTZAC ER 360 MG CAPSULE	1	HSA*
DIOVAN 160 MG TABLET	NC	
DIOVAN 320 MG TABLET	NC	
DIOVAN 40 MG TABLET	NC	
DIOVAN 80 MG TABLET	NC	
DIOVAN HCT 160-12.5 MG TAB	NC	
DIOVAN HCT 160-25 MG TABLET	NC	
DIOVAN HCT 320-12.5 MG TAB	NC	
DIOVAN HCT 320-25 MG TABLET	NC	
DIOVAN HCT 80-12.5 MG TABLET	NC	
DIPENTUM 250 MG CAPSULE	3	
DIPHENOXYLAT-ATROP 2.5-0.025/5	1	
DIPHENOXYLATE-ATROP 2.5-0.025	1	
DIPROLENE 0.05% LOTION	NC	
DIPROLENE 0.05% OINTMENT	NC	
DIPROLENE AF 0.05% CREAM	NC	
DIPYRIDAMOLE 25 MG TABLET	1	HSA*
DIPYRIDAMOLE 50 MG TABLET	1	HSA*
DIPYRIDAMOLE 75 MG TABLET	1	HSA*
DISALCID 500 MG TABLET	NC	
DISALCID 750 MG TABLET	NC	
DISKETTS 40 MG TABLET DISPR	NC	
DISOPYRAMIDE 100 MG CAPSULE	1	
DISOPYRAMIDE 150 MG CAPSULE	1	
DISULFIRAM 250 MG TABLET	1	
DISULFIRAM 500 MG TABLET	1	
DITROPAN XL 10 MG TABLET	NC	
DITROPAN XL 15 MG TABLET	NC	
DITROPAN XL 5 MG TABLET	NC	
DIURIL 250 MG/5 ML ORAL SUSP	3	HSA*
DIVALPROEX DR 125 MG CAP SPRNK	1	
DIVALPROEX SOD DR 125 MG TAB	1	
DIVALPROEX SOD DR 250 MG TAB	1	
DIVALPROEX SOD DR 500 MG TAB	1	
DIVALPROEX SOD ER 250 MG TAB	1	
DIVALPROEX SOD ER 500 MG TAB	1	
DIVIGEL 1 MG GEL PACKET	2	
DOFETILIDE 125 MCG CAPSULE	2	
DOFETILIDE 250 MCG CAPSULE	2	
DOFETILIDE 500 MCG CAPSULE	2	
DOLOPHINE HCL 10 MG TABLET	NC	
DOLOPHINE HCL 5 MG TABLET	NC	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DORAL 15 MG TABLET	NC	
DORYX DR 150 MG TABLET	NC	
DORYX DR 200 MG TABLET	NC	
DORYX DR 50 MG TABLET	NC	
DORYX MPC DR 120 MG TABLET	1	
DORZOLAMIDE HCL 2% EYE DROPS	1	
DORZOLAMIDE-TIMOLOL EYE DROPS	1	
DOVER BULB SYRINGE 60 ML	3	
DOVONEX 0.005% CREAM	NC	
DOXAZOSIN MESYLATE 1 MG TAB	1	HSA*
DOXAZOSIN MESYLATE 2 MG TAB	1	HSA*
DOXAZOSIN MESYLATE 4 MG TAB	1	HSA*
DOXAZOSIN MESYLATE 8 MG TAB	1	HSA*
DOXEPIN 10 MG CAPSULE	1	
DOXEPIN 10 MG/ML ORAL CONC	1	
DOXEPIN 100 MG CAPSULE	1	
DOXEPIN 150 MG CAPSULE	1	
DOXEPIN 25 MG CAPSULE	1	
DOXEPIN 5% CREAM	1	
DOXEPIN 50 MG CAPSULE	1	
DOXEPIN 75 MG CAPSULE	1	
DOXERCALCIFEROL 0.5 MCG CAP	1	
DOXERCALCIFEROL 1 MCG CAPSULE	1	
DOXERCALCIFEROL 2.5 MCG CAP	1	
DOXYCYCLINE 25 MG/5 ML SUSP	1	
DOXYCYCLINE HYC DR 100 MG TAB	1	
DOXYCYCLINE HYC DR 150 MG TAB	1	
DOXYCYCLINE HYC DR 200 MG TAB	3	
DOXYCYCLINE HYC DR 50 MG TAB	3	
DOXYCYCLINE HYC DR 75 MG TAB	1	
DOXYCYCLINE HYCLATE 100 MG CAP	1	
DOXYCYCLINE HYCLATE 100 MG TAB	1	
DOXYCYCLINE HYCLATE 150 MG TAB	2	
DOXYCYCLINE HYCLATE 20 MG TAB	1	
DOXYCYCLINE HYCLATE 50 MG CAP	1	
DOXYCYCLINE HYCLATE 75 MG TAB	2	
DOXYCYCLINE IR-DR 40 MG CAP	1	
DOXYCYCLINE MONO 100 MG CAP	1	
DOXYCYCLINE MONO 100 MG TABLET	1	
DOXYCYCLINE MONO 150 MG CAP	1	
DOXYCYCLINE MONO 150 MG TABLET	1	
DOXYCYCLINE MONO 50 MG CAP	1	
DOXYCYCLINE MONO 50 MG TABLET	1	
DOXYCYCLINE MONO 75 MG CAPSULE	1	
DOXYCYCLINE MONO 75 MG TABLET	1	
DRISDOL 50,000 UNITS CAPSULE	NC	
DRITHOCREME HP 1% CREAM	2	
DRONABINOL 10 MG CAPSULE	1	
DRONABINOL 2.5 MG CAPSULE	1	
DRONABINOL 5 MG CAPSULE	1	
DROPLET 30G LANCETS	2	
		HSA*
DROSP-EE-LEVOMEF 3-0.02-0.451	0	ACA*
		ACA*
DROSPIRENONE-EE 3-0.02 MG TAB	0	ACA*
		ACA*
DROSPIRENONE-EE 3-0.03 MG TAB	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
DROXIA 200 MG CAPSULE	3	
DROXIA 300 MG CAPSULE	3	
DROXIA 400 MG CAPSULE	3	
DRYSOL DAB-O-MATIC SOLUTION	2	
DUAC 1.2-5% GEL	NC	
DUAVEE 0.45-20 MG TABLET	3	HSA*
DUETACT 30-2 MG TABLET	NC	
DUETACT 30-4 MG TABLET	NC	
DUEXIS 800-26.6 MG TABLET	NC	
DULERA 100 MCG/5 MCG INHALER	2	Max. 13 GM(s) in 30 days HSA*
DULERA 200 MCG/5 MCG INHALER	2	Max. 13 GM(s) in 30 days HSA*
DULOXETINE HCL DR 20 MG CAP	1	
DULOXETINE HCL DR 30 MG CAP	1	
DULOXETINE HCL DR 40 MG CAP	1	
DULOXETINE HCL DR 60 MG CAP	1	
DUONEB 0.5 MG-3 MG/3 ML SOLN	NC	
DUOPA 4.63 MG-20 MG/ML SUSPENS	3	Max. 2800 ML(s) per 28 days LDD*: Accredo (866) 815-4717
DUPIXENT 300 MG/2 ML SAFE SYRG	3	Prior Authorization required;Max. 4 ML(s) per 28 days SPP*: Must use CVS Specialty
DURAGESIC 100 MCG/HR PATCH	NC	
DURAGESIC 12 MCG/HR PATCH	NC	
DURAGESIC 25 MCG/HR PATCH	NC	
DURAGESIC 50 MCG/HR PATCH	NC	
DURAGESIC 75 MCG/HR PATCH	NC	
DUREZOL 0.05% EYE DROPS	3	
DURLAZA ER 162.5 MG CAPSULE	3	Prior Authorization required HSA*
DUTASTERIDE 0.5 MG CAPSULE	1	
DUTASTERIDE-TAMSULOSIN 0.5-0.4	1	
DUTOPROL 100-12.5 MG TABLET	NC	
DUTOPROL 25-12.5 MG TABLET	NC	
DUTOPROL 50-12.5 MG TABLET	NC	
DUZALLO 200-200 MG TABLET	3	Prior Authorization required;Max. 1 per day PA NTM*
DUZALLO 200-300 MG TABLET	3	Prior Authorization required;Max. 1 per day PA NTM*
DYANAVEL XR 2.5 MG/ML SUSP	3	Max. 60 Days Supply
DYAZIDE 37.5-25 CAPSULE	NC	
DYMISTA NASAL SPRAY	2	
DYRENIUM 100 MG CAPSULE	3	HSA*
DYRENIUM 50 MG CAPSULE	3	HSA*
DYSPORT 300 UNIT VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
DYSPORT 500 UNITS VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
<b>E</b>		
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*



DRUG NAME	TIER	LIMITATIONS/ * NOTES
E-ZJECT THIN LANCETS	2	HSA*
E.E.S. 200 MG/5 ML GRANULES	1	
E.E.S. 400 FILMTAB	1	
EASIVENT HOLDING CHAMBER	MD	
EASIVENT MASK-LARGE	MD	
EASIVENT MASK-MEDIUM	MD	
EASIVENT MASK-SMALL	MD	
EASY COMFORT 30G LANCETS	2	HSA*
EASY GLIDE CATH TIP 60 ML SYRN	3	
EASY GLIDE DENTAL IRR 10ML SYR	3	
EASY GLIDE LUER LOCK 1 ML SYR	3	
EASY GLIDE LUER LOCK 10 ML SYR	3	
EASY GLIDE LUER LOCK 3 ML SYR	3	
EASY GLIDE LUER LOCK 60 ML SYR	3	
EASY GLIDE LUER SLIP TB 1 ML	3	
EASY GLUCO G2 TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY PLUS GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY PLUS II TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY STEP GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY TALK GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY TOUCH 28G LANCETS	2	HSA*
EASY TOUCH FLIPLK 10ML 18GX1.5	3	
EASY TOUCH FLIPLK 10ML 20GX1.5	3	
EASY TOUCH FLIPLK 10ML 21GX1.5	3	
EASY TOUCH FLIPLK 10ML 22GX1.5	3	
EASY TOUCH FLIPLK 5 ML 20GX1.5	3	
EASY TOUCH FLIPLK 5 ML 21GX1.5	3	
EASY TOUCH FLIPLK 5 ML 22GX1.5	3	
EASY TOUCH FLIPLK 5 ML 25GX5/8	3	
EASY TOUCH FLIPLK 1 ML 25GX1	3	
EASY TOUCH FLIPLK 10ML 21GX1	3	
EASY TOUCH FLIPLK 3 ML 18GX1	3	
EASY TOUCH FLIPLK 3 ML 19GX1	3	
EASY TOUCH FLIPLK 3 ML 20GX1	3	
EASY TOUCH FLIPLK 3 ML 21GX1	3	
EASY TOUCH FLIPLK 3 ML 22GX1	3	
EASY TOUCH FLIPLK 3 ML 23GX1	3	
EASY TOUCH FLIPLK 3 ML 25GX1	3	
EASY TOUCH FLIPLK 5 ML 18GX1	3	
EASY TOUCH FLIPLK 5 ML 20GX1	3	
EASY TOUCH FLIPLK 5 ML 21GX1	3	
EASY TOUCH FLIPLK 5 ML 25GX1	3	
EASY TOUCH FLIPLK 10 ML 18GX1	3	
EASY TOUCH FLIPLK 10 ML 20GX1	3	
EASY TOUCH FLIPLK 10 ML 25GX1	3	
EASY TOUCH FLIPLK 1ML 26GX3/8	3	
EASY TOUCH FLIPLK 3ML 18GX1.5	3	
EASY TOUCH FLIPLK 3ML 19GX1.5	3	
EASY TOUCH FLIPLK 3ML 20GX1.5	3	
EASY TOUCH FLIPLK 3ML 21GX1.5	3	
EASY TOUCH FLIPLK 3ML 22GX1.5	3	
EASY TOUCH FLIPLK 3ML 23GX1.5	3	
EASY TOUCH FLIPLK 3ML 25GX5/8	3	
EASY TOUCH FLIRING 1ML 25GX5/8	3	

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EASY TOUCH SHEATHLOCK 5 ML SYR	3	
EASY TOUCH SYR 1 ML 25GX5/8"	3	
EASY TOUCH SYR 3 ML 22GX1-1/2"	3	
EASY TOUCH SYR 3 ML 25GX5/8"	3	
EASY TOUCH SYRINGE 1 ML 25GX1"	3	
EASY TOUCH SYRINGE 3 ML 20GX1"	3	
EASY TOUCH SYRINGE 3 ML 21GX1"	3	
EASY TOUCH SYRINGE 3 ML 22GX1"	3	
EASY TOUCH SYRINGE 3 ML 23GX1"	3	
EASY TOUCH SYRINGE 3 ML 25GX1"	3	
EASY TOUCH TB FLP 1 ML 26GX5/8	3	
EASY TOUCH TB FLP 1 ML 27GX1/2	3	
EASY TOUCH TB FLP 1 ML 28GX1/2	3	
EASY TOUCH TB SHLK 1ML 25GX5/8	3	
EASY TOUCH TB SHLK 1ML 26GX5/8	3	
EASY TOUCH TB SHLK 1ML 27GX1/2	3	
EASY TOUCH TB SHLK 1ML 28GX1/2	3	
EASY TOUCH TWIST 28G LANCETS	2	HSA*
EASY TOUCH TWIST 30G LANCETS	2	HSA*
EASY TOUCH TWIST 32G LANCETS	2	HSA*
EASY TOUCH TWIST 33G LANCETS	2	HSA*
EASY TOUCH UNI-SLIP 10 ML SYR	3	
EASY TOUCH UNI-SLIP 3 ML SYR	3	
EASY TOUCH UNI-SLIP 5 ML SYR	3	
EASY TRAK GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASY TWIST & CAP 28G LANCETS	2	HSA*
EASYGLUCO PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASYGLUCO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASYMAX 15 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EASYMAX GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EC-NAPROSYN EC 375 MG TABLET	NC	
EC-NAPROSYN EC 500 MG TABLET	NC	
ECONAZOLE NITRATE 1% CREAM	1	
ECONTRA EZ 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
ECOTRIN EC 325 MG TABLET	0	ACA*
ECOZA 1% FOAM	3	
ECPIRIN EC 325 MG TABLET	0	ACA*
EDARBI 40 MG TABLET	3	HSA*
EDARBI 80 MG TABLET	3	HSA*
EDARBYCLOR 40-12.5 MG TABLET	3	HSA*
EDARBYCLOR 40-25 MG TABLET	3	HSA*
EDECRIN 25 MG TABLET	NC	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EDEX 40 MCG CARTRIDGE 2-PK KIT	2	Covered for males only;Not covered for members 17 and younger; Max. 3 in 30 days
EDLUAR 10 MG SL TABLET	3	Step Therapy required STA*: 18 and older
EDLUAR 5 MG SL TABLET	3	Step Therapy required STA*: 18 and older
EDURANT 25 MG TABLET	3	
EFFER-K 10 MEQ TABLET EFF	3	
EFFER-K 20 MEQ TABLET EFF	3	
EFFER-K 25 MEQ TABLET EFF	1	
EFFEXOR XR 150 MG CAPSULE	NC	
EFFEXOR XR 37.5 MG CAPSULE	NC	
EFFEXOR XR 75 MG CAPSULE	NC	
EFFIENT 10 MG TABLET	3	HSA*
EFFIENT 5 MG TABLET	3	HSA*
EFUDEX 5% CREAM	NC	
EGRIFTA 1 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty 1-844-EGRIFTA (1-844-347-4382)
EGRIFTA 2 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty 1-844-EGRIFTA (1-844-347-4382)
ELDEPRYL 5 MG CAPSULE	NC	
ELDERCAPS CAPSULE	NC	
ELEMENT COMPACT TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ELEMENT PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ELEMENT TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ELESTAT 0.05% EYE DROPS	NC	
ELESTRIN 0.06% GEL	3	
ELESTONE CREAM	NC	
ELESTONE CREAM TWIN PACK	NC	
ELETRIPTAN HBR 20 MG TABLET	2	Max. quantity of 12 per fill MQC*: 12 tabs per copay
ELETRIPTAN HBR 40 MG TABLET	2	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ELIDEL 1% CREAM	2	Prior Authorization required
ELIMITE 5% CREAM	NC	
ELINEST-28 TABLET	0	ACA*
ELIPHOS 667 MG TABLET	1	
ELIQUIS 2.5 MG TABLET	2	HSA*
ELIQUIS 5 MG TABLET	2	HSA*
ELIXOPHYLLIN 80 MG/15 ML ELIX	1	HSA*
ELLA 30 MG TABLET	0	Max. quantity of 1 per fill ACA*
ELMIRON 100 MG CAPSULE	3	
ELOCON 0.1% CREAM	NC	
ELOCON 0.1% LOTION	NC	
ELOCON 0.1% OINTMENT	NC	
ELOCTATE 3,000 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
EMADINE 0.05% EYE DROPS	3	
EMBEDA ER 100-4 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 20-0.8 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 30-1.2 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 50-2 MG CAPSULE	2	Max. 3 per day
EMBEDA ER 60-2.4 MG CAPSULE	2	Max. 3 per day

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EMBEDA ER 80-3.2 MG CAPSULE	2	Max. 3 per day
EMBRACE 30G LANCETS	2	
EMBRACE EVO TEST STRIPS	3	HSA*
EMBRACE PRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EMBRACE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EMCYT 140 MG CAPSULE	2	CH*
EMEND 125 MG CAPSULE	3	Max. 30 Days Supply;Max. quantity of 1 per fill MQC*: 1 cap/copay
EMEND 125 MG POWDER PACKET	3	Max. 30 Days Supply;Max. quantity of 1 per fill MQC*: 1 packet/copay
EMEND 40 MG CAPSULE	3	Max. 30 Days Supply;Max. quantity of 4 per fill MQC*: 4 caps/copay
EMEND 80 MG CAPSULE	NC	
EMEND TRIPACK	NC	
EMFLAZA 18 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 22.75 MG/ML ORAL SUSP	3	Prior Authorization required;Max. 1 ML(s) per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 30 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 36 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMFLAZA 6 MG TABLET	3	Prior Authorization required;Max. 1 per day LDD*: Must use U.S. Bioservices (888) 518-7246
EMLA CREAM	NC	
EMOQUETTE 28 DAY TABLET	0	ACA*
EMSAM 12 MG/24 HOURS PATCH	3	
EMSAM 6 MG/24 HOURS PATCH	3	
EMSAM 9 MG/24 HOURS PATCH	3	
EMTRIVA 10 MG/ML SOLUTION	3	
EMTRIVA 200 MG CAPSULE	3	
EMULSION SB TOPICAL EMULSION	1	
EMVERM 100 MG TABLET CHEW	3	Max. quantity of 6 per fill;Max. 6 in 21 days MQC*: 6 tabs/copay. Max 6 tabs/21- day supply
ENABLEX 15 MG TABLET	NC	
ENABLEX 7.5 MG TABLET	NC	
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*
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
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	NC	
ENDOMETRIN 100 MG SUPPOSITORY	2	Max. 30 Days Supply IVF*
ENGERIX-B 10 MCG/0.5 ML PED VL	MD	Not covered for members 17 and younger
ENGERIX-B 20 MCG/ML SYRN	MD	Not covered for members 17 and younger
ENGERIX-B 20 MCG/ML VIAL	MD	Not covered for members 17 and younger
ENGERIX-B PEDI 10 MCG/0.5 SYRN	MD	Not covered for members 17 and younger
ENJUWIA 0.3 MG TABLET	2	
ENJUWIA 0.45 MG TABLET	2	
ENJUWIA 0.625 MG TABLET	2	
ENJUWIA 0.9 MG TABLET	2	
ENJUWIA 1.25 MG TABLET	2	
ENOXAPARIN 100 MG/ML SYRINGE	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 120 MG/0.8 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 150 MG/ML SYRINGE	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 30 MG/0.3 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 300 MG/3 ML VIAL	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 40 MG/0.4 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 60 MG/0.6 ML SYR	1	HSA*; SPP*: CVS Specialty
ENOXAPARIN 80 MG/0.8 ML SYR	1	HSA*; SPP*: CVS Specialty
ENPRESSE-28 TABLET	0	ACA*
ENSKYCE 28 TABLET	0	ACA*
ENSTILAR 0.005%-0.064% FOAM	3	Max. 2 GM(s) per day Max 60g/28 days supply
ENTACAPONE 200 MG TABLET	1	
ENTECAVIR 0.5 MG TABLET	1	
ENTECAVIR 1 MG TABLET	1	
ENTEREG 12 MG CAPSULE	3	
ENTOCORT EC 3 MG CAPSULE	NC	
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*
ENULOSE 10 GM/15 ML SOLUTION	1	
ENVARUSUS XR 0.75 MG TABLET	3	
ENVARUSUS XR 1 MG TABLET	3	
ENVARUSUS XR 4 MG TABLET	3	
EPANED 1 MG/ML ORAL SOLUTION	3	HSA*
EPCLUSA 400 MG-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
EPICERAM SKIN BARRIER EMULSION	NC	
EPIDUO 0.1-2.5% GEL PUMP	3	Prior Authorization required for members 30 and older
EPIDUO FORTE 0.3-2.5% GEL PUMP	3	Prior Authorization required for members 30 and older
EPIFOAM FOAM	3	
EPINASTINE HCL 0.05% EYE DROPS	1	
EPINEPHRINE 0.15 MG AUTO-INJECT	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	NC	
EPIPEN 2-PAK 0.3 MG AUTO-INJECT	NC	
EPIPEN JR 2-PAK 0.15 MG INJECT	NC	
EPISIL LIQUID	2	
EPITOL 200 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EPIVIR 10 MG/ML ORAL SOLN	NC	
EPIVIR 150 MG TABLET	NC	
EPIVIR 300 MG TABLET	NC	
EPIVIR HBV 100 MG TABLET	NC	
EPIVIR HBV 25 MG/5 ML SOLN	2	
EPLERENONE 25 MG TABLET	1	HSA*
EPLERENONE 50 MG TABLET	1	HSA*
EPOGEN 10,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPOGEN 2,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPOGEN 20,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
EPOGEN 3,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPOGEN 4,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
EPROSARTAN MESYLATE 600 MG TAB	1	HSA*
EPZICOM TABLET	NC	
EQ BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EQUETRO 100 MG CAPSULE	3	
EQUETRO 200 MG CAPSULE	3	
EQUETRO 300 MG CAPSULE	3	
ERGOLOID MESYLATES 1 MG TAB	1	
ERGOMAR 2 MG TABLET SL	2	
ERGOTAMINE-CAFFEINE 1-100MG TB	1	
ERIVEDGE 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ERRIN 0.35 MG TABLET	0	ACA*
ERTACZO 2% CREAM	NC	
ERY 2% PADS	1	
ERY-TAB EC 250 MG TABLET	1	
ERY-TAB EC 333 MG TABLET	3	
ERY-TAB EC 500 MG TABLET	1	
ERYGEL 2% GEL	NC	
ERYPED 200 MG/5 ML SUSPENSION	NC	
ERYPED 400 MG/5 ML SUSPENSION	2	
ERYTHROCIN 250 MG FILMTAB	1	
ERYTHROMYCIN 0.5% EYE OINTMENT	1	
ERYTHROMYCIN 2% GEL	1	
ERYTHROMYCIN 2% PLEDGETS	1	
ERYTHROMYCIN 2% SOLUTION	1	
ERYTHROMYCIN 200 MG/5 ML GRAN	1	
ERYTHROMYCIN 250 MG FILMTAB	1	
ERYTHROMYCIN 500 MG FILMTAB	1	
ERYTHROMYCIN DR 250 MG CAP	1	
ERYTHROMYCIN ES 400 MG TAB	1	
ERYTHROMYCIN-BENZOYL GEL	1	
ERYTHROMYCIN-SULFISOX SUSP	1	
ESBRIET 267 MG CAPSULE	2	Max. 9 per day SPP*: Must use CVS Specialty
ESBRIET 267 MG TABLET	2	Max. 9 per day SPP*: Must use CVS Specialty
ESBRIET 801 MG TABLET	2	Max. 3 per day SPP*: Must use CVS Specialty
ESCITALOPRAM 10 MG TABLET	1	
ESCITALOPRAM 20 MG TABLET	1	
ESCITALOPRAM 5 MG TABLET	1	
ESCITALOPRAM OXALATE 5 MG/5 ML	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ESGIC 50-325-40 MG TABLET	NC	
ESGIC CAPSULE	NC	
ESGIC PLUS CAPSULE	2	
ESGIC-PLUS 50-500-40 MG TABLET	NC	
ESOMEPRAZOLE DR 24.65 MG CAP	3	
ESOMEPRAZOLE DR 49.3 MG CAP	3	
ESOMEPRAZOLE MAG DR 20 MG CAP	2	Prior Authorization required
ESOMEPRAZOLE MAG DR 20 MG CAP	1	OTC Version
ESOMEPRAZOLE MAG DR 40 MG CAP	2	Prior Authorization required
ESTARYLLA 0.25-0.035 MG TABLET	0	ACA*
ESTAZOLAM 1 MG TABLET	1	
ESTAZOLAM 2 MG TABLET	1	
ESTRACE 0.01% CREAM	2	
ESTRACE 0.5 MG TABLET	NC	
ESTRACE 1 MG TABLET	NC	
ESTRACE 2 MG TABLET	NC	
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	
ESTROGEN-METHYLTESTOS F.S. TAB	1	Max. 30 Days Supply
ESTROGEN-METHYLTESTOS H.S. TAB	1	Max. 30 Days Supply
ESTROPIPATE 0.625(0.75 MG) TAB	1	
ESTROPIPATE 1.25(1.5 MG) TAB	1	
ESTROPIPATE 2.5(3 MG) TAB	1	
ESTROSTEP FE-28 TABLET	NC	
ESZOPICLONE 1 MG TABLET	1	
ESZOPICLONE 2 MG TABLET	1	
ESZOPICLONE 3 MG TABLET	1	
ETHACRYNIC ACID 25 MG TABLET	2	HSA*
ETHAMBUTOL HCL 100 MG TABLET	1	
ETHAMBUTOL HCL 400 MG TABLET	1	
ETHOSUXIMIDE 250 MG CAPSULE	1	
ETHOSUXIMIDE 250 MG/5 ML SOLN	1	
ETHYL ACETATE LIQUID	3	
ETHYL CHLORIDE SPRAY	1	
ETHYNODIOL-ETH ESTRA 1MG-50MCG	0	ACA*
ETIDRONATE DISODIUM 200 MG TAB	1	HSA*
ETIDRONATE DISODIUM 400 MG TAB	1	HSA*



DRUG NAME	TIER	LIMITATIONS/ * NOTES
ETODOLAC 200 MG CAPSULE	1	
ETODOLAC 300 MG CAPSULE	1	
ETODOLAC 400 MG TABLET	1	
ETODOLAC 500 MG TABLET	1	
ETODOLAC ER 400 MG TABLET	1	
ETODOLAC ER 500 MG TABLET	1	
ETODOLAC ER 600 MG TABLET	1	
ETOPOSIDE 50 MG CAPSULE	1	CH*
EUCRISA 2% OINTMENT	3	Prior Authorization required
EURAX 10% CREAM	3	
EURAX 10% LOTION	3	
EVAMIST 1.53 MG/SPRAY	3	Max. quantity of 1 per fill MQC*: 1 bottle/copay
EVEKEO 10 MG TABLET	3	Max. 60 Days Supply
EVEKEO 5 MG TABLET	3	Max. 60 Days Supply
EVENCARE G2 TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVENCARE G3 TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVENCARE GLUCOSE TST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVENCARE MINI GLUCOSE TEST STR	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVISTA 60 MG TABLET	NC	
EVOCLIN 1% FOAM	NC	
EVOLUTION TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EVOTAZ 300 MG-150 MG TABLET	3	
EVOXAC 30 MG CAPSULE	NC	
EVZIO 0.4 MG AUTO-INJECTOR	NC	
EVZIO 2 MG AUTO-INJECTOR	NC	
EXALGO ER 12 MG TABLET	NC	
EXALGO ER 16 MG TABLET	NC	
EXALGO ER 32 MG TABLET	NC	
EXALGO ER 8 MG TABLET	NC	
EXEL 3 ML SYRN 27G X 1 1/4"	3	
EXEL ALLERGY SYRINGE 27G-1 ML	3	
EXEL HYPO NEEDLE 16GX0.05"	3	
EXEL HYPO NEEDLE 16GX1"	3	
EXEL HYPO NEEDLE 18GX0.5"	3	
EXEL HYPO NEEDLE 18GX1"	3	
EXEL HYPO NEEDLE 19GX1"	3	
EXEL HYPO NEEDLE 19GX1.5"	3	
EXEL HYPO NEEDLE 20GX0.5"	3	
EXEL HYPO NEEDLE 20GX0.75"	3	
EXEL HYPO NEEDLE 20GX1"	3	
EXEL HYPO NEEDLE 21GX0.5"	3	
EXEL HYPO NEEDLE 21GX1"	3	
EXEL HYPO NEEDLE 21GX2"	3	
EXEL HYPO NEEDLE 22GX0.5"	3	
EXEL HYPO NEEDLE 22GX0.75"	3	
EXEL HYPO NEEDLE 22GX1"	3	
EXEL HYPO NEEDLE 23GX0.75"	3	
EXEL HYPO NEEDLE 23GX1"	3	
EXEL HYPO NEEDLE 23GX1.5"	3	
EXEL HYPO NEEDLE 25GX0.5"	3	
EXEL HYPO NEEDLE 25GX0.625"	3	
EXEL HYPO NEEDLE 25GX0.75"	3	
EXEL HYPO NEEDLE 25GX1"	3	
EXEL HYPO NEEDLE 26GX0.375"	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EXEL HYPO NEEDLE 26GX0.5"	3	
EXEL HYPO NEEDLE 26GX0.625"	3	
EXEL HYPO NEEDLE 26GX1.5"	3	
EXEL HYPO NEEDLE 27GX0.5"	3	
EXEL HYPO NEEDLE 30GX1.5"	3	
EXEL SYRINGE 10 ML	3	
EXEL SYRINGE 20 ML	3	
EXEL SYRINGE 20GX1" 3 ML	3	
EXEL SYRINGE 20GX1-1/2" 3 ML	3	
EXEL SYRINGE 21GX1" 3 ML	3	
EXEL SYRINGE 21GX1-1/2" 3 ML	3	
EXEL SYRINGE 22GX1" 3 ML	3	
EXEL SYRINGE 22GX1-1/2" 3 ML	3	
EXEL SYRINGE 22GX3/4" 3 ML	3	
EXEL SYRINGE 23GX1" 3 ML	3	
EXEL SYRINGE 23GX1-1/2" 3 ML	3	
EXEL SYRINGE 25GX1" 3 ML	3	
EXEL SYRINGE 25GX5/8" 3 ML	3	
EXEL SYRINGE 3 ML	3	
EXEL SYRINGE 30 ML	3	
EXEL SYRINGE 5 ML	3	
EXEL SYRINGE 50 ML	3	
EXEL TB WITH NEEDLE 25GX5/8"	3	
EXEL TB WITH NEEDLE 26GX3/8"	3	
EXEL TB WITH NEEDLE 26GX5/8"	3	
EXEL TB WITH NEEDLE 27GX1/2"	3	
EXEL TUBERCULIN SYRINGE 1 ML	3	
EXELDERM 1% CREAM	NC	
EXELDERM 1% SOLUTION	NC	
EXELON 1.5 MG CAPSULE	NC	
EXELON 13.3 MG/24HR PATCH	NC	
EXELON 2 MG/ML ORAL SOLUTION	3	
EXELON 3 MG CAPSULE	NC	
EXELON 4.5 MG CAPSULE	NC	
EXELON 4.6 MG/24HR PATCH	NC	
EXELON 6 MG CAPSULE	NC	
EXELON 9.5 MG/24HR PATCH	NC	
EXEMESTANE 25 MG TABLET	1	CH*; HSA*
EXFORGE 10-160 MG TABLET	NC	
EXFORGE 10-320 MG TABLET	NC	
EXFORGE 5-160 MG TABLET	NC	
EXFORGE 5-320 MG TABLET	NC	
EXFORGE HCT 10-160-12.5 MG TAB	NC	
EXFORGE HCT 10-160-25 MG TAB	NC	
EXFORGE HCT 10-320-25 MG TAB	NC	
EXFORGE HCT 5-160-12.5 MG TAB	NC	
EXFORGE HCT 5-160-25 MG TAB	NC	
EXJADE 125 MG TABLET	3	SPP*: Must use CVS Specialty
EXJADE 250 MG TABLET	3	SPP*: Must use CVS Specialty
EXJADE 500 MG TABLET	3	SPP*: Must use CVS Specialty
EXODERM LOTION	1	
EXOTIC-HC EAR DROP	1	
EXTAVIA 0.3 MG KIT	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
EXTINA 2% FOAM	3	
EYLEA 2 MG/0.05 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
EZ SMART 28G LANCETS	2	HSA*
EZ SMART PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EZ SMART TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
EZETIMIBE 10 MG TABLET	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-10 MG	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-20 MG	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-40 MG	2	Max. 1 per day HSA*
EZETIMIBE-SIMVASTATIN 10-80 MG	2	Max. 1 per day HSA*

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FABIOR 0.1% FOAM	3	Prior Authorization required for members 30 and older
FACTIVE 320 MG TABLET	3	
FALLBACK SOLO 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
FALMINA-28 TABLET	0	ACA*
FAMCICLOVIR 125 MG TABLET	1	
FAMCICLOVIR 250 MG TABLET	1	
FAMCICLOVIR 500 MG TABLET	1	
FAMOTIDINE 20 MG TABLET	1	
FAMOTIDINE 40 MG TABLET	1	
FAMOTIDINE 40 MG/5 ML SUSP	1	
FAMVIR 125 MG TABLET	NC	
FAMVIR 250 MG TABLET	NC	
FAMVIR 500 MG TABLET	NC	
FANAPT 1 MG TABLET	3	
FANAPT 10 MG TABLET	3	
FANAPT 12 MG TABLET	3	
FANAPT 2 MG TABLET	3	
FANAPT 4 MG TABLET	3	
FANAPT 6 MG TABLET	3	
FANAPT 8 MG TABLET	3	
FANAPT TITRATION PACK	3	
FANATREX ORAL SUSPENSION	3	
FARESTON 60 MG TABLET	2	CH*; HSA*
FARXIGA 10 MG TABLET	NC	
FARXIGA 5 MG TABLET	NC	
FARYDAK 10 MG CAPSULE	3	CH*; SPP*: CVS Specialty
FARYDAK 15 MG CAPSULE	3	CH*; SPP*: CVS Specialty
FARYDAK 20 MG CAPSULE	3	CH*; SPP*: CVS Specialty
FAYOSIM TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
FAZACLO 100 MG ODT	NC	
FAZACLO 12.5 MG ODT	NC	
FAZACLO 150 MG ODT	NC	
FAZACLO 200 MG ODT	NC	
FAZACLO 25 MG ODT	NC	
FC2 FEMALE CONDOM	0	ACA*
FEIBA NF 2,500 UNIT (NOMINAL)	MD	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FELBAMATE 400 MG TABLET	1	
FELBAMATE 600 MG TABLET	1	
FELBAMATE 600 MG/5 ML SUSP	1	
FELBATOL 400 MG TABLET	NC	
FELBATOL 600 MG TABLET	NC	
FELBATOL 600 MG/5 ML SUSP	NC	
FELDENE 10 MG CAPSULE	NC	
FELDENE 20 MG CAPSULE	NC	
FELODIPINE ER 10 MG TABLET	1	HSA*
FELODIPINE ER 2.5 MG TABLET	1	HSA*
FELODIPINE ER 5 MG TABLET	1	HSA*
FEM PH VAGINAL JELLY	3	
FEMARA 2.5 MG TABLET	NC	
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	NC	
FEMHRT 0.5 MG-2.5 MCG TABLET	NC	
FEMRING 0.05 MG VAGINAL RING	3	Max. 90 Days Supply;Max. 1 in 90 days
FEMRING 0.10 MG VAGINAL RING	3	Max. 90 Days Supply;Max. 1 in 90 days
FEMYNOR 28 TABLET	0	ACA*
FENOFIBRATE 120 MG TABLET	1	HSA*
FENOFIBRATE 130 MG CAPSULE	1	HSA*
FENOFIBRATE 134 MG CAPSULE	1	HSA*
FENOFIBRATE 145 MG TABLET	1	HSA*
FENOFIBRATE 150 MG CAPSULE	1	HSA*
FENOFIBRATE 160 MG TABLET	1	HSA*
FENOFIBRATE 200 MG CAPSULE	1	HSA*
FENOFIBRATE 40 MG TABLET	1	HSA*
FENOFIBRATE 43 MG CAPSULE	1	HSA*
FENOFIBRATE 48 MG TABLET	1	HSA*
FENOFIBRATE 50 MG CAPSULE	1	HSA*
FENOFIBRATE 54 MG TABLET	1	HSA*
FENOFIBRATE 67 MG CAPSULE	1	HSA*
FENOFIBRIC ACID 105 MG TABLET	1	HSA*
FENOFIBRIC ACID 35 MG TABLET	1	HSA*
FENOFIBRIC ACID DR 135 MG CAP	1	HSA*
FENOFIBRIC ACID DR 45 MG CAP	1	HSA*
FENOGLIDE 120 MG TABLET	NC	
FENOGLIDE 40 MG TABLET	NC	
FENOPROFEN 200 MG CAPSULE	1	
FENOPROFEN 400 MG CAPSULE	1	
FENOPROFEN 600 MG TABLET	1	

FENORTHO 200 MG CAPSULE	NC	
FENORTHO 400 MG CAPSULE	NC	
FENTANYL 100 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 12 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 25 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 37.5 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 50 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 62.5 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 75 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL 87.5 MCG/HR PATCH	1	Max. 15 per 30 days
FENTANYL CIT OTFC 1,200 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CIT OTFC 1,600 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 200 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 400 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 600 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL CITRATE OTFC 800 MCG	1	Prior Authorization required;Max. 120 per 30 days
FENTANYL-ROPIV-NS 2 MCG-0.1%	1	
FENTORA 100 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 200 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 400 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 600 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FENTORA 800 MCG BUCCAL TABLET	3	Prior Authorization required;Max. 120 per 30 days
FEROCON CAPSULE	1	
FERREX 150 FORTE CAPSULE	1	
FERREX 150 FORTE PLUS CAPSULE	1	
FERRIPROX 100 MG/ML SOLUTION	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
FERRIPROX 500 MG TABLET	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
FERROCITE PLUS TABLET	1	
FERROGELS FORTE SOFTGEL	1	
FETZIMA 20-40 MG TITRATION PAK	3	Step Therapy required STA*: 18 and older
FETZIMA ER 120 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FETZIMA ER 20 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FETZIMA ER 40 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FETZIMA ER 80 MG CAPSULE	3	Step Therapy required STA*: 18 and older
FEXMID 7.5 MG TABLET	NC	
FEXOFENADINE-PSE ER 180-240 TB	1	
FIASP 100 UNIT/ML FLEXTOUCH	3	Prior Authorization required HSA*; PA NTM*
FIASP 100 UNIT/ML VIAL	3	Prior Authorization required HSA*; PA NTM*
FIBRICOR 105 MG TABLET	NC	
FIBRICOR 35 MG TABLET	NC	
FIFTY50 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FIFTY50 SAFETY SEAL 30G LANCET	2	HSA*
FIFTY50 SAFETY SEAL 32G LANCET	2	HSA*
FINACEA 15% FOAM	2	
FINACEA 15% GEL	2	
FINASTERIDE 5 MG TABLET	1	
FINE 30 UNIVERSAL 30G LANCETS	2	HSA*
FINGERSTIX LANCETS	2	HSA*
FIORICET 50-300-40 MG CAPSULE	NC	
FIORICET-COD 50-300-40-30 CAP	NC	
FIORINAL 50-325-40 MG CAPSULE	NC	
FIORINAL-COD 30-50-325-40 CAP	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FIRAZYR 30 MG/3 ML SYRINGE	3	SPP*: Must use CVS Specialty
FIRST 2% TESTOSTERONE OINT	3	Max. 30 Days Supply
FIRST HYDROCORT 10% GEL	3	
FIRST-DUKE'S MOUTHWASH	3	
FIRST-LANSOPRAZOLE 3 MG/ML	3	
FIRST-MARY'S MOUTHWASH	3	
FIRST-MOUTHWASH BLM SUSPENSION	3	
FIRST-OMEPRAZOLE 2 MG/ML SUSP	3	
FIRST-PROGESTERONE VGS 100 SUP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 200 SUP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 25 SUPP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 400 SUP	3	Max. 30 Days Supply
FIRST-PROGESTERONE VGS 50 SUPP	3	Max. 30 Days Supply
FIRST-TESTOSTERONE MC 2% CR	3	Max. 30 Days Supply
FLAGYL 250 MG TABLET	NC	
FLAGYL 375 CAPSULE	NC	
FLAGYL 500 MG TABLET	NC	
FLAGYL ER 750 MG TABLET	3	
FLAREX 0.1% EYE DROPS	3	
FLAVOXATE HCL 100 MG TABLET	1	
FLECAINIDE ACETATE 100 MG TAB	1	
FLECAINIDE ACETATE 150 MG TAB	1	
FLECAINIDE ACETATE 50 MG TAB	1	
FLECTOR 1.3% PATCH	2	
FLEXICHAMBER	MD	
FLEXICHAMBER-LG CHILD MASK	MD	
FLEXICHAMBER-SM ADULT MASK	MD	
FLEXICHAMBER-SM CHILD MASK	MD	
FLO-PRED 16.7(15) MG/5 ML SUSP	3	
FLOLIPID 20 MG/5 ML ORAL SUSP	3	Prior Authorization required HSA*; PA NTM*
FLOLIPID 40 MG/5 ML ORAL SUSP	3	Prior Authorization required HSA*; PA NTM*
FLOMAX 0.4 MG CAPSULE	NC	
FLOXASE 0.05% NASAL SPRAY	NC	
FLOVENT 100 MCG DISKUS	2	HSA*
FLOVENT 250 MCG DISKUS	2	HSA*
FLOVENT 50 MCG DISKUS	2	HSA*
FLOVENT HFA 110 MCG INHALER	2	HSA*
FLOVENT HFA 220 MCG INHALER	2	HSA*
FLOVENT HFA 44 MCG INHALER	2	HSA*
FLOW-EZE VENTED NEEDLE	3	
FLOWTUSS 2.5-200 MG/5 ML SOLN	NC	
FLOXIN 0.3% EAR DROPS	NC	
FLUAD 2017-2018 SYRINGE	0	Not covered for members 64 and younger ACA*
FLUARIX QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
FLUBLOK 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUBLOK QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
FLUCAINE EYE DROPS	1	
FLUCELVAX QUAD 2017-2018 SYR	0	Not covered for members 18 and younger ACA*
FLUCELVAX QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FLUCONAZOLE 10 MG/ML SUSP	1	
FLUCONAZOLE 100 MG TABLET	1	
FLUCONAZOLE 150 MG TABLET	1	
FLUCONAZOLE 200 MG TABLET	1	
FLUCONAZOLE 40 MG/ML SUSP	1	
FLUCONAZOLE 50 MG TABLET	1	
FLUCYTOSINE 250 MG CAPSULE	1	
FLUCYTOSINE 500 MG CAPSULE	1	
FLUDROCORTISONE 0.1 MG TABLET	1	
FLULAVAL QUAD 2017-2018 SYR	0	Not covered for members 18 and younger ACA*
FLULAVAL QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUMADINE 100 MG TABLET	NC	
FLUNISOLIDE 0.025% SPRAY	1	
FLUOCINOLONE 0.01% BODY OIL	1	
FLUOCINOLONE 0.01% CREAM	1	
FLUOCINOLONE 0.01% SOLUTION	1	
FLUOCINOLONE 0.025% CREAM	1	
FLUOCINOLONE 0.025% OINTMENT	1	
FLUOCINOLONE OIL 0.01% EAR DRP	1	
FLUOCINONIDE 0.05% CREAM	1	
FLUOCINONIDE 0.05% GEL	1	
FLUOCINONIDE 0.05% OINTMENT	1	
FLUOCINONIDE 0.05% SOLUTION	1	
FLUOCINONIDE 0.1% CREAM	NC	
FLUOCINONIDE-E 0.05% CREAM	1	
FLUORESCIN-BENOXINATE EYE DRP	NC	
FLUORIDEX DAILY DEFENSE	NC	
FLUORIDEX SENSITIVITY RLF GEL	1	
FLUOROMETHOLONE 0.1% DROPS	1	
FLUOROPLEX 1% CREAM	3	
FLUOROURACIL 0.5% CREAM	1	
FLUOROURACIL 2% TOPICAL SOLN	1	
FLUOROURACIL 5% CREAM	1	
FLUOROURACIL 5% TOPICAL SOLN	1	
FLUOXETINE 20 MG/5 ML SOLUTION	1	
FLUOXETINE DR 90 MG CAPSULE	1	
FLUOXETINE HCL 10 MG CAPSULE	1	
FLUOXETINE HCL 10 MG TABLET	1	
FLUOXETINE HCL 20 MG CAPSULE	1	
FLUOXETINE HCL 20 MG TABLET	1	
FLUOXETINE HCL 40 MG CAPSULE	1	
FLUOXETINE HCL 60 MG TABLET	3	Step Therapy required
FLUPHENAZINE 1 MG TABLET	1	
FLUPHENAZINE 10 MG TABLET	1	
FLUPHENAZINE 2.5 MG TABLET	1	
FLUPHENAZINE 2.5 MG/5 ML ELIX	1	
FLUPHENAZINE 5 MG TABLET	1	
FLUPHENAZINE 5 MG/ML CONC	1	
FLURANDRENOLIDE 0.05% CREAM	1	
FLURANDRENOLIDE 0.05% LOTION	1	
FLURANDRENOLIDE 0.05% OINTMENT	2	
FLURAZEPAM 15 MG CAPSULE	1	
FLURAZEPAM 30 MG CAPSULE	1	
FLURBIPROFEN 0.03% EYE DROP	1	
FLURBIPROFEN 100 MG TABLET	1	
FLURBIPROFEN 50 MG TABLET	1	
FLURESS EYE DROPS	NC	
FLUROX EYE DROPS	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FLUTAMIDE 125 MG CAPSULE	1	CH*
FLUTICASONE PROP 0.005% OINT	1	
FLUTICASONE PROP 0.05% CREAM	1	
FLUTICASONE PROP 0.05% LOTION	1	
FLUTICASONE PROP 50 MCG SPRAY	1	
FLUTICASONE-SALMETEROL 113-14	1	Max. 60 in 30 days HSA*
FLUTICASONE-SALMETEROL 232-14	1	Max. 60 in 30 days HSA*
FLUTICASONE-SALMETEROL 55-14	1	Max. 60 in 30 days HSA*
FLUVASTATIN ER 80 MG TABLET	1	HSA*
FLUVASTATIN SODIUM 20 MG CAP	1	HSA*
FLUVASTATIN SODIUM 40 MG CAP	1	HSA*
FLUVIRIN 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
FLUVIRIN 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUVOXAMINE ER 100 MG CAPSULE	1	
FLUVOXAMINE ER 150 MG CAPSULE	1	
FLUVOXAMINE MALEATE 100 MG TAB	1	
FLUVOXAMINE MALEATE 25 MG TAB	1	
FLUVOXAMINE MALEATE 50 MG TAB	1	
FLUZONE HIGH-DOSE 2017-18 SYR	0	Not covered for members 64 and younger ACA*
FLUZONE INTRADERM QUAD 2017-18	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD 2017-2018 SYRINGE	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD 2017-2018 VIAL	0	Not covered for members 18 and younger ACA*
FLUZONE QUAD PEDI 2017-18 SYR	0	Not covered for members 18 and younger ACA*
FML FORTE 0.25% EYE DROPS	2	
FML LIQUIFILM 0.1% EYE DROP	NC	
FML S.O.P. 0.1% OINTMENT	2	
FOCALIN 10 MG TABLET	NC	
FOCALIN 2.5 MG TABLET	NC	
FOCALIN 5 MG TABLET	NC	
FOCALIN XR 10 MG CAPSULE	NC	
FOCALIN XR 15 MG CAPSULE	NC	
FOCALIN XR 20 MG CAPSULE	NC	
FOCALIN XR 25 MG CAPSULE	NC	
FOCALIN XR 30 MG CAPSULE	NC	
FOCALIN XR 35 MG CAPSULE	NC	
FOCALIN XR 40 MG CAPSULE	NC	
FOCALIN XR 5 MG CAPSULE	NC	
FOLBEE PLUS TABLET	1	
FOLCAPS TABLET	1	
FOLGARD OS TABLET	NC	
FOLGARD RX TABLET	NC	
FOLIC ACID 1 MG TABLET	1	ACA*: Females 12-50 years of age
FOLIC ACID-VIT B6-VIT B12 TAB	1	
FOLLISTIM AQ 150 UNIT VIAL	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLLISTIM AQ 300 UNIT CARTRIDG	3	Max. 30 Days Supply;Step Therapy required IVF*



DRUG NAME	TIER	LIMITATIONS/ * NOTES
FOLLISTIM AQ 600 UNIT CARTRIDG	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLLISTIM AQ 75 UNIT VIAL	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLLISTIM AQ 900 UNIT CARTRIDG	3	Max. 30 Days Supply;Step Therapy required IVF*
FOLPLEX 2.2 TABLET	1	
FOLTRATE TABLET	NC	
FONDAPARINUX 10 MG/0.8 ML SYR	1	HSA*; SPP*: CVS Specialty
FONDAPARINUX 2.5 MG/0.5 ML SYR	1	HSA*; SPP*: CVS Specialty
FONDAPARINUX 5 MG/0.4 ML SYR	1	HSA*; SPP*: CVS Specialty
FONDAPARINUX 7.5 MG/0.6 ML SYR	1	HSA*; SPP*: CVS Specialty
FORA 30G LANCETS	2	HSA*
FORA BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D15C GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D15G GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D15Z GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D20 GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA D40-G31 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G20 GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G30A GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G71A GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA G90 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA GD50 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA TEST N'GO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA TN'G VOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V10 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V10-V12-D10-D20 STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V12 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V20 GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V22 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORA V30A GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORACARE 30G LANCETS	2	HSA*
FORACARE GD20 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORACARE GD40 GLUCOSE STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FORADIL AEROLIZER 12 MCG CAP	2	Max. 2 per day HSA*
FORFIVO XL 450 MG TABLET	2	
FORMA-RAY 20% SOLUTION	2	
FORMADON 10% SOLUTION	1	
FORMALDEHYDE 10% SOLUTION	1	
FORTAMET ER 1,000 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FORTAMET ER 500 MG TABLET	NC	
FORTAVIT SOFTGEL	3	
FORTEO 600 MCG/2.4 ML PEN INJ	2	Prior Authorization required;Max. 2.4 ML(s) per 28 days HSA*; Max 1 syringe/28 days supply; SPP: Must use CVS Specialty
FORTESTA 10 MG GEL PUMP	NC	
FORTICAL 200 UNITS NASAL SPRAY	2	HSA*
FORTISCARE GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
FOSAMAX 70 MG TABLET	NC	
FOSAMAX PLUS D 70 MG-2,800 IU	3	Max. 28 Days Supply;Max. 4 per 28 days HSA*
FOSAMAX PLUS D 70 MG-5,600 IU	3	Max. 4 per 28 days HSA*
FOSAMPRENAVIR 700 MG TABLET	2	
FOSINOPRIL SODIUM 10 MG TAB	1	HSA*
FOSINOPRIL SODIUM 20 MG TAB	1	HSA*
FOSINOPRIL SODIUM 40 MG TAB	1	HSA*
FOSINOPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
FOSINOPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
FOSRENOL 1,000 MG POWDER PACK	3	
FOSRENOL 1,000 MG TABLET CHEW	3	
FOSRENOL 500 MG TABLET CHEW	3	
FOSRENOL 750 MG POWDER PACKET	3	
FOSRENOL 750 MG TABLET CHEW	3	
FRAGMIN 10,000 UNITS/ML SYRING	2	HSA*; SPP*: CVS Specialty
FRAGMIN 12,500 UNITS/0.5 ML	2	HSA*; SPP*: CVS Specialty
FRAGMIN 15,000 UNITS/0.6 ML	2	HSA*; SPP*: CVS Specialty
FRAGMIN 18,000 UNITS/0.72 ML	2	HSA*; SPP*: CVS Specialty
FRAGMIN 2,500 UNITS/0.2 ML SYR	2	HSA*; SPP*: CVS Specialty
FRAGMIN 5,000 UNITS/0.2 ML SYR	2	HSA*; SPP*: CVS Specialty
FRAGMIN 7,500 UNITS/0.3 ML SYR	2	HSA*; SPP*: CVS Specialty
FRAGMIN 95,000 UNITS/3.8 ML VL	2	HSA*; SPP*: CVS Specialty
FREESTYLE 28G LANCETS	2	HSA*
FREESTYLE FREEDOM LITE METER	MD	Max. 1 in 365 days HSA*
FREESTYLE INSULINX GLUCOSE SYS	MD	Max. 1 in 365 days HSA*
FREESTYLE INSULINX TEST STRIP	2	Max. 204 per 30 days HSA*
FREESTYLE INSULINX TEST STRIPS	2	Max. 204 per 30 days HSA*
FREESTYLE LITE METER	MD	Max. 1 in 365 days HSA*
FREESTYLE LITE TEST STRIP	2	Max. 204 per 30 days HSA*
FREESTYLE LITE TEST STRIPS	2	Max. 204 per 30 days HSA*
FREESTYLE PREC NEO TEST STRIPS	2	Max. 204 per 30 days HSA*
FREESTYLE PRECISION NEO METER	MD	Max. 1 in 365 days HSA*
FREESTYLE TEST STRIPS	2	Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
FREESTYLE UNISTIK 2 LANCETS	2	HSA*
FROVA 2.5 MG TABLET	NC	
FROVATRIPTAN SUCC 2.5 MG TAB	1	Max. quantity of 9 per fill; Step Therapy required MQC*: 9 tabs/copay
FULYZAQ 125 MG DR TABLET	3	Step Therapy required
FURADANTIN 25 MG/5 ML SUSP	NC	
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*
FUSION SPRINKLES POWDER PACKET	3	
FUZEON 90 MG VIAL	2	SPP*: Must use CVS Specialty
FYAVOLV 0.5 MG-2.5 MCG TABLET	1	
FYAVOLV 1 MG-5 MCG TABLET	1	
FYCOMPA 0.5 MG/ML ORAL SUSP	3	
FYCOMPA 10 MG TABLET	3	
FYCOMPA 12 MG TABLET	3	
FYCOMPA 2 MG TABLET	3	
FYCOMPA 4 MG TABLET	3	
FYCOMPA 6 MG TABLET	3	
FYCOMPA 8 MG TABLET	3	
<b>G</b>		
G TUSSIN AC LIQUID	1	
G-4 TEST STRIPS	3	Prior Authorization required; Max. 204 per 30 days HSA*
GABAPENTIN 100 MG CAPSULE	1	
GABAPENTIN 250 MG/5 ML SOLN	1	
GABAPENTIN 300 MG CAPSULE	1	
GABAPENTIN 400 MG CAPSULE	1	
GABAPENTIN 600 MG TABLET	1	
GABAPENTIN 800 MG TABLET	1	
GABITRIL 12 MG TABLET	2	
GABITRIL 16 MG TABLET	2	
GABITRIL 2 MG TABLET	3	
GABITRIL 4 MG TABLET	3	
GALANTAMINE 4 MG/ML ORAL SOLN	1	
GALANTAMINE ER 16 MG CAPSULE	1	
GALANTAMINE ER 24 MG CAPSULE	1	
GALANTAMINE ER 8 MG CAPSULE	1	
GALANTAMINE HBR 12 MG TABLET	1	
GALANTAMINE HBR 4 MG TABLET	1	
GALANTAMINE HBR 8 MG TABLET	1	
GALZIN 25 MG CAPSULE	3	
GALZIN 50 MG CAPSULE	3	
GANIRELIX ACET 250 MCG/0.5 ML	2	Max. 30 Days Supply IVF*
GARAMYCIN 0.3% EYE DROPS	NC	
GARAMYCIN 3 MG/GM EYE OINTMENT	NC	
GARDASIL 9 SYRINGE	0	Not covered for members 27 and older ACA*
GARDASIL 9 VIAL	0	Not covered for members 27 and older ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GARDASIL SYRINGE	0	Not covered for members 27 and older ACA*
GARDASIL VIAL	0	Not covered for members 27 and older ACA*
GASTROCROM 100 MG/5 ML CONC	NC	
GATIFLOXACIN 0.5% EYE DROPS	1	
GATTEX 5 MG 30-VIAL KIT	3	Prior Authorization required SPP*: Must use CVS Specialty
GAVILYTE-C SOLUTION	0	ACA*
GAVILYTE-G SOLUTION	0	ACA*
GAVILYTE-H AND BISACODYL KIT	0	ACA*
GAVILYTE-N SOLUTION	0	ACA*
GE100 BLOOD GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GELCLAIR ORAL GEL PACKET	2	
GELFILM OPHTHALMIC 25X50MM	3	
GELFOAM POWDER	NC	
GELNIQUE 10% GEL SACHETS	3	Max. 1 GM(s) per day Max 30 packets or 1 pump/30 days supply
GELNIQUE 3% GEL	3	Max. 92 GM(s) in 30 days Max 1 pump/30 days supply
GELX ORAL GEL	3	
GEMFIBROZIL 600 MG TABLET	1	HSA*
GENERESS FE CHEWABLE TABLET	NC	
GENERLAC 10 GM/15 ML SOLUTION	1	
GENGRAF 100 MG CAPSULE	1	
GENGRAF 100 MG/ML SOLUTION	1	
GENGRAF 25 MG CAPSULE	1	
GENGRAF 50 MG CAPSULE	1	
GENOTROPIN 12 MG CARTRIDGE	NC	
GENOTROPIN 5 MG CARTRIDGE	NC	
GENOTROPIN MINIQUICK 0.2 MG	NC	
GENOTROPIN MINIQUICK 0.4 MG	NC	
GENOTROPIN MINIQUICK 0.6 MG	NC	
GENOTROPIN MINIQUICK 0.8 MG	NC	
GENOTROPIN MINIQUICK 1 MG	NC	
GENOTROPIN MINIQUICK 1.2 MG	NC	
GENOTROPIN MINIQUICK 1.4 MG	NC	
GENOTROPIN MINIQUICK 1.6 MG	NC	
GENOTROPIN MINIQUICK 1.8 MG	NC	
GENOTROPIN MINIQUICK 2 MG	NC	
GENSTRIP GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GENTAK 0.3 % EYE OINTMENT	1	
GENTAMICIN 0.1% CREAM	1	
GENTAMICIN 0.1% OINTMENT	1	
GENTAMICIN 3 MG/GM EYE OINT	1	
GENTAMICIN 3 MG/ML EYE DROPS	1	
GENULTIMATE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
GENVOYA TABLET	3	
GEODON 20 MG CAPSULE	NC	
GEODON 40 MG CAPSULE	NC	
GEODON 60 MG CAPSULE	NC	
GEODON 80 MG CAPSULE	NC	
GIANVI 3 MG-0.02 MG TABLET	0	ACA*
GIAZO 1.1 GM TABLET	3	

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

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
GMATE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
GNP UNIVERSAL 1 STANDARD 21G	2	HSA*
GNP UNIVERSAL 1 SUPER THIN 30G	2	HSA*
GOCOVRI ER 137 MG CAPSULE	3	Prior Authorization required PA NTM*
GOCOVRI ER 68.5 MG CAPSULE	3	Prior Authorization required PA NTM*
GOLYTELY PACKET	3	
GOLYTELY SOLUTION	NC	
GONAL-F 450 UNITS VIAL	2	Max. 30 Days Supply IVF*
GONAL-F RFF 300 UNITS PEN	2	Max. 30 Days Supply
GONAL-F RFF 450 UNITS PEN	2	Max. 30 Days Supply
GONAL-F RFF 75 UNITS VIAL	2	Max. 30 Days Supply
GONAL-F RFF REDI-JECT 300 UNIT	2	Max. 30 Days Supply
GONAL-F RFF REDI-JECT 450 UNIT	2	Max. 30 Days Supply
GONAL-F RFF REDI-JECT 900 UNIT	2	Max. 30 Days Supply
GONITRO 0.4 MG SUBLINGUAL PWD	3	HSA*
GORDO-UREA 22% OINTMENT	3	
GORDO-UREA 40% OINTMENT	3	
GRALISE 30-DAY STARTER PACK	NC	
GRALISE ER 300 MG TABLET	NC	
GRALISE ER 600 MG TABLET	NC	
GRANISETRON HCL 1 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
GRANISOL 2 MG/10 ML SOLUTION	1	Max. quantity of 30 per fill MQC*: 30mL/copay
GRANIX 300 MCG/0.5 ML SAFE SYR	3	Prior Authorization required SPP*: CVS Specialty
GRANIX 480 MCG/0.8 ML SAFE SYR	3	Prior Authorization required SPP*: CVS Specialty
GRANULEX SPRAY	1	
GRASTEK 2,800 BAU SL TABLET	3	Max. 1 per day
GRIFULVIN V 500 MG TABLET	NC	
GRIS-PEG 125 MG TABLET	NC	
GRIS-PEG 250 MG TABLET	NC	
GRISEOFULVIN 125 MG/5 ML SUSP	1	
GRISEOFULVIN MICRO 500 MG TAB	1	
GRISEOFULVIN ULTRA 125 MG TAB	1	
GRISEOFULVIN ULTRA 250 MG TAB	1	
GUAIACOL LIQUID PURIFIED	3	
GUAIATUSSIN AC LIQUID	1	
GUAIFEN-CODEINE 100-10 MG/5 ML	1	
GUAIFENESIN AC COUGH SYRUP	1	
GUAIFENESIN DAC ORAL SOLUTION	1	
GUAIFENESIN-CODEINE SYRUP	1	
GUANFACINE 1 MG TABLET	1	HSA*
GUANFACINE 2 MG TABLET	1	HSA*
GUANFACINE HCL ER 1 MG TABLET	1	
GUANFACINE HCL ER 2 MG TABLET	1	
GUANFACINE HCL ER 3 MG TABLET	1	
GUANFACINE HCL ER 4 MG TABLET	1	
GUANIDINE HCL 125 MG TABLET	1	
GYNAZOLE 1 2% CREAM	3	
GYNOL II 3% GEL	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
<b>H</b>		
HAEGARDA 2,000 UNIT VIAL	3	Prior Authorization required PA NTM*; SPP*: Must use CVS Specialty
HAEGARDA 3,000 UNIT VIAL	3	Prior Authorization required PA NTM*; SPP*: Must use CVS Specialty
HALCION 0.25 MG TABLET	NC	
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	NC	
HALOPERIDOL 0.5 MG TABLET	1	
HALOPERIDOL 1 MG TABLET	1	
HALOPERIDOL 10 MG TABLET	1	
HALOPERIDOL 2 MG TABLET	1	
HALOPERIDOL 20 MG TABLET	1	
HALOPERIDOL 5 MG TABLET	1	
HALOPERIDOL LAC 2 MG/ML CONC	1	
HARVONI 90-400 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
HAVRIX 1,440 UNITS/ML SYRINGE	MD	Not covered for members 17 and younger
HAVRIX 1,440 UNITS/ML VIAL	MD	Not covered for members 17 and younger
HAVRIX 720 UNIT/0.5 ML SYRINGE	MD	Not covered for members 17 and younger
HAVRIX 720 UNITS/0.5 ML VIAL	MD	Not covered for members 17 and younger
HEALTHPRO GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
HEALTHY ACCENTS UNILET 30G	2	HSA*
HEATHER TABLET	0	ACA*
HECORIA 0.5 MG CAPSULE	2	
HECORIA 1 MG CAPSULE	2	
HECORIA 5 MG CAPSULE	2	
HECTOROL 0.5 MCG CAPSULE	NC	
HECTOROL 1 MCG CAPSULE	NC	
HECTOROL 2.5 MCG CAPSULE	NC	
HELIDAC THERAPY	3	
HELIXATE FS 2,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty; Kogenate Preferred
HEMA-COMBISTIX REAGENT STRIPS	2	
HEMANGEOL 4.28 MG/ML ORAL SOLN	3	HSA*
HEMATINIC-FOLIC ACID TABLET	1	
HEMATINIC-VITAMIN-MINERAL TAB	1	
HEMATOGEN FA SOFTGEL	1	
HEMATOGEN FORTE SOFTGEL	1	
HEMATRON LIQUID	3	
HEMMOREX-HC 25 MG SUPPOSITORY	NC	
HEMMOREX-HC 30 MG SUPPOSITORY	NC	
HEMOCYTE PLUS CAPSULE	NC	
HEMOCYTE-F TABLET	NC	
HEMOFIL M 1,700 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
HEMRIL-30 30 MG SUPPOSITORY	1	
HEPARIN SOD 10,000 UNIT/ML VL	1	
HEPARIN SOD 20,000 UNIT/ML VL	1	
HEPARIN SOD 5,000 UNIT/ML VIAL	1	
HEPSERA 10 MG TABLET	NC	
HETLIOZ 20 MG CAPSULE	3	Prior Authorization required;Max. 1 per day LDD*: Diplomat Pharmacy (877) 977-9118



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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
HYCANTIN 0.25 MG CAPSULE	3	CH*; SPP*: CVS Specialty
HYCANTIN 1 MG CAPSULE	3	CH*; SPP*: CVS Specialty
HYCET 7.5 MG-325 MG/15 ML SOLN	NC	
HYCOFENIX 2.5-30-200 MG/5 ML	3	
HYDRALAZINE 10 MG TABLET	1	HSA*
HYDRALAZINE 100 MG TABLET	1	HSA*
HYDRALAZINE 25 MG TABLET	1	HSA*
HYDRALAZINE 50 MG TABLET	1	HSA*
HYDREA 500 MG CAPSULE	NC	
HYDROCHLOROTHIAZIDE 12.5 MG CP	1	HSA*
HYDROCHLOROTHIAZIDE 12.5 MG TB	1	HSA*
HYDROCHLOROTHIAZIDE 25 MG TAB	1	HSA*
HYDROCHLOROTHIAZIDE 50 MG TAB	1	HSA*
HYDROCOD-CPM-PSEUDOEP 5-4-60/5	1	
HYDROCOD-HOMATROP 5-1.5 MG TAB	1	
HYDROCODON-ACETAMIN 7.5-325/15	1	
HYDROCODON-ACETAMINOPH 2.5-325	1	
HYDROCODON-ACETAMINOPH 2.5-500	1	
HYDROCODON-ACETAMINOPH 7.5-300	1	
HYDROCODON-ACETAMINOPH 7.5-325	1	
HYDROCODON-ACETAMINOPH 7.5-500	1	
HYDROCODON-ACETAMINOPH 7.5-650	1	
HYDROCODON-ACETAMINOPH 7.5-750	1	
HYDROCODON-ACETAMINOPHEN 5-300	1	
HYDROCODON-ACETAMINOPHEN 5-325	1	
HYDROCODON-ACETAMINOPHEN 5-500	1	
HYDROCODON-ACETAMINOPHN 10-300	1	
HYDROCODON-ACETAMINOPHN 10-325	1	
HYDROCODON-ACETAMINOPHN 10-500	1	
HYDROCODON-ACETAMINOPHN 10-650	1	
HYDROCODON-ACETAMINOPHN 10-660	1	
HYDROCODON-ACETAMINOPHN 10-750	1	
HYDROCODONE-ACETAMIN 2.5-167/5	1	
HYDROCODONE-ACETAMIN 5-163/7.5	1	
HYDROCODONE-CHLORPHEN ER SUSP	1	
HYDROCODONE-HOMATROPINE SYRUP	1	
HYDROCODONE-IBUPROFEN 10-200	1	
HYDROCODONE-IBUPROFEN 2.5-200	1	
HYDROCODONE-IBUPROFEN 5-200 MG	1	
HYDROCODONE-IBUPROFEN 7.5-200	1	
HYDROCORT-PRAMOXINE 1%-1% CRM	1	
HYDROCORT-PRAMOXINE 2.5-1% CRM	1	
HYDROCORTISON-ACETIC ACID SOLN	1	
HYDROCORTISONE 1% CREAM	1	
HYDROCORTISONE 1% OINTMENT	1	
HYDROCORTISONE 10 MG TABLET	1	
HYDROCORTISONE 100 MG/60 ML	1	
HYDROCORTISONE 2.5% CREAM	1	
HYDROCORTISONE 2.5% LOTION	1	
HYDROCORTISONE 2.5% OINTMENT	1	
HYDROCORTISONE 20 MG TABLET	1	
HYDROCORTISONE 5 MG TABLET	1	

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
IBRANCE 100 MG CAPSULE	3	CH*; SPP*: CVS Specialty
IBRANCE 125 MG CAPSULE	3	CH*; SPP*: CVS Specialty
IBRANCE 75 MG CAPSULE	3	CH*; SPP*: CVS Specialty
IBUDONE 10-200 MG TABLET	NC	
IBUDONE 5-200 MG TABLET	NC	
IBUPROFEN 100 MG/5 ML SUSP	1	
IBUPROFEN 400 MG TABLET	1	
IBUPROFEN 600 MG TABLET	1	
IBUPROFEN 800 MG TABLET	1	
ICLUSIG 15 MG TABLET	3	CH*
ICLUSIG 45 MG TABLET	3	CH*
IDELVION 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
IDHIFA 100 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
IDHIFA 50 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
IFEREX 150 FORTE CAPSULE	1	
ILARIS 150 MG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ILARIS 180 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
ILEVRO 0.3% OPHTH DROPS	3	
ILOTYCIN 0.5% EYE OINTMENT	NC	
IMATINIB MESYLATE 100 MG TAB	2	Max. 30 Days Supply CH*; SPP*: CVS Specialty
IMATINIB MESYLATE 400 MG TAB	2	Max. 30 Days Supply CH*; SPP*: CVS Specialty
IMBRUVICA 140 MG CAPSULE	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
IMDUR ER 120 MG TABLET	NC	
IMDUR ER 30 MG TABLET	NC	
IMDUR ER 60 MG TABLET	NC	
IMIPRAMINE HCL 10 MG TABLET	1	
IMIPRAMINE HCL 25 MG TABLET	1	
IMIPRAMINE HCL 50 MG TABLET	1	
IMIPRAMINE PAMOATE 100 MG CAP	1	
IMIPRAMINE PAMOATE 125 MG CAP	1	
IMIPRAMINE PAMOATE 150 MG CAP	1	
IMIPRAMINE PAMOATE 75 MG CAP	1	
IMIQUIMOD 5% CREAM PACKET	1	
IMITREX 100 MG TABLET	NC	
IMITREX 20 MG NASAL SPRAY	NC	
IMITREX 25 MG TABLET	NC	
IMITREX 4 MG/0.5 ML PEN INJECT	NC	
IMITREX 5 MG NASAL SPRAY	NC	
IMITREX 50 MG TABLET	NC	
IMITREX 6 MG/0.5 ML PEN INJECT	NC	
IMITREX 6 MG/0.5 ML VIAL	NC	
IMOGAM RABIES-HT 150 UNIT/ML	MD	
IMOVAX RABIES VACCINE+DILUENT	MD	
IMPAVIDO 50 MG CAPSULE	3	
IMURAN 50 MG TABLET	NC	
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
INCONTROL ULTRA THIN 28G LANCT	2	HSA*
INCRELEX 40 MG/4 ML VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
INCRUSE ELLIPTA 62.5 MCG INH	2	Max. quantity of 30 per fill;Max. 30 in 30 days HSA*
INDAPAMIDE 1.25 MG TABLET	1	HSA*
INDAPAMIDE 2.5 MG TABLET	1	HSA*
INDERAL LA 160 MG CAPSULE	NC	
INDERAL LA 60 MG CAPSULE	NC	
INDERAL LA 80 MG CAPSULE	NC	
INDERAL XL 120 MG CAPSULE	3	HSA*
INDOCIN 25 MG/5 ML SUSPENSION	3	
INDOCIN 50 MG SUPPOSITORY	2	
INDOMETHACIN 25 MG CAPSULE	1	
INDOMETHACIN 50 MG CAPSULE	1	
INDOMETHACIN ER 75 MG CAPSULE	1	
INFASURF 35 MG/ML VIAL	3	
INFERGEN 15 MCG/0.5 ML VIAL	2	LDD*: Accredo (866) 815-4717
INFERGEN 9 MCG/0.3 ML VIAL	2	LDD*: Accredo (866) 815-4717
INFINITY TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
INGREZZA 40 MG CAPSULE	3	Prior Authorization required;Max. 2 per day LDD*: Pantherx Specialty Pharmacy 1-855-726-8479; PA NTM*
INGREZZA 80 MG CAPSULE	3	Prior Authorization required;Max. 1 per day LDD*: Pantherx Specialty Pharmacy 1-855-726-8479; PA NTM*
INJECT EASE 28G LANCETS	2	HSA*
INJECT EASE 30G LANCETS	2	HSA*
INLYTA 1 MG TABLET	3	CH*; SPP*: CVS Specialty
INLYTA 5 MG TABLET	3	CH*; SPP*: CVS Specialty
INNOPRAN XL 120 MG CAPSULE	2	HSA*
INNOPRAN XL 80 MG CAPSULE	2	HSA*
INOVA 4% EASY PAD	3	
INOVA 4-1 EASY PAD	3	
INOVA 8% EASY PAD	3	
INOVA 8-2 EASY PAD	3	
INSPIRACHAMBER	MD	
INSPIRACHAMBER WITH MASK-MED	MD	
INSPRA 25 MG TABLET	NC	
INSPRA 50 MG TABLET	NC	
INTELENCE 100 MG TABLET	3	
INTELENCE 200 MG TABLET	3	
INTELENCE 25 MG TABLET	3	
INTERMEZZO 1.75 MG TAB SUBLING	NC	
INTERMEZZO 3.5 MG TAB SUBLING	NC	
INTRAROSA 6.5 MG VAG INSERT	NC	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
INTRON A 50 MILLION UNITS VIAL	2	SPP*: Must use CVS Specialty
INTROVALE 0.15-0.03 MG TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
INTUNIV ER 1 MG TABLET	NC	
INTUNIV ER 2 MG TABLET	NC	
INTUNIV ER 3 MG TABLET	NC	
INTUNIV ER 4 MG TABLET	NC	
INVACARE 30G LANCETS	2	HSA*
INVEGA ER 1.5 MG TABLET	NC	
INVEGA ER 3 MG TABLET	NC	
INVEGA ER 6 MG TABLET	NC	
INVEGA ER 9 MG TABLET	NC	
INVEGA SUSTENNA 117 MG/0.75 ML	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 156 MG/ML SYRG	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 234 MG/1.5 ML	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 39 MG/0.25 ML	MD	SPP*: Must use CVS Specialty
INVEGA SUSTENNA 78 MG/0.5 ML	MD	SPP*: Must use CVS Specialty
INVIRASE 200 MG CAPSULE	2	
INVIRASE 500 MG TABLET	2	
INVOKAMET 150-1,000 MG TABLET	2	HSA*
INVOKAMET 150-500 MG TABLET	2	HSA*
INVOKAMET 50-1,000 MG TABLET	2	HSA*
INVOKAMET 50-500 MG TABLET	2	HSA*
INVOKAMET XR 150-1,000 MG TAB	2	HSA*
INVOKAMET XR 150-500 MG TABLET	2	HSA*
INVOKAMET XR 50-1,000 MG TAB	2	HSA*
INVOKAMET XR 50-500 MG TABLET	2	HSA*
INVOKANA 100 MG TABLET	2	HSA*
INVOKANA 300 MG TABLET	2	HSA*
IODOFLEX PAD	3	
IODOSORB GEL	3	
IOPHEN-C NR LIQUID	1	
IOPIDINE 0.5% EYE DROPS	NC	
IOPIDINE 1% EYE DROPS	3	
IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	1	HSA*
IPRATROPIUM 0.03% SPRAY	1	
IPRATROPIUM 0.06% SPRAY	1	
IPRATROPIUM BR 0.02% SOLN	1	HSA*
IPRIVASK 15 MG VIAL	3	HSA*; SPP*: CVS Specialty
IRBESARTAN 150 MG TABLET	1	HSA*
IRBESARTAN 300 MG TABLET	1	HSA*
IRBESARTAN 75 MG TABLET	1	HSA*
IRBESARTAN-HCTZ 150-12.5 MG TB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
IRBESARTAN-HCTZ 300-12.5 MG TB	1	HSA*
IRENKA DR 40 MG CAPSULE	NC	
IRESSA 250 MG TABLET	3	CH*; SPP*: CVS Specialty
IRON AG-PS-ASC-B12-FA-THRE-SUC	1	
IRRIGATION SYRINGE	3	
ISENTRESS 100 MG POWDER PACKET	2	
ISENTRESS 100 MG TABLET CHEW	2	
ISENTRESS 25 MG TABLET CHEW	2	
ISENTRESS 400 MG TABLET	2	
ISENTRESS HD 600 MG TABLET	2	
ISIBLOOM 28 DAY TABLET	0	ACA*
ISOCHRON 40 MG TABLET SA	NC	
ISOMETHEPT-DICHLORALP-ACETAMIN	1	
ISONIAZID 100 MG TABLET	1	
ISONIAZID 300 MG TABLET	1	
ISONIAZID 50 MG/5 ML SOLUTION	1	
ISOPTO ATROPINE 1% EYE DROPS	NC	
ISOPTO CARBACHOL 3% DROPS	3	
ISOPTO CARPINE 1% EYE DROPS	NC	
ISOPTO CARPINE 2% EYE DROPS	NC	
ISOPTO CARPINE 4% EYE DROPS	NC	
ISOPTO HOMATROPINE 5% DROPS	NC	
ISOPTO HYOSCINE 0.25% DROPS	3	
ISORDIL 40 MG TABLET	2	
ISORDIL TITRADOSE 5 MG TAB	NC	
ISOSORBIDE DN 10 MG TABLET	1	
ISOSORBIDE DN 2.5 MG TAB SL	1	
ISOSORBIDE DN 20 MG TABLET	1	
ISOSORBIDE DN 30 MG TABLET	1	
ISOSORBIDE DN 5 MG TABLET	1	
ISOSORBIDE DN 5 MG TABLET SL	1	
ISOSORBIDE DN ER 40 MG TABLET	1	
ISOSORBIDE MN 10 MG TABLET	1	
ISOSORBIDE MN 20 MG TABLET	1	
ISOSORBIDE MN ER 120 MG TAB	1	
ISOSORBIDE MN ER 30 MG TABLET	1	
ISOSORBIDE MN ER 60 MG TABLET	1	
ISOXSUPRINE 10 MG TABLET	1	
ISOXSUPRINE 20 MG TABLET	1	
ISRADIPINE 2.5 MG CAPSULE	1	HSA*
ISRADIPINE 5 MG CAPSULE	1	HSA*
ISTALOL 0.5% EYE DROPS	NC	
ITRACONAZOLE 100 MG CAPSULE	1	Max. 84 Days Supply; Prior Authorization required; Max. 168 in 365 days
IV INFUSION CPI KIT	3	
IVERMECTIN 3 MG TABLET	1	
IXINITY 500 UNIT RANGE	MD	SPP*: Must use CVS Specialty
<b>J</b>		
J-COF DHC LIQUID	1	
J-MAX DHC LIQUID	1	
JADENU 180 MG TABLET	3	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
JADENU 360 MG TABLET	3	SPP*: Must use CVS Specialty
JADENU 90 MG TABLET	3	SPP*: Must use CVS Specialty
JADENU SPRINKLE 180 MG GRANULE	3	SPP*: Must use CVS Specialty
JADENU SPRINKLE 360 MG GRANULE	3	SPP*: Must use CVS Specialty
JADENU SPRINKLE 90 MG GRANULE	3	SPP*: Must use CVS Specialty
JAKAFI 10 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 15 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 20 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 25 MG TABLET	3	CH*; SPP*: CVS Specialty
JAKAFI 5 MG TABLET	3	CH*; SPP*: CVS Specialty
JALYN 0.5-0.4 MG CAPSULE	NC	
JANTOVEN 1 MG TABLET	1	HSA*
JANTOVEN 10 MG TABLET	1	HSA*
JANTOVEN 2 MG TABLET	1	HSA*
JANTOVEN 2.5 MG TABLET	1	HSA*
JANTOVEN 3 MG TABLET	1	HSA*
JANTOVEN 4 MG TABLET	1	HSA*
JANTOVEN 5 MG TABLET	1	HSA*
JANTOVEN 6 MG TABLET	1	HSA*
JANTOVEN 7.5 MG TABLET	1	HSA*
JANUMET 50-1,000 MG TABLET	2	HSA*
JANUMET 50-500 MG TABLET	2	HSA*
JANUMET XR 100-1,000 MG TABLET	2	HSA*
JANUMET XR 50-1,000 MG TABLET	2	HSA*
JANUMET XR 50-500 MG TABLET	2	HSA*
JANUVIA 100 MG TABLET	2	HSA*
JANUVIA 25 MG TABLET	2	HSA*
JANUVIA 50 MG TABLET	2	HSA*
JARDIANCE 10 MG TABLET	2	HSA*
JARDIANCE 25 MG TABLET	2	HSA*
JENCYCLA 0.35 MG TABLET	0	ACA*
JENTADUETO 2.5 MG-1000 MG TAB	2	HSA*
JENTADUETO 2.5 MG-500 MG TAB	2	HSA*
JENTADUETO 2.5 MG-850 MG TAB	2	HSA*
JENTADUETO XR 2.5 MG-1,000 MG	2	HSA*
JENTADUETO XR 5 MG-1,000 MG TB	2	HSA*



DRUG NAME	TIER	LIMITATIONS/ * NOTES
JEVANTIQUE LO 0.5 MG-2.5 MCG	NC	
JINTELI 1 MG-5 MCG TABLET	1	
JOLESSA 0.15 MG-0.03 MG TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
JOLIVETTE TABLET	0	ACA*
JUBLIA 10% TOPICAL SOLUTION	NC	
JULEBER 28 DAY TABLET	0	ACA*
JUNEL 1 MG-20 MCG TABLET	0	ACA*
JUNEL 1.5 MG-30 MCG TABLET	0	ACA*
JUNEL FE 1 MG-20 MCG TABLET	0	ACA*
JUNEL FE 1.5 MG-30 MCG TABLET	0	ACA*
JUNEL FE 24 TABLET	0	ACA*
JUXTAPID 10 MG CAPSULE	3	HSA*; LDD*: Dohmen Life Sciences. 1-800-305-7881.
JUXTAPID 20 MG CAPSULE	3	HSA*; LDD*: Dohmen Life Sciences. 1-800-305-7881.
JUXTAPID 30 MG CAPSULE	3	HSA*; LDD*: Dohmen Life Sciences. 1-800-305-7881.
JUXTAPID 40 MG CAPSULE	3	HSA*; LDD*: Dohmen Life Sciences. 1-800-305-7881.
JUXTAPID 5 MG CAPSULE	3	HSA*; LDD*: Dohmen Life Sciences. 1-800-305-7881.
JUXTAPID 60 MG CAPSULE	3	HSA*; LDD*: Dohmen Life Sciences. 1-800-305-7881.

## K

K EFFERVESCENT 25 MEQ TABLET	1	
K-PHOS #2 TABLET	3	
K-PHOS NEUTRAL TABLET	NC	
K-PHOS ORIGINAL TABLET	3	
K-SOL 20% (40 MEQ/15 ML) LIQ	1	
K-TAB ER 10 MEQ TABLET	NC	
K-TAB ER 20 MEQ TABLET	NC	
K-TAB ER 8 MEQ TABLET	NC	
KADIAN ER 10 MG CAPSULE	NC	
KADIAN ER 100 MG CAPSULE	NC	
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	NC	
KADIAN ER 200 MG CAPSULE	2	Max. 2 per day
KADIAN ER 30 MG CAPSULE	NC	
KADIAN ER 40 MG CAPSULE	2	Max. 2 per day
KADIAN ER 50 MG CAPSULE	NC	
KADIAN ER 60 MG CAPSULE	NC	
KADIAN ER 70 MG CAPSULE	2	Max. 2 per day
KADIAN ER 80 MG CAPSULE	NC	
KAITLIB FE CHEWABLE TABLET	0	ACA*
KALETRA 100-25 MG TABLET	2	
KALETRA 200-50 MG TABLET	2	
KALETRA 80 MG-20 MG/ML SOLN	NC	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
KALYDECO 75 MG GRANULES PACKET	2	Prior Authorization required LDD*: Diplomat Pharmacy (877) 977-9118
KAOCHLOR-EFF 20 MEQ TABLET	3	
KAPVAY 0.1-0.2 MG DOSEPACK	3	
KAPVAY ER 0.1 MG TABLET	NC	
KARBINAL ER 4 MG/ 5 ML SUSP	NC	
KARIVA 28 DAY TABLET	0	ACA*
KAYEXALATE POWDER	NC	
KAZANO 12.5-1,000 MG TABLET	NC	
KAZANO 12.5-500 MG TABLET	NC	
KEFLEX 250 MG CAPSULE	NC	
KEFLEX 500 MG CAPSULE	NC	
KEFLEX 750 MG CAPSULE	NC	
KELNOR 1-35 28 TABLET	0	ACA*
KENALOG 0.147 MG/GRAM SPRAY	NC	
KEPPRA 1,000 MG TABLET	3	
KEPPRA 100 MG/ML ORAL SOLN	3	
KEPPRA 250 MG TABLET	3	
KEPPRA 500 MG TABLET	3	
KEPPRA 500 MG/5 ML VIAL	3	
KEPPRA 750 MG TABLET	3	
KEPPRA XR 500 MG TABLET	3	
KEPPRA XR 750 MG TABLET	3	
KERAFOAM 30% FOAM	3	
KERALYT 6% GEL	NC	
KERALYT SCALP COMPLETE KIT	3	
KERYDIN 5% TOPICAL SOLUTION	NC	
KETALAR 200 MG/20 ML VIAL	NC	
KETALAR 500 MG/10 ML VIAL	NC	
KETALAR 500 MG/5 ML VIAL	NC	
KETAMINE 100 MG/ML VIAL	1	
KETAMINE 200 MG/20 ML VIAL	1	
KETAMINE 500 MG/10 ML VIAL	1	
KETEK 300 MG TABLET	3	
KETEK 400 MG TABLET	3	
KETO-DIASTIX REAGENT STRIPS	2	HSA*
KETOCONAZOLE 2% CREAM	1	
KETOCONAZOLE 2% FOAM	1	
KETOCONAZOLE 2% SHAMPOO	1	
KETOCONAZOLE 200 MG TABLET	1	
KETODAN 2% FOAM	1	
KETODAN 2% FOAM KIT	3	
KETONE TEST STRIPS	2	
KETOPROFEN 50 MG CAPSULE	1	
KETOPROFEN 75 MG CAPSULE	1	
KETOPROFEN ER 200 MG CAPSULE	1	
KETOROLAC 0.4% OPTH SOLUTION	1	
KETOROLAC 0.5% OPTH SOLUTION	1	
KETOROLAC 10 MG TABLET	1	Max. 5 Days Supply;Max. quantity of 20 per fill
KETOSTIX REAGENT STRIPS	2	
KEVEYIS 50 MG TABLET	3	Prior Authorization required LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
KEVZARA 150 MG/1.14 ML SYRINGE	3	Prior Authorization required;Max. 2.28 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
KEVZARA 200 MG/1.14 ML SYRINGE	3	Prior Authorization required;Max. 2.28 ML(s) per 28 days PA NTM*; SPP*: Must use CVS Specialty
KEYNOTE GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
KHEDEZLA ER 100 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
KHEDEZLA ER 50 MG TABLET	NC	
KIDS VITAMIN D3 TAB CHEW	NC	
KIMIDESS 28 DAY TABLET	0	ACA*
KINERET 100 MG/0.67 ML SYRINGE	3	Prior Authorization required LDD*: Omnicare/RX Crossroads. 866-547-0644.
KINNEY BRAND 23G LANCETS	2	HSA*
KIONEX 15 GM/60 ML SUSPENSION	1	
KISQALI 200 MG DAILY DOSE	3	Prior Authorization required;Max. 63 per 28 days CH*; PA NTM*; SPP*: CVS Specialty
KISQALI 400 MG DAILY DOSE	3	Prior Authorization required;Max. 63 per 28 days CH*; PA NTM*; SPP*: CVS Specialty
KISQALI 600 MG DAILY DOSE	3	Prior Authorization required;Max. 63 per 28 days CH*; PA NTM*; SPP*: CVS Specialty
KISQALI FEMARA 200 MG CO-PACK	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
KISQALI FEMARA 400 MG CO-PACK	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
KISQALI FEMARA 600 MG CO-PACK	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
KITABIS PAK 300 MG/5 ML	2	SPP*: Must use CVS Specialty
KLARON 10% LOTION	NC	
KLONOPIN 0.5 MG TABLET	NC	
KLONOPIN 1 MG TABLET	NC	
KLONOPIN 2 MG TABLET	NC	
KLOR-CON 10 MEQ TABLET	3	
KLOR-CON 20 MEQ PACKET	NC	
KLOR-CON 25 MEQ PACKET	3	
KLOR-CON 8 MEQ TABLET	NC	
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	NC	
KOATE 250 UNIT VIAL	MD	SPP*: Must use CVS Specialty
KOGENATE FS 500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
KOMBIGLYZE XR 2.5-1,000 MG TAB	3	HSA*
KOMBIGLYZE XR 5-1,000 MG TAB	3	HSA*
KOMBIGLYZE XR 5-500 MG TABLET	3	HSA*
KORLYM 300 MG TABLET	3	HSA*; LDD; SPP*: Must use Dohmen Life Sciences. 1-800-305-7881.
KOVALTRY 3,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
KRISTALOSE 10 GM PACKET	2	
KRISTALOSE 20 GM PACKET	2	
KRO PREMIUM BLOOD GLUCOSE TEST	3	Prior Authorization required;Max. 204 per 30 days HSA*
KRO UNIVERSAL 1 THIN 26G LANCT	2	HSA*
KROGER SUPER THIN LANCETS	2	HSA*
KRYSTEXXA 8 MG/ML VIAL	MD	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
KURVELO TABLET	0	ACA*
KUVAN 100 MG POWDER PACKET	2	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
KUVAN 100 MG TABLET	2	SPP*: Must use CVS Specialty
KUVAN 500 MG POWDER PACKET	2	SPP*: Must use CVS Specialty
KYNAMRO 200 MG/ML SYRINGE	3	SPP*: Must use CVS Specialty

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LAMOTRIGINE 25 MG TABLET	1	
LAMOTRIGINE 5 MG DISPER TABLET	1	
LAMOTRIGINE ER 100 MG TABLET	1	
LAMOTRIGINE ER 200 MG TABLET	1	
LAMOTRIGINE ER 25 MG TABLET	1	
LAMOTRIGINE ER 250 MG TABLET	1	
LAMOTRIGINE ER 300 MG TABLET	1	
LAMOTRIGINE ER 50 MG TABLET	1	
LAMOTRIGINE ODT 100 MG TABLET	1	
LAMOTRIGINE ODT 200 MG TABLET	1	
LAMOTRIGINE ODT 25 MG TABLET	1	
LAMOTRIGINE ODT 50 MG TABLET	1	
LAMOTRIGINE ODT KIT (BLUE)	1	
LAMOTRIGINE ODT KIT (GREEN)	1	
LAMOTRIGINE ODT KIT (ORANGE)	1	
LAMOTRIGINE TAB START KIT-BLUE	1	
LAMOTRIGINE TAB START KT-GREEN	2	
LAMOTRIGINE TAB START KT-ORANG	2	
LANCETS 33G	2	
LANCETS THIN 23G	2	HSA*
LANCETS ULTRA THIN 26G	2	HSA*
LANOXIN 125 MCG TABLET	3	HSA*
LANOXIN 187.5 MCG TABLET	3	HSA*
LANOXIN 250 MCG TABLET	3	HSA*
LANOXIN 62.5 MCG TABLET	3	HSA*
LANSOPRAZOL-AMOXICIL-CLARITHRO	1	
LANSOPRAZOLE DR 15 MG CAPSULE	2	
LANSOPRAZOLE DR 30 MG CAPSULE	2	
LANTHANUM CARB 1,000 MG TB CHW	2	
LANTHANUM CARB 500 MG TAB CHEW	2	
LANTHANUM CARB 750 MG TAB CHEW	2	
LANTUS 100 UNIT/ML VIAL	2	HSA*
LANTUS SOLOSTAR 100 UNIT/ML	2	HSA*
LARIN 1.5 MG-30 MCG TABLET	0	ACA*
LARIN 21 1-20 TABLET	0	ACA*
LARIN 24 FE 1 MG-20 MCG TABLET	0	ACA*
LARIN FE 1-20 TABLET	0	ACA*
LARIN FE 1.5-30 TABLET	0	ACA*
LARISSIA-28 TABLET	0	ACA*
LASIX 20 MG TABLET	NC	
LASIX 40 MG TABLET	NC	
LASIX 80 MG TABLET	NC	
LASTACRAFT 0.25% EYE DROPS	NC	
LATANOPROST 0.005% EYE DROPS	1	
LATRIX 50% TOPICAL SUSPENSION	NC	
LATUDA 120 MG TABLET	2	
LATUDA 20 MG TABLET	2	
LATUDA 40 MG TABLET	2	
LATUDA 60 MG TABLET	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LATUDA 80 MG TABLET	2	
LAYOLIS FE CHEWABLE TABLET	0	
LAZANDA 100 MCG NASAL SPRAY	3	ACA*
LAZANDA 300 MCG NASAL SPRAY	3	Prior Authorization required;Max. 1 per 2 days
LAZANDA 400 MCG NASAL SPRAY	3	Prior Authorization required;Max. 1 per 2 days
LEENA 28 TABLET	0	
LEFLUNOMIDE 10 MG TABLET	1	
LEFLUNOMIDE 20 MG TABLET	1	
LENVIMA 10 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 14 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 18 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 20 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 24 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LENVIMA 8 MG DAILY DOSE	3	CH*; LDD*: Accredo (866) 815-4717
LESCOL 20 MG CAPSULE	NC	
LESCOL 40 MG CAPSULE	NC	
LESCOL XL 80 MG TABLET	NC	
LESSINA-28 TABLET	0	
LETAIRIS 10 MG TABLET	2	ACA*
LETAIRIS 5 MG TABLET	2	SPP*: Must Use CVS Specialty
LETROZOLE 2.5 MG TABLET	1	SPP*: Must Use CVS Specialty
LEUCOVORIN CALCIUM 10 MG TAB	1	CH*; HSA*
LEUCOVORIN CALCIUM 15 MG TAB	1	
LEUCOVORIN CALCIUM 25 MG TAB	1	
LEUCOVORIN CALCIUM 5 MG TAB	1	
LEUKERAN 2 MG TABLET	2	CH*
LEUPROLIDE 2WK 14 MG/2.8 ML KT	1	Max. 30 Days Supply IVF*
LEVALBUTEROL 0.31 MG/3 ML SOL	1	HSA*
LEVALBUTEROL 0.63 MG/3 ML SOL	1	HSA*
LEVALBUTEROL 1.25 MG/3 ML SOL	1	HSA*
LEVALBUTEROL CONC 1.25 MG/0.5	1	HSA*
LEVALBUTEROL TAR HFA 45MCG INH	2	HSA*
LEVAQUIN 25 MG/ML SOLUTION	NC	
LEVAQUIN 250 MG TABLET	NC	
LEVAQUIN 500 MG TABLET	NC	
LEVAQUIN 750 MG TABLET	NC	
LEVATOL 20 MG TABLET	3	HSA*
LEVEMIR 100 UNITS/ML VIAL	2	HSA*
LEVEMIR FLEXTOUCH 100 UNITS/ML	2	HSA*
LEVETIRACETAM 1,000 MG TABLET	1	
LEVETIRACETAM 100 MG/ML SOLN	1	
LEVETIRACETAM 250 MG TABLET	1	
LEVETIRACETAM 500 MG TABLET	1	
LEVETIRACETAM 750 MG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LEVETIRACETAM ER 500 MG TABLET	1	
LEVETIRACETAM ER 750 MG TABLET	1	
LEVITRA 10 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVITRA 2.5 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVITRA 20 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVITRA 5 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
LEVO-T 100 MCG TABLET	3	
LEVO-T 112 MCG TABLET	3	
LEVO-T 125 MCG TABLET	3	
LEVO-T 137 MCG TABLET	3	
LEVO-T 150 MCG TABLET	3	
LEVO-T 175 MCG TABLET	3	
LEVO-T 200 MCG TABLET	3	
LEVO-T 25 MCG TABLET	3	
LEVO-T 300 MCG TABLET	3	
LEVO-T 50 MCG TABLET	3	
LEVO-T 75 MCG TABLET	3	
LEVO-T 88 MCG TABLET	3	
LEVOBUNOLOL 0.25% EYE DROPS	1	
LEVOBUNOLOL 0.5% EYE DROPS	1	
LEVOCARNITINE 1 G/10 ML SOLN	1	
LEVOCARNITINE 330 MG TABLET	1	
LEVOCETIRIZINE 2.5 MG/5 ML SOL	1	
LEVOCETIRIZINE 5 MG TABLET	1	
LEVOFLOXACIN 0.5% EYE DROPS	1	
LEVOFLOXACIN 25 MG/ML SOLUTION	1	
LEVOFLOXACIN 250 MG TABLET	1	
LEVOFLOXACIN 500 MG TABLET	1	
LEVOFLOXACIN 750 MG TABLET	1	
LEVONEST-28 TABLET	0	ACA*
LEVONO-E ESTRAD 0.10-0.02-0.01	0	Max. 91 Days Supply;Max. 1 per day ACA*
LEVONO-E ESTRAD 0.15-0.03-0.01	0	Max. 91 Days Supply;Max. 1 per day ACA*
LEVONOR-ETH ESTRA 0.09-0.02 MG	0	ACA*
LEVONOR-ETH ESTRAD 0.1-0.02 MG	0	ACA*
LEVONOR-ETH ESTRAD 0.15-0.03	0	ACA*
LEVONOR-ETH ESTRAD TRIPHASIC	0	Max. 91 Days Supply ACA*
LEVONORGESTREL 0.75 MG TABLET	0	Max. quantity of 1 per fill ACA*
LEVONORGESTREL 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
LEVORA-28 TABLET	0	ACA*
LEVORPHANOL 2 MG TABLET	1	
LEVOTHYROXINE 100 MCG TABLET	1	
LEVOTHYROXINE 112 MCG TABLET	1	
LEVOTHYROXINE 125 MCG TABLET	1	
LEVOTHYROXINE 137 MCG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LEVOTHYROXINE 150 MCG TABLET	1	
LEVOTHYROXINE 175 MCG TABLET	1	
LEVOTHYROXINE 200 MCG TABLET	1	
LEVOTHYROXINE 25 MCG TABLET	1	
LEVOTHYROXINE 300 MCG TABLET	1	
LEVOTHYROXINE 50 MCG TABLET	1	
LEVOTHYROXINE 75 MCG TABLET	1	
LEVOTHYROXINE 88 MCG TABLET	1	
LEVOXYL 100 MCG TABLET	1	
LEVOXYL 112 MCG TABLET	1	
LEVOXYL 125 MCG TABLET	1	
LEVOXYL 137 MCG TABLET	1	
LEVOXYL 150 MCG TABLET	1	
LEVOXYL 175 MCG TABLET	1	
LEVOXYL 200 MCG TABLET	1	
LEVOXYL 25 MCG TABLET	1	
LEVOXYL 50 MCG TABLET	1	
LEVOXYL 75 MCG TABLET	1	
LEVOXYL 88 MCG TABLET	1	
LEVULAN KERASTICK	3	
LEXAPRO 10 MG TABLET	NC	
LEXAPRO 20 MG TABLET	NC	
LEXAPRO 5 MG TABLET	NC	
LEXAPRO 5 MG/5 ML SOLUTION	NC	
LEXIVA 50 MG/ML SUSPENSION	2	
LEXIVA 700 MG TABLET	3	
LIALDA DR 1.2 GM TABLET	3	
LIBERTY TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
LIBRAX CAPSULE	NC	
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	NC	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LIFESHIELD BLUNT CANNULA	3	
LILLOW-28 TABLET	0	ACA*
LINDANE 1% LOTION	1	
LINDANE 1% SHAMPOO	1	
LINEZOLID 100 MG/5 ML SUSP	1	
LINEZOLID 600 MG TABLET	1	
LINZESS 145 MCG CAPSULE	2	
LINZESS 290 MCG CAPSULE	2	
LINZESS 72 MCG CAPSULE	2	
LIOETHYRONINE SOD 25 MCG TAB	1	
LIOETHYRONINE SOD 5 MCG TAB	1	
LIOETHYRONINE SOD 50 MCG TAB	1	
LIPITOR 10 MG TABLET	NC	
LIPITOR 20 MG TABLET	NC	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
LIPITOR 40 MG TABLET	NC	
LIPITOR 80 MG TABLET	NC	
LIPOFEN 150 MG CAPSULE	NC	
LIPOFEN 50 MG CAPSULE	NC	
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*
LISINAPRIL 10 MG TABLET	1	HSA*
LISINAPRIL 2.5 MG TABLET	1	HSA*
LISINAPRIL 20 MG TABLET	1	HSA*
LISINAPRIL 30 MG TABLET	1	HSA*
LISINAPRIL 40 MG TABLET	1	HSA*
LISINAPRIL 5 MG TABLET	1	HSA*
LISINAPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
LISINAPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
LISINAPRIL-HCTZ 20-25 MG TAB	1	HSA*
LITE TOUCH 30G LANCETS	2	HSA*
LITE TOUCH 33G LANCETS	2	HSA*
LITEAIRE MDI CHAMBER	MD	
LITETOUCH MEDIUM MASK	MD	
LITHIUM 8 MEQ/5 ML SOLUTION	1	
LITHIUM CARBONATE 150 MG CAP	1	
LITHIUM CARBONATE 300 MG CAP	1	
LITHIUM CARBONATE 300 MG TAB	1	
LITHIUM CARBONATE 600 MG CAP	1	
LITHIUM CARBONATE ER 300 MG TB	1	
LITHIUM CARBONATE ER 450 MG TB	1	
LITHOBID ER 300 MG TABLET	3	
LITHOSTAT 250 MG TABLET	3	
LIVALO 1 MG TABLET	3	HSA*
LIVALO 2 MG TABLET	3	HSA*
LIVALO 4 MG TABLET	3	HSA*
LO LOESTRIN FE 1-10 TABLET	0	ACA*
LOCOID 0.1% CREAM	NC	
LOCOID 0.1% LOTION	3	
LOCOID 0.1% OINTMENT	NC	
LOCOID 0.1% SOLUTION	NC	
LOCORT 11 DAY 1.5 MG TABLET	NC	
LOCORT 7 DAY 1.5 MG TABLET	NC	
LODINE 400 MG TABLET	NC	
LODOSYN 25 MG TABLET	NC	
LOESTRIN 21 1-20 TABLET	NC	
LOESTRIN 21 1.5-30 TABLET	NC	
LOESTRIN FE 1-20 TABLET	NC	
LOESTRIN FE 1.5-30 TABLET	NC	
LOFIBRA 134 MG CAPSULE	NC	
LOFIBRA 160 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LOFIBRA 200 MG CAPSULE	NC	
LOFIBRA 54 MG TABLET	NC	
LOFIBRA 67 MG CAPSULE	NC	
LOMEDIA 24 FE 1 MG-20 MCG TAB	0	ACA*
LOMOTIL 2.5-0.025 MG TABLET	NC	
LOMUSTINE 10 MG CAPSULE	1	CH*
LOMUSTINE 100 MG CAPSULE	1	CH*
LOMUSTINE 40 MG CAPSULE	1	CH*
LONGS THIN LANCETS 26G	2	HSA*
LONSURF 15 MG-6.14 MG TABLET	3	CH*; SPP*: CVS Specialty
LONSURF 20 MG-8.19 MG TABLET	3	CH*; SPP*: CVS Specialty
LOPERAMIDE 2 MG CAPSULE	1	
LOPID 600 MG TABLET	NC	
LOPINAVIR-RITONAVIR 80-20MG/ML	2	
LOPREEZA 0.5 MG-0.1 MG TABLET	1	
LOPREEZA 1 MG-0.5 MG TABLET	1	
LOPRESSOR 100 MG TABLET	NC	
LOPRESSOR 50 MG TABLET	NC	
LOPRESSOR HCT 50-25 TABLET	NC	
LOPROX 0.77% CREAM	NC	
LOPROX 0.77% GEL	NC	
LOPROX 0.77% TOPICAL SUSP	NC	
LOPROX 1% SHAMPOO	NC	
LORAZEPAM 0.5 MG TABLET	1	
LORAZEPAM 1 MG TABLET	1	
LORAZEPAM 2 MG TABLET	1	
LORAZEPAM 2 MG/ML ORAL CONCENT	1	
LORCET 10-650 TABLET	NC	
LORCET 5-325 MG TABLET	1	
LORCET HD 10-325 MG TABLET	1	
LORCET PLUS 7.5-325 MG TABLET	1	
LORCET PLUS TABLET	NC	
LORENZA 4%-1% PATCH	NC	
LORTAB 10 MG-300 MG/15 ML ELXR	3	
LORTAB 10-325 MG TABLET	NC	
LORTAB 10-500 TABLET	NC	
LORTAB 5-325 MG TABLET	NC	
LORTAB 5-500 TABLET	NC	
LORTAB 7.5-325 MG TABLET	NC	
LORTAB 7.5-500 TABLET	NC	
LORTUSS EX LIQUID	1	
LORYNA 3 MG-0.02 MG TABLET	0	ACA*
LORZONE 375 MG TABLET	3	
LORZONE 750 MG TABLET	3	
LOSARTAN POTASSIUM 100 MG TAB	1	HSA*
LOSARTAN POTASSIUM 25 MG TAB	1	HSA*
LOSARTAN POTASSIUM 50 MG TAB	1	HSA*
LOSARTAN-HCTZ 100-12.5 MG TAB	1	HSA*
LOSARTAN-HCTZ 100-25 MG TAB	1	HSA*
LOSARTAN-HCTZ 50-12.5 MG TAB	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
LOSEASONIQUE TABLET	NC	
LOTEMAX 0.5% EYE DROPS	2	
LOTEMAX 0.5% EYE OINTMENT	2	
LOTEMAX 0.5% OPHTHALMIC GEL	2	
LOTENSIN 20 MG TABLET	NC	
LOTENSIN 40 MG TABLET	NC	
LOTENSIN HCT 10-12.5 MG TABLET	NC	
LOTENSIN HCT 20-12.5 MG TABLET	NC	
LOTENSIN HCT 20-25 MG TABLET	NC	
LOTREL 10-20 MG CAPSULE	NC	
LOTREL 10-40 MG CAPSULE	NC	
LOTREL 2.5-10 MG CAPSULE	NC	
LOTREL 5-10 MG CAPSULE	NC	
LOTREL 5-20 MG CAPSULE	NC	
LOTREL 5-40 MG CAPSULE	NC	
LOTRISONE CREAM	NC	
LOTRONEX 0.5 MG TABLET	NC	
LOTRONEX 1 MG TABLET	NC	
LOVASTATIN 10 MG TABLET	0	ACA*
LOVASTATIN 20 MG TABLET	0	ACA*
LOVASTATIN 40 MG TABLET	0	ACA*
LOVAZA 1 GM CAPSULE	NC	
LOVENOX 100 MG/ML SYRINGE	NC	
LOVENOX 120 MG/0.8 ML SYRINGE	NC	
LOVENOX 150 MG/ML SYRINGE	NC	
LOVENOX 30 MG/0.3 ML SYRINGE	NC	
LOVENOX 300 MG/3 ML VIAL	NC	
LOVENOX 40 MG/0.4 ML SYRINGE	NC	
LOVENOX 60 MG/0.6 ML SYRINGE	NC	
LOVENOX 80 MG/0.8 ML SYRINGE	NC	
LOW-OGESTREL-28 TABLET	0	ACA*
LOXAPINE 10 MG CAPSULE	1	
LOXAPINE 25 MG CAPSULE	1	
LOXAPINE 5 MG CAPSULE	1	
LOXAPINE 50 MG CAPSULE	1	
LOXITANE 5 MG CAPSULE	NC	
LUER LOCK SYRINGE 30 ML	3	
LUER SLIP TIP SYR TRAY 1 ML	3	
LUER-LOCK SYRINGE 60 ML	3	
LUFYLLIN 200 MG TABLET	2	HSA*
LUFYLLIN-400 TABLET	3	HSA*
LUGOL'S STRONG IODINE SOLUTION	1	
LUMIGAN 0.01% EYE DROPS	2	
LUNESTA 1 MG TABLET	NC	
LUNESTA 2 MG TABLET	NC	
LUNESTA 3 MG TABLET	NC	
LUPANETA PK 11.25-5 MG 3MO KIT	3	Max. 1 in 90 days
LUPANETA PK 3.75-5 MG 1MO KIT	3	Max. 1 in 30 days
LUPRON DEPOT 11.25 MG 3MO KIT	MD	Prior Authorization required;Max. 1 in 90 days SPP*: CVS Specialty
LUPRON DEPOT 22.5 MG 3MO KIT	MD	Prior Authorization required;Max. 1 in 84 days SPP*: CVS Specialty
LUPRON DEPOT 3.75 MG KIT	MD	Prior Authorization required;Max. 1 per 30 days SPP*: CVS Specialty
LUPRON DEPOT 45 MG 6MO KIT	MD	Prior Authorization required;Max. 1 in 168 days SPP*: CVS Specialty

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

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MALARONE 250-100 MG TABLET	NC	
MALARONE 62.5-25 MG PED TAB	NC	
MALATHION 0.5% LOTION	1	
MAPROTILINE 25 MG TABLET	1	
MAPROTILINE 50 MG TABLET	1	
MAPROTILINE 75 MG TABLET	1	
MARGESIC CAPSULE	1	
MARINOL 10 MG CAPSULE	NC	
MARINOL 2.5 MG CAPSULE	NC	
MARINOL 5 MG CAPSULE	NC	
MARLISSA-28 TABLET	0	ACA*
MARPLAN 10 MG TABLET	3	
MARTEN-TAB 325-50 TABLET	1	
MATULANE 50 MG CAPSULE	2	CH*; LDD*: Walgreens Specialty (800) 424-9002
MATZIM LA 180 MG TABLET	1	HSA*
MATZIM LA 240 MG TABLET	1	HSA*
MATZIM LA 300 MG TABLET	1	HSA*
MATZIM LA 360 MG TABLET	1	HSA*
MATZIM LA 420 MG TABLET	1	HSA*
MAVIK 1 MG TABLET	NC	
MAVIK 2 MG TABLET	NC	
MAVIK 4 MG TABLET	NC	
MAVYRET 100-40 MG TABLET	2	Prior Authorization required;Max. 84 per 28 days SPP*: Must use CVS Specialty
MAXAIR AUTOHALER 0.2 MG AERO	2	HSA*
MAXALT 10 MG TABLET	NC	
MAXALT 5 MG TABLET	NC	
MAXALT MLT 10 MG TABLET	NC	
MAXALT MLT 5 MG TABLET	NC	
MAXIDEX 0.1% EYE DROPS	3	
MAXIDONE 10-750 MG TABLET	NC	
MAXIFLU CD TABLET	3	
MAXIFLU CDX TABLET	3	
MAXIMA TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
MAXITROL EYE DROPS	NC	
MAXITROL EYE OINTMENT	NC	
MAXZIDE 37.5 MG-25 MG TABLET	NC	
MAXZIDE 75 MG-50 MG TABLET	NC	
MB HYDROGEL KIT	1	
MECLIZINE 12.5 MG TABLET	1	
MECLIZINE 25 MG TABLET	1	
MECLOFENAMATE 100 MG CAPSULE	1	
MECLOFENAMATE 50 MG CAPSULE	1	
MEDI-LANCE LANCETS	2	HSA*
MEDLANCE PLUS 21G LANCETS	2	HSA*
MEDLANCE PLUS 30G LANCETS	2	HSA*
MEDLANCE PLUS LITE 25G LANCETS	2	HSA*
MEDLANCE PLUS SPECIAL BLADE	2	HSA*
MEDROL 16 MG TABLET	NC	
MEDROL 2 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MEDROL 32 MG TABLET	NC	
MEDROL 4 MG DOSEPAK	NC	
MEDROL 4 MG TABLET	NC	
MEDROL 8 MG TABLET	NC	
MEDROXYPROGESTERONE 10 MG TAB	1	
MEDROXYPROGESTERONE 150 MG/ML	0	Max. 90 Days Supply;Max. 1 ML(s) in 90 days ACA*
MEDROXYPROGESTERONE 150 MG/ML	0	Max. 90 Days Supply;Max. 1 ML(s) in 60 days
MEDROXYPROGESTERONE 2.5 MG TAB	1	
MEDROXYPROGESTERONE 5 MG TAB	1	
MEFENAMIC ACID 250 MG CAPSULE	1	
MEFLOQUINE HCL 250 MG TABLET	1	
MEGACE 40 MG/ML ORAL SUSP	NC	
MEGACE ES 625 MG/5 ML SUSP	NC	
MEGESTROL 20 MG TABLET	1	CH*
MEGESTROL 40 MG TABLET	1	CH*
MEGESTROL 625 MG/5 ML SUSP	1	CH*
MEGESTROL ACET 40 MG/ML SUSP	1	CH*
MEKINIST 0.5 MG TABLET	3	CH*; SPP*: CVS Specialty
MEKINIST 2 MG TABLET	3	CH*; SPP*: CVS Specialty
MELODETTA 24 FE CHEWABLE TAB	0	ACA*
MELOXICAM 15 MG TABLET	1	
MELOXICAM 7.5 MG TABLET	1	
MELOXICAM 7.5 MG/5 ML SUSP	1	
MELPHALAN 2 MG TABLET	2	CH*
MEMANTINE 5-10 MG TITRATION PK	1	
MEMANTINE HCL 10 MG TABLET	1	
MEMANTINE HCL 2 MG/ML SOLUTION	1	
MEMANTINE HCL 5 MG TABLET	1	
MENACTRA VIAL	MD	
MENEST 0.3 MG TABLET	2	
MENEST 0.625 MG TABLET	2	
MENEST 1.25 MG TABLET	2	
MENEST 2.5 MG TABLET	2	
MENOMUNE-A-C-Y-W-135 VIAL	MD	
MENOMUNE-A-C-Y-W-135 W-DILUENT	MD	
MENOPUR 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
MENOSTAR 14 MCG/DAY PATCH	3	
MENTAX 1% CREAM	NC	
MEPERIDINE 100 MG TABLET	1	
MEPERIDINE 50 MG TABLET	1	
MEPERIDINE 50 MG/5 ML SOLUTION	1	
MEPERIDINE 550 MG/55 ML-NS SYR	1	
MEPHYTON 5 MG TABLET	2	HSA*
MEPROBAMATE 200 MG TABLET	1	
MEPROBAMATE 400 MG TABLET	1	
MEPRON 750 MG/5 ML SUSPENSION	NC	
MERCAPTOPYRINE 50 MG TABLET	1	CH*
MESALAMINE 4 GM/60 ML ENEMA	1	
MESALAMINE 800 MG DR TABLET	2	
MESALAMINE DR 1.2 GM TABLET	2	
MESNEX 400 MG TABLET	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MESTINON 180 MG TIMESPAN	NC	
MESTINON 60 MG TABLET	NC	
MESTINON 60 MG/5 ML SYRUP	2	
METADATE CD 10 MG CAPSULE	NC	
METADATE CD 20 MG CAPSULE	NC	
METADATE CD 30 MG CAPSULE	NC	
METADATE CD 40 MG CAPSULE	NC	
METADATE CD 50 MG CAPSULE	NC	
METADATE CD 60 MG CAPSULE	NC	
METADATE ER 20 MG TABLET	1	Max. 60 Days Supply
METAPROTERENOL 10 MG TABLET	1	HSA*
METAPROTERENOL 10 MG/5 ML SYR	1	HSA*
METAPROTERENOL 20 MG TABLET	1	HSA*
METAXALL 800 MG TABLET	1	
METAXALONE 400 MG TABLET	1	
METAXALONE 800 MG TABLET	1	
METFORMIN ER 1,000 MG OSM-TAB	1	HSA*; (generic Fortamet)
METFORMIN HCL 1,000 MG TABLET	1	HSA*
METFORMIN HCL 500 MG TABLET	1	HSA*
METFORMIN HCL 850 MG TABLET	1	HSA*
METFORMIN HCL ER 1,000 MG TAB	NC	
METFORMIN HCL ER 500 MG OSM-TB	1	HSA*; (generic Fortamet)
METFORMIN HCL ER 500 MG TABLET	NC	
METFORMIN HCL ER 500 MG TABLET	1	HSA*
METFORMIN HCL ER 750 MG TABLET	1	HSA*
METHADONE 10 MG/5 ML SOLUTION	1	
METHADONE 10 MG/ML ORAL CONC	1	
METHADONE 5 MG/5 ML SOLUTION	1	
METHADONE HCL 10 MG TABLET	1	
METHADONE HCL 10 MG/ML VIAL	1	
METHADONE HCL 5 MG TABLET	1	
METHADOSE 10 MG/ML ORAL CONC	NC	
METHADOSE 40 MG TABLET DISPR	1	
METHAMPHETAMINE 5 MG TABLET	1	Max. 60 Days Supply
METHAZOLAMIDE 25 MG TABLET	1	
METHAZOLAMIDE 50 MG TABLET	1	
METHENAMINE HIPP 1 GM TABLET	1	
METHENAMINE MD 1 GM TABLET	1	
METHENAMINE MD 500 MG TABLET	1	
METHERGINE 0.2 MG TABLET	3	
METHIMAZOLE 10 MG TABLET	1	
METHIMAZOLE 5 MG TABLET	1	
METHITEST 10 MG TABLET	3	Max. 30 Days Supply;Prior Authorization required
METHOCARBAMOL 500 MG TABLET	1	
METHOCARBAMOL 750 MG TABLET	1	
METHOTREXATE 1 GM VIAL	MD	
METHOTREXATE 1 GRAM/40 ML VIAL	MD	
METHOTREXATE 100 MG/4 ML VIAL	MD	
METHOTREXATE 2.5 MG TABLET	1	
METHOTREXATE 50 MG/2 ML VIAL	MD	
METHOXSALLEN 10 MG CAPSULE	1	
METHSCOPOLAMINE BROM 2.5 MG TB	1	

METHSCOPOLAMINE BROM 5 MG TAB	1	
METHYCLOTHIAZIDE 5 MG TABLET	1	HSA*
METHYLDOPA 250 MG TABLET	1	HSA*
METHYLDOPA 500 MG TABLET	1	HSA*
METHYLDOPA-HCTZ 250-15 MG TAB	1	HSA*
METHYLDOPA-HCTZ 250-25 MG TAB	1	HSA*
METHYLERGONOVINE 0.2 MG TABLET	1	
METHYLIN 10 MG CHEWABLE TABLET	NC	
METHYLIN 10 MG/5 ML SOLUTION	NC	
METHYLIN 2.5 MG CHEWABLE TAB	NC	
METHYLIN 5 MG CHEWABLE TABLET	NC	
METHYLIN 5 MG/5 ML SOLUTION	NC	
METHYLPHENIDATE 10 MG CHEW TAB	1	Max. 60 Days Supply
METHYLPHENIDATE 10 MG TABLET	1	Max. 60 Days Supply
METHYLPHENIDATE 10 MG/5 ML SOL	1	Max. 60 Days Supply
METHYLPHENIDATE 2.5 MG CHEW TB	1	Max. 60 Days Supply
METHYLPHENIDATE 20 MG TABLET	1	Max. 60 Days Supply
METHYLPHENIDATE 5 MG CHEW TAB	1	Max. 60 Days Supply
METHYLPHENIDATE 5 MG TABLET	1	Max. 60 Days Supply
METHYLPHENIDATE 5 MG/5 ML SOLN	1	Max. 60 Days Supply
METHYLPHENIDATE CD 10 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 20 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 40 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 50 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE CD 60 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE ER 10 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 18 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 20 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE ER 20 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 27 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 36 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE ER 40 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE ER 54 MG TAB	1	Max. 60 Days Supply
METHYLPHENIDATE LA 30 MG CAP	1	Max. 60 Days Supply
METHYLPHENIDATE LA 60 MG CAP	1	Max. 60 Days Supply
METHYLPREDNISOLONE 16 MG TAB	1	
METHYLPREDNISOLONE 32 MG TAB	1	
METHYLPREDNISOLONE 4 MG DOSEPK	1	
METHYLPREDNISOLONE 4 MG TABLET	1	
METHYLPREDNISOLONE 8 MG TAB	1	
METHYLTESTOSTERONE 10 MG CAP	1	Max. 30 Days Supply;Prior Authorization required
METIPRANOLOL 0.3% EYE DROPS	1	
METOCLOPRAMIDE 10 MG TABLET	1	
METOCLOPRAMIDE 5 MG TABLET	1	
METOCLOPRAMIDE 5 MG/5 ML SOLN	1	
METOCLOPRAMIDE HCL 10 MG ODT	1	
METOCLOPRAMIDE HCL 5 MG ODT	1	
METOLAZONE 10 MG TABLET	1	HSA*
METOLAZONE 2.5 MG TABLET	1	HSA*
METOLAZONE 5 MG TABLET	1	HSA*
METOPIRONE 250 MG CAPSULE	3	
METOPROLOL ER-HCTZ 100-12.5 MG	2	HSA*
METOPROLOL ER-HCTZ 25-12.5 MG	2	HSA*
METOPROLOL ER-HCTZ 50-12.5 MG	2	HSA*



DRUG NAME	TIER	LIMITATIONS/ * NOTES
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*
METOSOLV ODT 5 MG TABLET	NC	
METOCREAM 0.75% CREAM	NC	
METROGEL TOPICAL 1% GEL	NC	
METROGEL-VAGINAL 0.75% GEL	NC	
METROLOTION TOPICAL 0.75%	NC	
METRONIDAZOLE 0.75% CREAM	1	
METRONIDAZOLE 0.75% LOTION	1	
METRONIDAZOLE 250 MG TABLET	1	
METRONIDAZOLE 375 MG CAPSULE	1	
METRONIDAZOLE 500 MG TABLET	1	
METRONIDAZOLE TOPICAL 0.75% GL	1	
METRONIDAZOLE TOPICAL 1% GEL	1	
METRONIDAZOLE VAGINAL 0.75% GL	1	
MEVACOR 20 MG TABLET	NC	
MEVACOR 40 MG TABLET	NC	
MEXILETINE 150 MG CAPSULE	1	
MEXILETINE 200 MG CAPSULE	1	
MEXILETINE 250 MG CAPSULE	1	
MIACALCIN 200 UNIT NASAL SPRAY	NC	
MIBELAS 24 FE CHEWABLE TABLET	0	ACA*
MICARDIS 20 MG TABLET	NC	
MICARDIS 40 MG TABLET	NC	
MICARDIS 80 MG TABLET	NC	
MICARDIS HCT 40-12.5 MG TABLET	NC	
MICARDIS HCT 80-12.5 MG TABLET	NC	
MICARDIS HCT 80-25 MG TABLET	NC	
MICONAZOLE 3 200 MG VAG SUPP	1	
MICORT HC 2.5% CREAM	3	
MICRHOGAM ULTRA-FILTD PLUS SYR	MD	SPP*: Must use CVS Specialty
MICRO THIN 33G LANCETS	2	HSA*
MICROCHAMBER	MD	
MICROCRYSTAL CELLULOSE POWDER	3	
MICROCYN SKIN-WOUND CARE SPRAY	3	
MICROCYN SKIN-WOUND HYDROGEL	3	
MICRODOT TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
MICRODOT XTRA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MICROGESTIN 21 1-20 TABLET	0	ACA*
MICROGESTIN 21 1.5-30 TAB	0	ACA*
MICROGESTIN 24 FE 1 MG-20 MCG	0	
MICROGESTIN FE 1-20 TABLET	0	ACA*
MICROGESTIN FE 1.5-30 TAB	0	ACA*
MICROLET LANCETS	2	HSA*
MICROLIFE PEAK FLOW METER	MD	
MICROSPACER FOR AEROSOL DEVICE	MD	
MICROZIDE 12.5 MG CAPSULE	NC	
MIDAZOLAM HCL 2 MG/ML SYRUP	1	
MIDODRINE HCL 10 MG TABLET	1	HSA*
MIDODRINE HCL 2.5 MG TABLET	1	HSA*
MIDODRINE HCL 5 MG TABLET	1	HSA*
MIFEPREX 200 MG TABLET	3	
MIGERGOT SUPPOSITORY	3	
MIGLITOL 100 MG TABLET	1	HSA*
MIGLITOL 25 MG TABLET	1	HSA*
MIGLITOL 50 MG TABLET	1	HSA*
MIGRANAL NASAL SPRAY	NC	
MILLIPRED 10 MG/5 ML SOLUTION	NC	
MILLIPRED 5 MG TABLET	3	
MILLIPRED DP 5 MG 12-DAY PACK	3	
MILLIPRED DP 5 MG 6-DAY PACK	3	
MIMVEY 1-0.5 MG TABLET	1	
MIMVEY LO 0.5-0.1 MG TABLET	1	
MINASTRIN 24 FE CHEWABLE TAB	NC	
MINI WRIGHT PEAK FLOW METER	MD	
MINIMED INFUSION SET	MD	
MINIMED RESERVOIR 3 ML	MD	
MINIPRESS 1 MG CAPSULE	NC	
MINIPRESS 2 MG CAPSULE	NC	
MINIPRESS 5 MG CAPSULE	NC	
MINIPRIN EC 81 MG TABLET	0	ACA*
MINITRAN 0.1 MG/HR PATCH	NC	
MINITRAN 0.2 MG/HR PATCH	NC	
MINITRAN 0.4 MG/HR PATCH	NC	
MINITRAN 0.6 MG/HR PATCH	NC	
MINIVELLE 0.025 MG PATCH	3	
MINIVELLE 0.0375 MG PATCH	3	
MINIVELLE 0.05 MG PATCH	3	
MINIVELLE 0.075 MG PATCH	3	
MINIVELLE 0.1 MG PATCH	3	
MINOCIN 100 MG PELLETIZED CAP	NC	
MINOCIN 50 MG PELLETIZED CAP	NC	
MINOCIN 75 MG PELLETIZED CAP	NC	
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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MINOCYCLINE ER 45 MG TABLET	1	Prior Authorization required
MINOCYCLINE ER 90 MG TABLET	1	Prior Authorization required
MINOCYCLINE HCL 100 MG TABLET	1	
MINOCYCLINE HCL 50 MG TABLET	1	
MINOCYCLINE HCL 75 MG TABLET	1	
MINOXIDIL 10 MG TABLET	1	HSA*
MINOXIDIL 2.5 MG TABLET	1	HSA*
MIRAPEX 0.125 MG TABLET	NC	
MIRAPEX 0.25 MG TABLET	NC	
MIRAPEX 0.5 MG TABLET	NC	
MIRAPEX 0.75 MG TABLET	NC	
MIRAPEX 1 MG TABLET	NC	
MIRAPEX 1.5 MG TABLET	NC	
MIRAPEX ER 0.375 MG TABLET	NC	
MIRAPEX ER 0.75 MG TABLET	NC	
MIRAPEX ER 1.5 MG TABLET	NC	
MIRAPEX ER 2.25 MG TABLET	NC	
MIRAPEX ER 3 MG TABLET	NC	
MIRAPEX ER 3.75 MG TABLET	NC	
MIRAPEX ER 4.5 MG TABLET	NC	
MIRCERA 100 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 150 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 200 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 30 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 50 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCERA 75 MCG/0.3 ML SYRINGE	3	Prior Authorization required
MIRCETTE 28 DAY TABLET	NC	
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	
MIRVASO 0.33% GEL PUMP	3	
MISOPROSTOL 100 MCG TABLET	1	
MISOPROSTOL 200 MCG TABLET	1	
MISTASSIST IFCD	MD	
MITIGARE 0.6 MG CAPSULE	NC	
MOBIC 15 MG TABLET	NC	
MOBIC 7.5 MG TABLET	NC	
MOBIC 7.5 MG/5 ML SUSPENSION	NC	
MODAFINIL 100 MG TABLET	2	Prior Authorization required;Max. 1 per day
MODAFINIL 200 MG TABLET	2	Prior Authorization required;Max. 1 per day
MODERIBA 200 MG TABLET	NC	
MODERIBA 200-400 MG DOSEPACK	NC	
MODERIBA 400-400 MG DOSEPACK	NC	
MODERIBA 600-400 MG DOSEPACK	NC	
MODERIBA 600-600 MG DOSEPACK	NC	
MODICON 28 TABLET	NC	
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*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MOEXIPRIL-HCTZ 7.5-12.5 MG TAB	1	HSA*
MOLINDONE HCL 10 MG TABLET	1	
MOLINDONE HCL 25 MG TABLET	1	
MOLINDONE HCL 5 MG TABLET	1	
MOMETASONE FUROATE 0.1% CREAM	1	
MOMETASONE FUROATE 0.1% OINT	1	
MOMETASONE FUROATE 0.1% SOLN	1	
MOMETASONE FUROATE 50 MCG SPRY	1	
MOMEXIN COMBO PACK	3	
MONAGHAN Z STAT CHAMBER-MD MSK	MD	
MONDOXYNE NL 100 MG CAPSULE	NC	
MONDOXYNE NL 50 MG CAPSULE	NC	
MONDOXYNE NL 75 MG CAPSULE	NC	
MONO-LINYAH 28 TABLET	0	ACA*
MONOCLATE-P 1,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
MONODOX 100 MG CAPSULE	NC	
MONODOX 50 MG CAPSULE	NC	
MONODOX 75 MG CAPSULE	NC	
MONOJECT 1 ML SYRN 28GX1/2"	2	HSA*
MONOJECT 12 ML SYRINGE 18GX1"	3	
MONOJECT 12 ML SYRN 20GX1.25	3	
MONOJECT 12 ML SYRN 21GX1"	3	
MONOJECT 12 ML SYRN 21GX1.5"	3	
MONOJECT 3 ML SYRINGE	3	
MONOJECT 3 ML SYRINGE 21GX1"	3	
MONOJECT 3 ML SYRINGE 23GX1"	3	
MONOJECT 3 ML SYRINGE 25GX1"	3	
MONOJECT 3 ML SYRN 21GX1-1/2"	3	
MONOJECT 3 ML SYRN 22GX1-1/2"	3	
MONOJECT 3 ML SYRN 25GX1"	3	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MONOJECT LUER LOCK TB SYR 1 ML	3	
MONOJECT MAGELLAN SYRINGE	3	
MONOJECT MAGELLAN SYRINGE 1 ML	3	
MONOJECT MAGELLAN SYRINGE 3 ML	3	
MONOJECT MEGELLAN TB SYR 1 ML	3	
MONOJECT PHARMACY TRAY	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SAFETY SYRINGE	3	
MONOJECT SMARTIP CANNULA 12 ML	3	
MONOJECT SMARTIP CANNULA 3 ML	3	
MONOJECT SMARTIP CANNULA 6 ML	3	
MONOJECT SYR PHARM TRAY PK	3	
MONOJECT SYR PHARM TRAY PK	3	
MONOJECT SYRINGE 1 ML	2	HSA*
MONOJECT SYRINGE 12 ML	3	
MONOJECT SYRINGE 140 ML	3	
MONOJECT SYRINGE 3 ML	3	
MONOJECT SYRINGE 3 ML 20GX1	3	
MONOJECT SYRINGE 3 ML 22GX1"	3	
MONOJECT SYRINGE 35 ML	3	
MONOJECT SYRINGE 6 ML	3	
MONOJECT SYRINGE 60 ML	3	
MONOJECT SYRN 3 ML 20GX1-1/2"	3	
MONOJECT SYRN 3 ML 20GX3/4"	3	
MONOJECT TB 1 ML SYRN 26X3/8"	3	
MONOJECT TB 1 ML SYRN 28GX1/2	3	
MONOJECT TB SAFETY SYRINGE	3	
MONOJECT TB SYRN 25GX5/8"	3	
MONOJECT TB SYRN 27GX1/2"	3	
MONOJECT TUBERCULIN SYR 1 ML	3	
MONOLET 21G LANCETS	2	HSA*
MONOLET THIN 28G LANCETS	2	HSA*
MONONESSA 28 TABLET	0	ACA*
MONONINE 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
MONTELUKAST SOD 10 MG TABLET	1	HSA*
MONTELUKAST SOD 4 MG GRANULES	1	HSA*
MONTELUKAST SOD 4 MG TAB CHEW	1	HSA*
MONTELUKAST SOD 5 MG TAB CHEW	1	HSA*
MONUROL 3 GM SACHET	3	
MORGIDOX 100 MG CAPSULE	NC	
MORGIDOX 1X100 MG KIT	3	
MORGIDOX 50 MG CAPSULE	NC	
MORPHABOND ER 100 MG TABLET	3	Max. 2 per day
MORPHABOND ER 15 MG TABLET	3	Max. 2 per day
MORPHABOND ER 30 MG TABLET	3	Max. 2 per day
MORPHABOND ER 60 MG TABLET	3	Max. 2 per day
MORPHINE 100MG/100ML-0.9% NACL	1	
MORPHINE 50 MG/50 ML-0.9% NACL	1	
MORPHINE SULF 10 MG SUPPOS	1	
MORPHINE SULF 10 MG/5 ML SOLN	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MORPHINE SULF 100 MG/5 ML SOLN	1	
MORPHINE SULF 20 MG SUPPOS	1	
MORPHINE SULF 20 MG/5 ML SOLN	1	
MORPHINE SULF 30 MG SUPPOS	1	
MORPHINE SULF 5 MG SUPPOS	1	
MORPHINE SULF ER 100 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 15 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 200 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 30 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULF ER 60 MG TABLET	1	Max. 90 per 30 days
MORPHINE SULFATE ER 10 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 100 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 120 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 20 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 30 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 45 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 50 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 60 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 75 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 80 MG CAP	1	Max. 2 per day
MORPHINE SULFATE ER 90 MG CAP	1	Max. 2 per day
MORPHINE SULFATE IR 15 MG TAB	2	
MORPHINE SULFATE IR 30 MG TAB	2	
MOTOFEN 1-0.025 MG TABLET	3	
MOVANTIK 12.5 MG TABLET	2	
MOVANTIK 25 MG TABLET	2	
MOVIPREP POWDER PACKET	2	
MOXATAG ER 775 MG TABLET	NC	
MOXEZA 0.5% EYE DROPS	3	
MOXIFLOXACIN 0.5% EYE DROPS	2	
MOXIFLOXACIN HCL 400 MG TABLET	1	
MS CONTIN 100 MG TABLET	NC	
MS CONTIN 15 MG TABLET	NC	
MS CONTIN 200 MG TABLET	NC	
MS CONTIN 30 MG TABLET	NC	
MS CONTIN 60 MG TABLET	NC	
MUGARD ORAL WOUND RINSE	2	
MULTAQ 400 MG TABLET	2	
MULTICHEW CHEWABLE TABLET	3	
MULTISTIX 10 SG REAGENT STRIPS	2	
MULTISTIX 5 STRIPS	2	
MULTISTIX 7 REAGENT STRIPS	2	
MULTISTIX 8 SG REAGENT STRIPS	2	
MULTISTIX 9 REAGENT STRIPS	2	
MULTISTIX 9 SG REAGENT STRIPS	2	
MULTISTIX REAGENT STRIPS	2	
MULTIVIT-FLUOR 0.25 MG TAB CHW	1	ACA*: Children through age 5; HSA
MULTIVITAMINS CHEWABLES TABLET	1	
MULTIVITAMINS PEDIATRIC DROPS	1	
MUPIROCIN 2% CREAM	1	
MUPIROCIN 2% OINTMENT	1	
MUSE 1,000 MCG URETHRAL SUPP	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
MUSE 125 MCG URETHRAL SUPPOS	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
MUSE 250 MCG URETHRAL SUPPOS	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days

DRUG NAME	TIER	LIMITATIONS/ * NOTES
MUSE 500 MCG URETHRAL SUPPOS	2	Covered for males only;Not covered for members 17 and younger; Max. 6 in 30 days
MY WAY 1.5 MG TABLET	0	Max. quantity of 1 per fill ACA*
MYALEPT 11.3 MG (5 MG/ML) VIAL	3	LDD*: Accredo (866) 815-4717
MYAMBUTOL 400 MG TABLET	NC	
MYCOBUTIN 150 MG CAPSULE	NC	
MYCOPHENOLATE 200 MG/ML SUSP	1	
MYCOPHENOLATE 250 MG CAPSULE	1	
MYCOPHENOLATE 500 MG TABLET	1	
MYCOPHENOLIC ACID DR 180 MG TB	1	
MYCOPHENOLIC ACID DR 360 MG TB	1	
MYDAYIS ER 12.5 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDAYIS ER 25 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDAYIS ER 37.5 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDAYIS ER 50 MG CAPSULE	3	Max. 60 Days Supply;Prior Authorization required PA NTM*
MYDFRIN 2.5% EYE DROPS	NC	
MYDRIACYL 1% EYE DROPS	NC	
MYFERON-150 FORTE CAPSULE	1	
MYFORTIC 180 MG TABLET	NC	
MYFORTIC 360 MG TABLET	NC	
MYGLUCOHEALTH 30G LANCETS	2	HSA*
MYGLUCOHEALTH TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
MYLERAN 2 MG TABLET	2	CH*
MYNEPHROCAPS SOFTGEL	1	
MYNEPHRON CAPSULE	2	
MYOBLOC 10,000 UNITS/2 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
MYOBLOC 2,500 UNIT/0.5 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
MYOBLOC 5,000 UNITS/1 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
MYORISAN 10 MG CAPSULE	1	
MYORISAN 20 MG CAPSULE	1	
MYORISAN 30 MG CAPSULE	1	
MYORISAN 40 MG CAPSULE	1	
MYRBETRIQ ER 25 MG TABLET	2	
MYRBETRIQ ER 50 MG TABLET	2	
MYSOLINE 250 MG TABLET	NC	
MYSOLINE 50 MG TABLET	NC	
MYTESI 125 MG DR TABLET	3	Step Therapy required
MYZILRA-28 TABLET	0	ACA*

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NABUMETONE 500 MG TABLET	1	
NABUMETONE 750 MG TABLET	1	
NADOLOL 20 MG TABLET	1	HSA*
NADOLOL 40 MG TABLET	1	HSA*
NADOLOL 80 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NADOLOL-BENDROFLU 40-5 MG TAB	1	HSA*
NADOLOL-BENDROFLU 80-5 MG TAB	1	HSA*
NAFRINSE DAILY-NEUTRAL RINSE	2	
NAFTIFINE HCL 1% CREAM	1	
NAFTIFINE HCL 2% CREAM	1	
NAFTIN 1% CREAM	NC	
NAFTIN 1% GEL	2	
NAFTIN 2% CREAM	NC	
NAFTIN 2% GEL	2	
NALFON 400 MG CAPSULE	NC	
NALOXONE 0.4 MG/ML CARPUJECT	MD	Max. 2 ML(s) per 15 days \$0 copayment
NALOXONE 0.4 MG/ML VIAL	MD	Max. 2 ML(s) per 15 days \$0 copayment
NALOXONE 2 MG/2 ML SYRINGE	MD	Max. 2 ML(s) per 15 days \$0 copayment
NALTREXONE 50 MG TABLET	1	
NAMENDA 10 MG TABLET	NC	
NAMENDA 2 MG/ML SOLUTION	NC	
NAMENDA 5 MG TABLET	NC	
NAMENDA 5-10 MG TITRATION PK	NC	
NAMENDA XR 14 MG CAPSULE	3	
NAMENDA XR 21 MG CAPSULE	3	
NAMENDA XR 28 MG CAPSULE	3	
NAMENDA XR 7 MG CAPSULE	3	
NAMENDA XR TITRATION PACK	3	
NAMZARIC 14 MG-10 MG CAPSULE	3	
NAMZARIC 21 MG-10 MG CAPSULE	3	
NAMZARIC 28 MG-10 MG CAPSULE	3	
NAMZARIC 7 MG-10 MG CAPSULE	3	
NAMZARIC TITRATION PACK	3	
NAPHAZOLINE 0.1% EYE DROPS	1	
NAPRELAN CR 375 MG TABLET	NC	
NAPRELAN CR 500 MG TABLET	NC	
NAPRELAN CR 750 MG TABLET	3	
NAPROSYN 125 MG/5 ML SUSPEN	NC	
NAPROSYN 250 MG TABLET	NC	
NAPROSYN 375 MG TABLET	NC	
NAPROSYN 500 MG TABLET	NC	
NAPROXEN 125 MG/5 ML SUSPEN	1	
NAPROXEN 250 MG TABLET	1	
NAPROXEN 375 MG TABLET	1	
NAPROXEN 500 MG TABLET	1	
NAPROXEN DR 375 MG TABLET	1	
NAPROXEN DR 500 MG TABLET	1	
NAPROXEN SOD CR 375 MG TABLET	1	
NAPROXEN SOD CR 500 MG TABLET	1	
NAPROXEN SODIUM 275 MG TAB	1	
NAPROXEN SODIUM 550 MG TAB	1	
NARATRIPTAN HCL 1 MG TABLET	1	Max. quantity of 15 per fill MQC*: 15 tabs/copay
NARATRIPTAN HCL 2.5 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
NARCAN 4 MG NASAL SPRAY	MD	Max. 2 per 15 days \$0 copayment
NARDIL 15 MG TABLET	NC	
NASACORT AQ NASAL SPRAY	NC	
NASCOBAL 500 MCG NASAL SPRAY	3	
NASONEX 50 MCG NASAL SPRAY	NC	
NATACYN EYE DROPS	2	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
NATAZIA 28 TABLET	0	ACA*
NATEGLINIDE 120 MG TABLET	1	HSA*
NATEGLINIDE 60 MG TABLET	1	HSA*
NATESTO NASAL 5.5 MG/0.122 GM	3	Max. 30 Days Supply; Prior Authorization required for members 18 and older
NATPARA 100 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATPARA 25 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATPARA 50 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATPARA 75 MCG DOSE CARTRIDGE	3	Max. 1 per 15 days Max 2 cartridges/28 days supply; SPP*: Must use CVS Specialty
NATROBA 0.9% TOPICAL SUSP	NC	
NATURE-THROID 113.75 MG TABLET	1	
NATURE-THROID 130 MG TABLET	1	
NATURE-THROID 146.25 MG TABLET	1	
NATURE-THROID 16.25 MG TABLET	1	
NATURE-THROID 162.5 MG TABLET	1	
NATURE-THROID 195 MG TABLET	1	
NATURE-THROID 260 MG TABLET	1	
NATURE-THROID 32.5 MG TABLET	1	
NATURE-THROID 325 MG TABLET	1	
NATURE-THROID 48.75 MG TABLET	1	
NATURE-THROID 65 MG TABLET	1	
NATURE-THROID 81.25 MG TABLET	1	
NATURE-THROID 97.5 MG TABLET	1	
NEBUPENT 300 MG INHAL POWDER	2	
NEBUSAL 3% VIAL	1	
NEBUSAL 6% VIAL	3	
NECON 0.5-35-28 TABLET	0	ACA*
NECON 1-35-28 TABLET	0	ACA*
NECON 1-50-28 TABLET	0	ACA*
NECON 10-11-28 TABLET	0	ACA*
NECON 7-7-7-28 TABLET	0	ACA*
NEFAZODONE HCL 100 MG TABLET	1	
NEFAZODONE HCL 150 MG TABLET	1	
NEFAZODONE HCL 200 MG TABLET	1	
NEFAZODONE HCL 250 MG TABLET	1	
NEFAZODONE HCL 50 MG TABLET	1	
NEO-BACIT-POLY-HC EYE OINTMENT	1	
NEO-POLYCIN EYE OINTMENT	1	
NEO-POLYCIN HC EYE OINTMENT	1	
NEO-SYNALAR 0.5%-0.025% CREAM	3	
NEO-SYNALAR 0.5-0.025% CRM KIT	3	
NEOMYC-BACIT-POLYMIX EYE OINT	1	
NEOMYC-POLYM-DEXAMET EYE OINTM	1	
NEOMYC-POLYM-DEXAMETH EYE DROP	1	
NEOMYC-POLYM-GRAMICID EYE DROP	1	
NEOMYCIN 500 MG TABLET	1	
NEOMYCIN-POLY-HC EYE DROPS	1	
NEOMYCIN-POLYMYXIN-HC EAR SOLN	1	
NEOMYCIN-POLYMYXIN-HC EAR SUSP	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NEORAL 100 MG GELATIN CAPSULE	3	
NEORAL 100 MG/ML SOLUTION	3	
NEORAL 25 MG GELATIN CAPSULE	3	
NEOSALUS CP CREAM	3	
NEOSALUS CREAM	3	
NEOSALUS FOAM	3	
NEOSALUS LOTION	3	
NEOSPORIN EYE DROPS	NC	
NEPHRO-VITE RX TABLET	1	
NEPHROCAPS QT TABLET	3	
NEPHROCAPS SOFTGEL	1	
NEPHRON FA TABLET	1	
NEPTAZANE 25 MG TABLET	NC	
NEPTAZANE 50 MG TABLET	NC	
NERLYNX 40 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
NESINA 12.5 MG TABLET	NC	
NESINA 25 MG TABLET	NC	
NESINA 6.25 MG TABLET	NC	
NESSI SPACER	MD	
NEUAC 1.2-5% KIT	NC	
NEUAC GEL	NC	
NEULASTA 6 MG/0.6 ML SYRINGE	2	Prior Authorization required;Max. 1.2 ML(s) per 28 days SPP*: CVS Specialty
NEULASTA ONPRO 6 MG/0.6 ML KIT	2	Prior Authorization required;Max. 1.2 ML(s) per 28 days SPP*: CVS Specialty
NEUMEGA 5 MG VIAL	2	SPP*: Must use CVS Specialty
NEUPOGEN 300 MCG/0.5 ML SYR	2	Prior Authorization required SPP*: CVS Specialty
NEUPOGEN 300 MCG/ML VIAL	2	Prior Authorization required SPP*: CVS Specialty
NEUPOGEN 480 MCG/0.8 ML SYR	3	Prior Authorization required SPP*: CVS Specialty
NEUPOGEN 480 MCG/1.6 ML VIAL	2	Prior Authorization required SPP*: CVS Specialty
NEUPRO 1 MG/24 HR PATCH	3	
NEUPRO 2 MG/24 HR PATCH	3	
NEUPRO 3 MG/24 HR PATCH	3	
NEUPRO 4 MG/24 HR PATCH	3	
NEUPRO 6 MG/24 HR PATCH	3	
NEUPRO 8 MG/24 HR PATCH	3	
NEURIN-SL TABLET SL	1	
NEURONTIN 100 MG CAPSULE	NC	
NEURONTIN 250 MG/5 ML SOLN	NC	
NEURONTIN 300 MG CAPSULE	NC	
NEURONTIN 400 MG CAPSULE	NC	
NEURONTIN 600 MG TABLET	NC	
NEURONTIN 800 MG TABLET	NC	
NEUTEK 2TEK TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
NEUTRAL SODIUM FLUORIDE	1	ACA*: Children through age 5; HSA
NEUTRASAL 538 MG POWDER PACKET	3	
NEUTRASAL POWDER PACKET	3	
NEVANAC 0.1% DROPTAINER	3	
NEVIRAPINE 200 MG TABLET	1	
NEVIRAPINE 50 MG/5 ML SUSP	1	
NEVIRAPINE ER 100 MG TABLET	1	
NEVIRAPINE ER 400 MG TABLET	1	
NEXAVAR 200 MG TABLET	3	CH*; SPP*: CVS Specialty
NEXIUM 24HR 20 MG CAPSULE	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NEXIUM 24HR 20 MG TABLET	1	
NEXIUM DR 10 MG PACKET	2	
NEXIUM DR 2.5 MG PACKET	2	
NEXIUM DR 20 MG CAPSULE	NC	
NEXIUM DR 20 MG PACKET	2	
NEXIUM DR 40 MG CAPSULE	NC	
NEXIUM DR 40 MG PACKET	2	
NEXIUM DR 5 MG PACKET	2	
NEXPLANON 68 MG IMPLANT	MD	SPP*: Must use CVS Specialty
NEXT CHOICE ONE DOSE 1.5 MG TB	0	Max. quantity of 1 per fill ACA*
NIACIN ER 1,000 MG TABLET	1	HSA*
NIACIN ER 500 MG TABLET	1	HSA*
NIACIN ER 750 MG TABLET	1	HSA*
NIACOR 500 MG TABLET	1	HSA*
NIASPAN ER 1,000 MG TABLET	NC	
NIASPAN ER 500 MG TABLET	NC	
NIASPAN ER 750 MG TABLET	NC	
NICARDIPINE 20 MG CAPSULE	1	HSA*
NICARDIPINE 30 MG CAPSULE	1	HSA*
NICODERM CQ 14 MG/24HR PATCH	NC	
NICODERM CQ 21 MG/24HR PATCH	NC	
NICODERM CQ 7 MG/24HR PATCH	NC	
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	NC	
NICORETTE 2 MG MINI LOZENGE	NC	
NICORETTE 4 MG CHEWING GUM	NC	
NICORETTE 4 MG MINI LOZENGE	NC	
NICOTINE 14 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE 2 MG CHEWING GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 2 MG LOZENGE	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 21 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE 22 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE 4 MG CHEWING GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 4 MG LOZENGE	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
NICOTINE 7 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTINE TRANSDERMAL SYSTEM	0	Max. 180 Days Supply;Max. 1 per day ACA*
NICOTROL CARTRIDGE INHALER	0	Max. 180 Days Supply;Max. quantity of 168 per fill ACA*
NICOTROL NS 10 MG/ML SPRAY	0	Max. 180 Days Supply;Max. quantity of 40 per fill;Max. 180 ML(s) in 365 days ACA*; Max 4 units/fill; Limit 180 days supply per year
NIFEDICAL XL 30 MG TABLET	1	HSA*
NIFEDICAL XL 60 MG TABLET	1	HSA*
NIFEDIPINE 10 MG CAPSULE	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NIFEDIPINE 20 MG CAPSULE	1	HSA*
NIFEDIPINE ER 30 MG TABLET	1	
NIFEDIPINE ER 30 MG TABLET	1	HSA*
NIFEDIPINE ER 60 MG TABLET	1	HSA*
NIFEDIPINE ER 60 MG TABLET	1	
NIFEDIPINE ER 90 MG TABLET	1	
NIFEDIPINE ER 90 MG TABLET	1	HSA*
NIKKI 3 MG-0.02 MG TABLET	0	ACA*
NILANDRON 150 MG TABLET	NC	
NILUTAMIDE 150 MG TABLET	2	CH*
NIMODIPINE 30 MG CAPSULE	1	HSA*
NINLARO 2.3 MG CAPSULE	3	CH*; SPP*: CVS Specialty
NINLARO 3 MG CAPSULE	3	CH*; SPP*: CVS Specialty
NINLARO 4 MG CAPSULE	3	CH*; SPP*: CVS Specialty
NIRAVAM 0.25 MG ODT	NC	
NIRAVAM 0.5 MG ODT	NC	
NIRAVAM 1 MG ODT	NC	
NIRAVAM 2 MG ODT	NC	
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*
NITRO-BID 2% OINTMENT	2	HSA*
NITRO-DUR 0.1 MG/HR PATCH	NC	
NITRO-DUR 0.2 MG/HR PATCH	NC	
NITRO-DUR 0.3 MG/HR PATCH	2	HSA*
NITRO-DUR 0.4 MG/HR PATCH	NC	
NITRO-DUR 0.6 MG/HR PATCH	NC	
NITRO-DUR 0.8 MG/HR PATCH	2	HSA*
NITROFURANTOIN 25 MG/5 ML SUSP	1	
NITROFURANTOIN MCR 100 MG CAP	1	
NITROFURANTOIN MCR 25 MG CAP	1	
NITROFURANTOIN MCR 50 MG CAP	1	
NITROFURANTOIN MONO-MCR 100 MG	1	
NITROGLYCERIN 0.1 MG/HR PATCH	1	HSA*
NITROGLYCERIN 0.2 MG/HR PATCH	1	HSA*
NITROGLYCERIN 0.3 MG TABLET SL	2	HSA*
NITROGLYCERIN 0.4 MG TABLET SL	2	HSA*
NITROGLYCERIN 0.4 MG/HR PATCH	1	HSA*

NITROGLYCERIN 0.6 MG TABLET SL	2	HSA*
NITROGLYCERIN 0.6 MG/HR PATCH	1	HSA*
NITROGLYCERIN ER 2.5 MG CAP	1	HSA*
NITROGLYCERIN ER 6.5 MG CAP	1	HSA*
NITROGLYCERIN ER 9 MG CAPSULE	1	HSA*
NITROGLYCERIN LINGUAL 0.4 MG	1	HSA*
NITROLINGUAL 0.4 MG SPRAY	NC	
NITROMIST 400 MCG SPRAY	NC	
NITROSTAT 0.3 MG TABLET SL	NC	
NITROSTAT 0.4 MG TABLET SL	NC	
NITROSTAT 0.6 MG TABLET SL	NC	
NITYR 10 MG TABLET	3	Prior Authorization required PA NTM*; LDD*: Diplomat Pharmacy (877) 977-9118
NITYR 2 MG TABLET	3	Prior Authorization required PA NTM*; LDD*: Diplomat Pharmacy (877) 977-9118
NITYR 5 MG TABLET	3	Prior Authorization required PA NTM*; LDD*: Diplomat Pharmacy (877) 977-9118
NIVATOPIC PLUS CREAM	3	
NIZATIDINE 15 MG/ML SOLUTION	1	
NIZATIDINE 150 MG CAPSULE	1	
NIZATIDINE 300 MG CAPSULE	1	
NIZORAL 2% SHAMPOO	NC	
NO-STICK GLUCOSE TEST STRIPS	2	HSA*
NODOLOR CAPSULE	1	
NOLIX 0.05% LOTION	3	
NOR-Q-D TABLET	NC	
NORA-BE TABLET	0	ACA*
NORCO 10-325 TABLET	NC	
NORCO 5-325 TABLET	NC	
NORCO 7.5-325 TABLET	NC	
NORDITROPIN FLEXPRO 10 MG/1.5	NC	
NORDITROPIN FLEXPRO 15 MG/1.5	NC	
NORDITROPIN FLEXPRO 30 MG/3 ML	NC	
NORDITROPIN FLEXPRO 5 MG/1.5	NC	
NORET-ESTR-FE 0.4-0.035(21)-75	0	ACA*
NORETH-ESTRAD-FE 1-0.02(21)-75	0	ACA*
NORETH-ESTRAD-FE 1-0.02(24)-75	0	ACA*
NORETHIN-ESTRA-FE 0.8-0.025 MG	0	ACA*
NORETHIN-ETH ESTRAD 1 MG-5 MCG	1	
NORETHIND-ETH ESTRAD 0.5-2.5	1	
NORETHIND-ETH ESTRAD 1-0.02 MG	0	ACA*
NORETHINDRONE 0.35 MG TABLET	0	ACA*
NORETHINDRONE 5 MG TABLET	1	
NORG-EE 0.18-0.215-0.25/0.035	0	ACA*
NORG-ETHIN ESTRA 0.25-0.035 MG	0	ACA*
NORINYL 1+50-28 TABLET	NC	
NORINYL 1-35 28 TABLET	0	ACA*
NORITATE 1% CREAM	NC	
NORLYDA 0.35 MG TABLET	0	ACA*
NORLYROC 0.35 MG TABLET	0	ACA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
NORM-JECT 1 ML SYRINGE	3	
NORMLGEL AG 0.11% WOUND GEL	3	
NOROXIN 400 MG TABLET	3	
NORPACE 100 MG CAPSULE	NC	
NORPACE 150 MG CAPSULE	NC	
NORPACE CR 100 MG CAPSULE	3	
NORPACE CR 150 MG CAPSULE	3	
NORPRAMIN 10 MG TABLET	NC	
NORPRAMIN 100 MG TABLET	NC	
NORPRAMIN 150 MG TABLET	NC	
NORPRAMIN 25 MG TABLET	NC	
NORPRAMIN 50 MG TABLET	NC	
NORPRAMIN 75 MG TABLET	NC	
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
NORTREL 0.5-35-28 TABLET	0	ACA*
NORTREL 1-35 21 TABLET	0	ACA*
NORTREL 1-35 28 TABLET	0	ACA*
NORTREL 7-7-7-28 TABLET	0	ACA*
NORTRIPTYLINE 10 MG/5 ML SOL	1	
NORTRIPTYLINE HCL 10 MG CAP	1	
NORTRIPTYLINE HCL 25 MG CAP	1	
NORTRIPTYLINE HCL 50 MG CAP	1	
NORTRIPTYLINE HCL 75 MG CAP	1	
NORVASC 10 MG TABLET	NC	
NORVASC 2.5 MG TABLET	NC	
NORVASC 5 MG TABLET	NC	
NORVIR 100 MG SOFTGEL CAP	2	
NORVIR 100 MG TABLET	2	
NORVIR 80 MG/ML SOLUTION	2	
NOVA MAX GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
NOVA SAFETY 23G LANCETS	2	HSA*
NOVA SAFETY 28G LANCETS	2	HSA*
NOVA SUREFLEX THIN LANCETS	2	HSA*
NOVAMAX PLUS KETONE TEST STRIP	3	Max. 204 per 30 days
NOVAREL 10,000 UNITS VIAL	2	Max. 30 Days Supply IVF*
NOVAREL 5,000 UNIT VIAL	2	Max. 30 Days Supply IVF*
NOVOEIGHT 1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
NOVOLIN 70-30 100 UNIT/ML VIAL	3	Prior Authorization required HSA*
NOVOLIN N 100 UNITS/ML VIAL	3	Prior Authorization required HSA*
NOVOLIN R 100 UNITS/ML VIAL	3	Prior Authorization required HSA*
NOVOLOG 100 UNIT/ML CARTRIDGE	3	Prior Authorization required HSA*
NOVOLOG 100 UNIT/ML VIAL	3	Prior Authorization required HSA*
NOVOLOG 100 UNITS/ML FLEXPEN	3	Prior Authorization required HSA*

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*
NOVOSEVEN RT 2 MG VIAL	MD	SPP*: Must use CVS Specialty
NOXAFIL 40 MG/ML SUSPENSION	3	
NOXAFIL DR 100 MG TABLET	3	
NOXIFOL-D3 2,500 UNIT-1 MG TAB	3	
NP THYROID 120 MG TABLET	1	
NP THYROID 15 MG TABLET	1	
NP THYROID 30 MG TABLET	1	
NP THYROID 60 MG TABLET	1	
NP THYROID 90 MG TABLET	1	
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
NUDEXTA 20-10 MG CAPSULE	2	
NULOJIX 250 MG VIAL	MD	SPP*: Must use CVS Specialty
NULYTELY WITH FLAVOR PACKS SOL	NC	
NUPLAZID 17 MG TABLET	3	Prior Authorization required;Max. 2 per day SPP*: Must use CVS Specialty
NUTRICAP CAPLET	3	
NUTROPIN 10 MG VIAL	NC	
NUTROPIN AQ 20 MG/2ML PEN CART	NC	
NUTROPIN AQ NUSPIN 10 INJECTOR	NC	
NUTROPIN AQ NUSPIN 20 INJECTOR	NC	
NUTROPIN AQ NUSPIN 5 INJECTOR	NC	
NUTROPIN AQ PEN CARTRIDGE	NC	
NUVAIL NAIL 16% SOLUTION	3	
NUVARING VAGINAL RING	0	ACA*
NUVESSA VAGINAL 1.3% GEL	3	
NUVIGIL 150 MG TABLET	NC	
NUVIGIL 200 MG TABLET	NC	
NUVIGIL 250 MG TABLET	NC	
NUVIGIL 50 MG TABLET	NC	
NUWIQ 250 UNIT VIAL PACK	MD	SPP*: Must use CVS Specialty
NYAMYC 100,000 UNITS/GM POWDER	1	
NYATA 100,000 UNIT/GM POWDER	1	
NYMALIZE 60 MG/20 ML SOLUTION	3	HSA*
NYSTATIN 100,000 UNIT/GM CREAM	1	
NYSTATIN 100,000 UNIT/GM POWD	1	
NYSTATIN 100,000 UNIT/ML SUSP	1	
NYSTATIN 100,000 UNITS/GM OINT	1	
NYSTATIN 150,000,000 UNITS PWD	1	
NYSTATIN 500,000 UNIT ORAL TAB	1	
NYSTATIN-TRIAMCINOLONE CREAM	1	
NYSTATIN-TRIAMCINOLONE OINTM	1	
NYSTOP 100,000 UNITS/GM POWDER	1	

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DRUG NAME	TIER	LIMITATIONS/ * NOTES
OBREDON 2.5-200 MG/5 ML SOLN	3	
OCALIVA 10 MG TABLET	3	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
OCALIVA 5 MG TABLET	3	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
OCELLA 3 MG-0.03 MG TABLET	0	ACA*
OCTREOTIDE 1,000 MCG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCTREOTIDE ACET 100 MCG/ML VL	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCTREOTIDE ACET 200 MCG/ML VL	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCTREOTIDE ACET 50 MCG/ML SYR	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCTREOTIDE ACET 500 MCG/ML VL	MD	Prior Authorization required SPP*: Must use CVS Specialty
OCUDOX CONVENIENCE KIT	NC	
OCUFEN 0.03% EYE DROPS	NC	
OCUFLOX 0.3% EYE DROPS	NC	
ODEFSEY TABLET	3	
ODOMZO 200 MG CAPSULE	3	CH*; SPP*: CVS Specialty
OFEV 100 MG CAPSULE	2	Max. 2 per day SPP*: Must use CVS Specialty
OFEV 150 MG CAPSULE	2	Max. 2 per day SPP*: Must use CVS Specialty
OFLOXACIN 0.3% EAR DROPS	1	
OFLOXACIN 0.3% EYE DROPS	1	
OFLOXACIN 200 MG TABLET	1	
OFLOXACIN 300 MG TABLET	1	
OFLOXACIN 400 MG TABLET	1	
OGESTREL TABLET	0	ACA*
OLANZAPINE 10 MG TABLET	1	
OLANZAPINE 10 MG VIAL	MD	SPP*: Must use CVS Specialty
OLANZAPINE 15 MG TABLET	1	
OLANZAPINE 2.5 MG TABLET	1	
OLANZAPINE 20 MG TABLET	1	
OLANZAPINE 5 MG TABLET	1	
OLANZAPINE 7.5 MG TABLET	1	
OLANZAPINE ODT 10 MG TABLET	1	
OLANZAPINE ODT 15 MG TABLET	1	
OLANZAPINE ODT 20 MG TABLET	1	
OLANZAPINE ODT 5 MG TABLET	1	
OLANZAPINE-FLUOXETINE 12-25 MG	1	
OLANZAPINE-FLUOXETINE 12-50 MG	1	
OLANZAPINE-FLUOXETINE 3-25 MG	1	
OLANZAPINE-FLUOXETINE 6-25 MG	1	
OLANZAPINE-FLUOXETINE 6-50 MG	1	
OLEPTRO ER 150 MG TABLET	3	
OLEPTRO ER 300 MG TABLET	3	
OLMESARTAN MEDOXOMIL 20 MG TAB	2	HSA*
OLMESARTAN MEDOXOMIL 40 MG TAB	2	HSA*
OLMESARTAN MEDOXOMIL 5 MG TAB	2	HSA*
OLMESARTAN-HCTZ 20-12.5 MG TAB	2	HSA*
OLMESARTAN-HCTZ 40-12.5 MG TAB	2	HSA*
OLMESARTAN-HCTZ 40-25 MG TAB	2	HSA*



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

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ORAPRED ODT 30 MG TABLET	NC	
ORAVIG 50 MG BUCCAL TABLET	3	
ORENCIA 125 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) per 7 days SPP*: Must use CVS Specialty
ORENCIA 50 MG/0.4 ML SYRINGE	3	Prior Authorization required;Max. 0.4 ML(s) per 7 days SPP*: Must use CVS Specialty
ORENCIA 87.5 MG/0.7 ML SYRINGE	3	Prior Authorization required;Max. 0.7 ML(s) per 7 days SPP*: Must use CVS Specialty
ORENCIA CLICKJECT 125 MG/ML	3	Prior Authorization required;Max. 1 ML(s) per 7 days SPP*: Must use CVS Specialty
ORENITRAM ER 0.125 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 0.25 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 1 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 2.5 MG TABLET	3	SPP*: Must use CVS Specialty
ORENITRAM ER 5 MG TABLET	3	SPP*: Must use CVS Specialty
ORFADIN 10 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 2 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 20 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 4 MG/ML SUSPENSION	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORFADIN 5 MG CAPSULE	3	LDD*: Dohmen Life Sciences. 1-800-305-7881.
ORKAMBI 100 MG-125 MG TABLET	3	Prior Authorization required;Max. 112 per 28 days LDD*: Diplomat Pharmacy (877) 977-9118
ORKAMBI 200 MG-125 MG TABLET	3	Prior Authorization required;Max. 112 per 28 days LDD*: Diplomat Pharmacy (877) 977-9118
ORPHENADRINE COMP FORTE TAB	1	
ORPHENADRINE COMP TABLET	1	
ORPHENADRINE ER 100 MG TABLET	1	
ORSYTHIA-28 TABLET	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 65MM	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 70MM	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 75MM	0	ACA*
ORTHO ALL-FLEX DIAPHRAGM 80MM	0	ACA*
ORTHO ALL-FLEX FITTING SET	0	ACA*
ORTHO EVRA PATCH	NC	
ORTHO MICRONOR 0.35 MG TABLET	NC	
ORTHO TRI-CYCLLEN 28 TABLET	NC	
ORTHO TRI-CYCLLEN LO TABLET	NC	
ORTHO-CEPT 28 DAY TABLET	NC	
ORTHO-CYCLLEN 28 TABLET	NC	
ORTHO-NOVUM 1-35-28 TABLET	NC	
ORTHO-NOVUM 7-7-7-28 TABLET	NC	
OSELTAMIVIR PHOS 30 MG CAPSULE	2	Max. 10 Days Supply;Max. 20 in 180 days
OSELTAMIVIR PHOS 45 MG CAPSULE	2	Max. 10 Days Supply;Max. 20 in 180 days
OSELTAMIVIR PHOS 75 MG CAPSULE	2	Max. 10 Days Supply;Max. 10 in 180 days
OSENI 12.5-15 MG TABLET	NC	
OSENI 12.5-30 MG TABLET	NC	
OSENI 12.5-45 MG TABLET	NC	
OSENI 25-15 MG TABLET	NC	
OSENI 25-30 MG TABLET	NC	
OSENI 25-45 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
OSMOPREP TABLET	3	
OSPHENA 60 MG TABLET	3	
OTEZLA 28 DAY STARTER PACK	3	Prior Authorization required SPP*: Must use CVS Specialty
OTEZLA 30 MG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
OTEZLA STARTER PACK	3	Prior Authorization required SPP*: Must use CVS Specialty
OTIC CARE OTIC SOLUTION	3	
OTICIN DROPS	1	
OTICIN HC DROPS	NC	
OTO-END 10 EAR DROPS	3	
OTOMAX-HC EAR DROPS	1	
OTOVEL 0.3%-0.025% EAR DROPS	3	Max. quantity of 2 per fill
OTREXUP 10 MG/0.4 ML AUTO-INJ	2	
OTREXUP 12.5 MG/0.4 ML AUTOINJ	2	
OTREXUP 15 MG/0.4 ML AUTO-INJ	2	
OTREXUP 17.5 MG/0.4 ML AUTOINJ	2	
OTREXUP 20 MG/0.4 ML AUTO-INJ	2	
OTREXUP 22.5 MG/0.4 ML AUTOINJ	2	
OTREXUP 25 MG/0.4 ML AUTO-INJ	2	
OTREXUP 7.5 MG/0.4 ML AUTO-INJ	2	
OVACE PLUS 10% SHAMPOO	3	
OVACE PLUS WASH 10% CLNSNG GEL	NC	
OVCON-35 28 TABLET	NC	
OVIDE 0.5% LOTION	NC	
OVIDREL 250 MCG/0.5 ML SYRG	2	Max. 30 Days Supply IVF*
OXALIS OINTMENT	3	
OXANDRIN 10 MG TABLET	NC	
OXANDRIN 2.5 MG TABLET	NC	
OXANDROLONE 10 MG TABLET	1	Max. 30 Days Supply
OXANDROLONE 2.5 MG TABLET	1	Max. 30 Days Supply
OXAPROZIN 600 MG TABLET	1	
OXAYDO 5 MG TABLET	3	
OXAYDO 7.5 MG TABLET	3	
OXAZEPAM 10 MG CAPSULE	1	
OXAZEPAM 15 MG CAPSULE	1	
OXAZEPAM 30 MG CAPSULE	1	
OXCARBAZEPINE 150 MG TABLET	1	
OXCARBAZEPINE 300 MG TABLET	1	
OXCARBAZEPINE 300 MG/5 ML SUSP	1	
OXCARBAZEPINE 600 MG TABLET	1	
OXECTA 5 MG TABLET	3	
OXECTA 7.5 MG TABLET	3	
OXICONAZOLE NITRATE 1% CREAM	1	
OXISTAT 1% CREAM	NC	
OXISTAT 1% LOTION	3	
OXSORALEN 1% LOTION	2	
OXSORALEN-ULTRA 10 MG CAP	NC	
OXTELLAR XR 150 MG TABLET	3	
OXTELLAR XR 300 MG TABLET	3	
OXTELLAR XR 600 MG TABLET	3	
OXYBUTYNIN 5 MG TABLET	1	
OXYBUTYNIN 5 MG/5 ML SYRUP	1	
OXYBUTYNIN CL ER 10 MG TABLET	1	
OXYBUTYNIN CL ER 15 MG TABLET	1	
OXYBUTYNIN CL ER 5 MG TABLET	1	
OXYCODON-ACETAMINOPHEN 2.5-325	1	
OXYCODON-ACETAMINOPHEN 7.5-300	1	

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

SPP\*: Must use CVS Specialty

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PALIPERIDONE ER 9 MG TABLET	1	
PAMELOR 10 MG CAPSULE	NC	
PAMELOR 25 MG CAPSULE	NC	
PAMELOR 50 MG CAPSULE	NC	
PAMELOR 75 MG CAPSULE	NC	
PAMINE 2.5 MG TABLET	NC	
PAMINE FORTE 5 MG TABLET	NC	
PANCREAZE DR 10,500 UNIT CAP	2	
PANCREAZE DR 16,800 UNIT CAP	2	
PANCREAZE DR 2,600 UNIT CAP	2	
PANCREAZE DR 21,000 UNIT CAP	2	
PANCREAZE DR 4,200 UNIT CAP	2	
PANCRELIPASE DR 5,000 UNIT CAP	1	
PANDA MASK SMALL	MD	
PANDEL 0.1% CREAM	3	
PANRETIN 0.1% GEL	3	
PANTOPRAZOLE SOD DR 20 MG TAB	1	
PANTOPRAZOLE SOD DR 40 MG TAB	1	
PAPAVERINE 150 MG CAPSULE SA	1	
PARADIGM INFUSION 24" SET	MD	
PARADIGM INSULIN PUMP	MD	
PARADIGM RESERVOIR 1.8 ML	MD	
PARADIGM RESERVOIR 3 ML	MD	
PARAFON FORTE DSC 500 MG CAPLT	NC	
PARCAINE 0.5% EYE DROPS	1	
PARCOPA 10 MG-100 MG ODT	NC	
PARCOPA 25 MG-100 MG ODT	NC	
PARCOPA 25 MG-250 MG ODT	NC	
PAREGORIC LIQUID	1	
PAREMYD EYE DROPS	3	
PARICALCITOL 1 MCG CAPSULE	1	
PARICALCITOL 2 MCG CAPSULE	1	
PARICALCITOL 4 MCG CAPSULE	1	
PARLODEL 2.5 MG TABLET	NC	
PARLODEL 5 MG CAPSULE	NC	
PARNATE 10 MG TABLET	NC	
PAROEX 0.12% ORAL RINSE	1	
PAROMOMYCIN 250 MG CAPSULE	1	
PAROXETINE ER 12.5 MG TABLET	1	
PAROXETINE ER 25 MG TABLET	1	
PAROXETINE ER 37.5 MG TABLET	1	
PAROXETINE HCL 10 MG TABLET	1	
PAROXETINE HCL 20 MG TABLET	1	
PAROXETINE HCL 30 MG TABLET	1	
PAROXETINE HCL 40 MG TABLET	1	
PAROXETINE MESYLATE 7.5 MG CAP	2	
PASER GRANULES 4 GM PACKET	3	
PATADAY 0.2% EYE DROPS	NC	
PATANASE 665 MCG NASAL SPRAY	NC	
PATANOL 0.1% EYE DROPS	NC	
PAXIL 10 MG TABLET	NC	
PAXIL 10 MG/5 ML SUSPENSION	2	Step Therapy required STA*: 18 and older
PAXIL 20 MG TABLET	NC	
PAXIL 30 MG TABLET	NC	
PAXIL 40 MG TABLET	NC	
PAXIL CR 12.5 MG TABLET	NC	
PAXIL CR 25 MG TABLET	NC	
PAXIL CR 37.5 MG TABLET	NC	

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PERCOCET 7.5-325 MG TABLET	NC	
PERCOCET 7.5-500 MG TABLET	NC	
PERCODAN 4.8355-325 MG TABLET	NC	
PERFOROMIST 20 MCG/2 ML SOLN	2	HSA*
PERIDEX 0.12% ORAL RINSE	NC	
PERINDOPRIL ERBUMINE 2 MG TAB	1	HSA*
PERINDOPRIL ERBUMINE 4 MG TAB	1	HSA*
PERINDOPRIL ERBUMINE 8 MG TAB	1	HSA*
PERIOGARD 0.12% ORAL RINSE	1	
PERMETHRIN 5% CREAM	1	
PERPHEN-AMITRIP 2 MG-10 MG TAB	1	
PERPHEN-AMITRIP 2 MG-25 MG TAB	1	
PERPHEN-AMITRIP 4 MG-10 MG TAB	1	
PERPHEN-AMITRIP 4 MG-25 MG TAB	1	
PERPHEN-AMITRIP 4 MG-50 MG TAB	1	
PERPHENAZINE 16 MG TABLET	1	
PERPHENAZINE 2 MG TABLET	1	
PERPHENAZINE 4 MG TABLET	1	
PERPHENAZINE 8 MG TABLET	1	
PERSANTINE 25 MG TABLET	NC	
PERSANTINE 50 MG TABLET	NC	
PERSANTINE 75 MG TABLET	NC	
PERSONAL BEST PEAK FLOW MTR	MD	
PERTZYE DR 16,000 UNIT CAPSULE	3	
PERTZYE DR 24,000 UNIT CAPSULE	3	
PERTZYE DR 4,000 UNIT CAPSULE	3	
PERTZYE DR 8,000 UNIT CAPSULE	3	
PEXEVA 10 MG TABLET	2	Step Therapy required STA*: 18 and older
PEXEVA 20 MG TABLET	2	Step Therapy required STA*: 18 and older
PEXEVA 30 MG TABLET	2	Step Therapy required STA*: 18 and older
PEXEVA 40 MG TABLET	2	Step Therapy required STA*: 18 and older
PFLEX INSPIRATORY TRAINER	MD	
PHARMACIST CHOICE 30G LANCETS	2	HSA*
PHARMACIST CHOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PHARMACIST CHOICE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PHENADOZ 12.5 MG SUPPOSITORY	1	
PHENADOZ 25 MG SUPPOSITORY	1	
PHENAZOPYRIDINE 100 MG TAB	1	
PHENAZOPYRIDINE 200 MG TAB	1	
PHENELZINE SULFATE 15 MG TAB	1	
PHENERGAN 12.5 MG SUPPOSITORY	NC	
PHENERGAN 25 MG SUPPOSITORY	NC	
PHENERGAN 50 MG SUPPOSITORY	NC	
PHENFLU CD TABLET	3	
PHENFLU CDX TABLET	3	
PHENOBARBITAL 100 MG TABLET	1	
PHENOBARBITAL 15 MG TABLET	1	
PHENOBARBITAL 16.2 MG TABLET	1	
PHENOBARBITAL 20 MG/5 ML ELIX	1	
PHENOBARBITAL 30 MG TABLET	1	
PHENOBARBITAL 32.4 MG TABLET	1	
PHENOBARBITAL 60 MG TABLET	1	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
PHENOBARBITAL 64.8 MG TABLET	1	
PHENOBARBITAL 97.2 MG TABLET	1	
PHENOXYBENZAMINE HCL 10 MG CAP	1	HSA*
PHENTOLAMINE 5 MG VIAL	1	
PHENTOLAMINE 5 MG/ML VIAL	1	
PHENYLEPHRINE 10% EYE DROPS	1	
PHENYLEPHRINE 2.5% EYE DROP	1	
PHENYLHISTINE DH LIQUID	1	
PHENYTEK 200 MG CAPSULE	3	
PHENYTEK 300 MG CAPSULE	3	
PHENYTOIN 125 MG/5 ML SUSP	1	
PHENYTOIN 50 MG INFATAB	1	
PHENYTOIN SOD EXT 100 MG CAP	1	
PHENYTOIN SOD EXT 200 MG CAP	1	
PHENYTOIN SOD EXT 300 MG CAP	1	
PHILITH 0.4-0.035 MG TABLET	0	ACA*
PHOSLO 667 MG GELCAP	NC	
PHOSLYRA 667 MG/5 ML SOLUTION	2	
PHOSPHA 250 NEUTRAL TABLET	1	
PHOSPHOLINE IODIDE 0.125%	2	
PHRENILIN FORTE CAPSULE	2	
PHYSICIANS EZ USE B-12 KIT	1	
PICATO 0.015% GEL	2	Max. 30 Days Supply
PICATO 0.05% GEL	2	Max. 30 Days Supply
PIKO 1 FLOW METER	MD	
PILOCARPINE 1% EYE DROPS	1	
PILOCARPINE 2% EYE DROPS	1	
PILOCARPINE 4% EYE DROPS	1	
PILOCARPINE HCL 5 MG TABLET	1	
PILOCARPINE HCL 7.5 MG TABLET	1	
PIMOZIDE 1 MG TABLET	1	
PIMOZIDE 2 MG TABLET	1	
PIMTREA 28 DAY TABLET	0	ACA*
PINDOLOL 10 MG TABLET	1	HSA*
PINDOLOL 5 MG TABLET	1	HSA*
PINNACAIN 20% OTIC DROPS	1	
PIOGLITAZONE HCL 15 MG TABLET	1	HSA*
PIOGLITAZONE HCL 30 MG TABLET	1	HSA*
PIOGLITAZONE HCL 45 MG TABLET	1	HSA*
PIOGLITAZONE-GLIMEPIRIDE 30-2	1	HSA*
PIOGLITAZONE-GLIMEPIRIDE 30-4	1	HSA*
PIOGLITAZONE-METFORMIN 15-500	1	HSA*
PIOGLITAZONE-METFORMIN 15-850	1	HSA*
PIRMELLA 1-35-28 TABLET	0	ACA*
PIRMELLA 7-7-7-28 TABLET	0	ACA*
PIROXICAM 10 MG CAPSULE	1	
PIROXICAM 20 MG CAPSULE	1	
PLAN B ONE-STEP 1.5 MG TABLET	NC	
PLAQUENIL 200 MG TABLET	NC	
PLAVIX 300 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PLAVIX 75 MG TABLET	NC	
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 SYRINGE	3	Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
PLEGRIDY PEN INJ STARTER PACK	3	Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
PLEGRIDY SYRINGE STARTER PACK	3	Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
PLETAL 100 MG TABLET	NC	
PLETAL 50 MG TABLET	NC	
PLEXION 9.8-4.8% CLEANSER	NC	
PNV PRENATAL PLUS MULTIVIT TAB	1	HSA*
POCKET CHAMBER	MD	
POCKET PEAK FLOW METER	MD	
PODOCON-25 LIQUID	1	
PODOFILOX 0.5% TOPICAL SOLN	1	
POLY-IRON 150 FORTE CAPSULE	1	
POLY-TUSSIN AC LIQUID	3	
POLY-VI-FLOR FS 0.25 MG FILM	3	
POLYCIN EYE OINTMENT	1	
POLYETHYLENE GLYCOL 3350 POWD	1	
POLYFIN QR INFUSION SET	MD	
POLYMYXIN B-TMP EYE DROPS	1	
POLYTRIM EYE DROPS	NC	
POMALYST 1 MG CAPSULE	3	CH*; SPP*: CVS Specialty
POMALYST 2 MG CAPSULE	3	CH*; SPP*: CVS Specialty
POMALYST 3 MG CAPSULE	3	CH*; SPP*: CVS Specialty
POMALYST 4 MG CAPSULE	3	CH*; SPP*: CVS Specialty
PONSTEL 250 MG KAPSEALS	NC	
PONTOCAINE 2% SOLUTION	3	
PORTIA-28 TABLET	0	ACA*
POT CITRATE-CITRIC ACID PACKET	1	
POTABA 500 MG CAPSULE	3	
POTASS CIT-SOD CIT-CITRIC SOLN	1	
POTASSIUM 25 MEQ TABLET EFF	1	
POTASSIUM CIT-CITRIC ACID SOLN	1	
POTASSIUM CITRATE ER 10 MEQ TB	1	
POTASSIUM CITRATE ER 15 MEQ TB	1	
POTASSIUM CITRATE ER 5 MEQ TAB	1	
POTASSIUM CL 10% (20 MEQ/15 ML	1	
POTASSIUM CL 20 MEQ PACKET	1	
POTASSIUM CL 20% (40 MEQ/15 ML	1	
POTASSIUM CL 25 MEQ TAB EFF	1	
POTASSIUM CL ER 10 MEQ CAPSULE	1	
POTASSIUM CL ER 10 MEQ TABLET	1	
POTASSIUM CL ER 20 MEQ TABLET	1	
POTASSIUM CL ER 8 MEQ CAPSULE	1	
POTASSIUM CL ER 8 MEQ TABLET	1	
POTASSIUM HYDROXIDE 5% SOLN	1	
POTIGA 200 MG TABLET	3	
POTIGA 300 MG TABLET	3	
POTIGA 400 MG TABLET	3	
POTIGA 50 MG TABLET	3	
PR CREAM KIT	1	
PRADAXA 110 MG CAPSULE	3	HSA*

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PRECISION POINT OF CARE STR	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRECISION Q-I-D TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRECISION XTR B-KETONE STRIP	2	Max. 204 per 30 days HSA*
PRECISION XTRA MONITOR	MD	Max. 1 in 365 days HSA*
PRECISION XTRA TEST STRIPS	2	Max. 204 per 30 days HSA*
PRECOSE 100 MG TABLET	NC	
PRECOSE 25 MG TABLET	NC	
PRECOSE 50 MG TABLET	NC	
PRED 1%-GATI 0.5%-NEPAF 0.1%	2	
PRED FORTE 1% EYE DROPS	NC	
PRED MILD 0.12% EYE DROPS	2	
PRED-G 1% EYE DROPS	3	
PRED-G S.O.P. EYE OINTMENT	3	
PREDNICARBATE 0.1% CREAM	1	
PREDNICARBATE 0.1% OINTMENT	1	
PREDNISOLONE 1%-GATIFLOX 0.5%	2	
PREDNISOLONE 1%-NEPAFENAC 0.1%	2	
PREDNISOLONE 10 MG/5 ML SOLN	1	
PREDNISOLONE 15 MG/5 ML SOLN	1	
PREDNISOLONE 20 MG/5 ML SOLN	1	
PREDNISOLONE 5 MG/5 ML SOLN	1	
PREDNISOLONE AC 1% EYE DROP	1	
PREDNISOLONE ODT 10 MG TABLET	1	
PREDNISOLONE ODT 15 MG TABLET	1	
PREDNISOLONE ODT 30 MG TABLET	1	
PREDNISOLONE SOD 1% EYE DROP	1	
PREDNISOLONE SOD PH 25 MG/5 ML	1	
PREDNISON 1 MG TABLET	1	
PREDNISON 10 MG TAB DOSE PACK	1	
PREDNISON 10 MG TABLET	1	
PREDNISON 2.5 MG TABLET	1	
PREDNISON 20 MG TABLET	1	
PREDNISON 5 MG TABLET	1	
PREDNISON 5 MG/5 ML SOLUTION	1	
PREDNISON 5 MG/ML SOLUTION	3	
PREDNISON 50 MG TABLET	1	
PREFEST TABLET	3	
PREGNYL 10,000 UNITS VIAL	2	Max. 30 Days Supply IVF*
PRELONE 15 MG/5 ML SYRUP	1	
PREMARIN 0.3 MG TABLET	2	
PREMARIN 0.45 MG TABLET	2	
PREMARIN 0.625 MG TABLET	2	
PREMARIN 0.9 MG TABLET	2	
PREMARIN 1.25 MG TABLET	2	
PREMARIN VAGINAL CREAM-APPL	2	
PREMIUM V10 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
PREMPHASE 0.625-5 MG TABLET	2	
PREMPRO 0.3 MG-1.5 MG TABLET	2	
PREMPRO 0.45-1.5 MG TABLET	2	
PREMPRO 0.625-2.5 MG TABLET	2	
PREMPRO 0.625-5 MG TABLET	2	
PRENA1 PEARL SOFTGEL	1	HSA*
PREPOIK POWDER PACKET	2	
PRESERA FOAM	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PRESSURE ACTIVATED 21G LANCETS	2	HSA*
PRESSURE ACTIVATED 28G LANCETS	2	HSA*
PRESTALIA 14 MG-10 MG TABLET	3	Max. 1 per day HSA*
PRESTALIA 3.5 MG-2.5 MG TABLET	3	Max. 1 per day HSA*
PRESTALIA 7 MG-5 MG TABLET	3	Max. 1 per day HSA*
PREVACID 15 MG SOLUTAB	3	
PREVACID 30 MG SOLUTAB	3	
PREVACID DR 15 MG CAPSULE	NC	
PREVACID DR 30 MG CAPSULE	NC	
PREVALITE PACKET	1	HSA*
PREVIDENT 0.2% RINSE	NC	
PREVIDENT 5000 BOOSTER PLUS	3	
PREVIDENT 5000 SENSITIVE PASTE	3	
PREVIFEM TABLET	0	ACA*
PREVPAC PATIENT PACK	NC	
PREZCOBIX 800 MG-150 MG TABLET	3	
PREZISTA 100 MG/ML SUSPENSION	2	
PREZISTA 150 MG TABLET	2	
PREZISTA 400 MG TABLET	2	
PREZISTA 600 MG TABLET	2	
PREZISTA 75 MG TABLET	2	
PREZISTA 800 MG TABLET	2	
PRIFTIN 150 MG TABLET	3	
PRILOSEC DR 10 MG CAPSULE	NC	
PRILOSEC DR 10 MG SUSPENSION	3	
PRILOSEC DR 2.5 MG SUSPENSION	3	
PRILOSEC DR 20 MG CAPSULE	NC	
PRILOSEC DR 40 MG CAPSULE	NC	
PRIMAQUINE 26.3 MG TABLET	2	
PRIMEAIRE CHAMBER	MD	
PRIMIDONE 250 MG TABLET	1	
PRIMIDONE 50 MG TABLET	1	
PRIMLEV 10-300 MG TABLET	3	
PRIMLEV 5-300 MG TABLET	3	
PRIMLEV 7.5-300 MG TABLET	3	
PRIMSOL 50 MG/5 ML ORAL SOLN	3	
PRINIVIL 10 MG TABLET	NC	
PRINIVIL 20 MG TABLET	NC	
PRINIVIL 5 MG TABLET	NC	
PRISTIQ ER 100 MG TABLET	NC	
PRISTIQ ER 25 MG TABLET	NC	
PRISTIQ ER 50 MG TABLET	NC	
PRO COMFORT 30G LANCETS	2	HSA*
PRO COMFORT 31G LANCET	2	HSA*
PROAIR HFA 90 MCG INHALER	2	HSA*
PROAIR RESPICLICK INHAL POWDER	2	HSA*
PROBENECID 500 MG TABLET	1	
PROBENECID-COLCHICINE TABS	1	
PROCARDIA 10 MG CAPSULE	NC	
PROCARDIA XL 30 MG TABLET	NC	
PROCARDIA XL 60 MG TABLET	NC	
PROCARDIA XL 90 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PROCENTRA 5 MG/5 ML SOLUTION	NC	
PROCHAMBER HOLDING CHAMBER	MD	
PROCHLORPERAZINE 10 MG TAB	1	
PROCHLORPERAZINE 25 MG SUPP	1	
PROCHLORPERAZINE 5 MG TABLET	1	
PROCRIPT 10,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIPT 2,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIPT 20,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
PROCRIPT 3,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIPT 4,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 12 per fill SPP*: CVS Specialty
PROCRIPT 40,000 UNITS/ML VIAL	2	Prior Authorization required;Max. quantity of 4 per fill SPP*: CVS Specialty
PROCTO-MED HC 2.5% CREAM	1	
PROCTO-PAK 1% CREAM	1	
PROCTOCORT 1% CREAM	NC	
PROCTOCORT 30 MG SUPPOSITORY	NC	
PROCTOFOAM-HC 1%-1% FOAM	2	
PROCTOSOL-HC 2.5% CREAM	1	
PROCTOZONE-HC 2.5% CREAM	1	
PROCYSBI DR 25 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
PROCYSBI DR 75 MG CAPSULE	3	LDD*: Accredo (866) 815-4717
PRODIGY NO CODING TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PRODIGY PRESSURE ACTIVATED 28G	2	HSA*
PRODIGY SAFETY 26G LANCETS	2	HSA*
PRODIGY TWIST TOP 28G LANCET	2	HSA*
PROFERRIN-FORTE TABLET	3	
PROFILNINE 500 UNITS VIAL	MD	SPP*: Must use CVS Specialty
PROGESTERONE 100 MG CAPSULE	1	HSA*
PROGESTERONE 200 MG CAPSULE	1	HSA*
PROGESTERONE OIL 50 MG/ML VL	1	Max. 30 Days Supply IVF*
PROGLYCEM 50 MG/ML ORAL SUSP	3	HSA*
PROGRAF 0.5 MG CAPSULE	2	
PROGRAF 1 MG CAPSULE	2	
PROGRAF 5 MG CAPSULE	2	
PROLASTIN C 1,000 MG VIAL	MD	Prior Authorization required LDD*: Dohmen Life Sciences. 1-800-305-7881.
PROLENSA 0.07% EYE DROPS	3	
PROLIA 60 MG/ML SYRINGE	MD	Prior Authorization required;Max. 1 ML(s) in 180 days SPP*: Must use CVS Specialty
PROMACET 50-650 MG TABLET	1	
PROMACTA 12.5 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMACTA 25 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMACTA 50 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMACTA 75 MG TABLET	3	HSA*; SPP*: Must use CVS Specialty
PROMETHAZINE 12.5 MG SUPPOS	1	
PROMETHAZINE 12.5 MG TABLET	1	
PROMETHAZINE 25 MG SUPPOSITORY	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PROMETHAZINE 25 MG TABLET	1	
PROMETHAZINE 50 MG SUPPOSITORY	1	
PROMETHAZINE 50 MG TABLET	1	
PROMETHAZINE 6.25 MG/5 ML SYRP	1	
PROMETHAZINE VC SYRUP	1	
PROMETHAZINE VC-CODEINE SYRUP	1	
PROMETHAZINE-CODEINE SYRUP	1	
PROMETHAZINE-DM SYRUP	1	
PROMETHEGAN 12.5 MG SUPPOS	1	
PROMETHEGAN 25 MG SUPPOSITORY	1	
PROMETHEGAN 50 MG SUPPOSITORY	1	
PROMETRIUM 100 MG CAPSULE	NC	
PROMETRIUM 200 MG CAPSULE	NC	
PROMISEB COMPLETE KIT	3	
PROMISEB TOPICAL CREAM	3	
PROPAFENONE HCL 150 MG TABLET	1	
PROPAFENONE HCL 225 MG TAB	1	
PROPAFENONE HCL 300 MG TAB	1	
PROPAFENONE HCL ER 225 MG CAP	1	
PROPAFENONE HCL ER 325 MG CAP	1	
PROPAFENONE HCL ER 425 MG CAP	1	
PROPANTHELINE 15 MG TABLET	1	
PROPARACAINE 0.5% EYE DROPS	1	
PROPRANOLOL 10 MG TABLET	1	HSA*
PROPRANOLOL 20 MG TABLET	1	HSA*
PROPRANOLOL 20 MG/5 ML SOLN	1	HSA*
PROPRANOLOL 40 MG TABLET	1	HSA*
PROPRANOLOL 40 MG/5 ML SOLN	1	HSA*
PROPRANOLOL 60 MG TABLET	1	HSA*
PROPRANOLOL 80 MG TABLET	1	HSA*
PROPRANOLOL ER 120 MG CAPSULE	1	HSA*
PROPRANOLOL ER 160 MG CAPSULE	1	HSA*
PROPRANOLOL ER 60 MG CAPSULE	1	HSA*
PROPRANOLOL ER 80 MG CAPSULE	1	HSA*
PROPRANOLOL-HCTZ 40-25 MG TAB	1	HSA*
PROPRANOLOL-HCTZ 80-25 MG TAB	1	HSA*
PROPYLTHIOURACIL 50 MG TABLET	1	
PROSCAR 5 MG TABLET	NC	
PROSTIGMIN 15 MG TABLET	3	
PROTHELIAL 1 GM/10 ML PASTE	3	
PROTONIX 40 MG SUSPENSION	3	
PROTONIX DR 20 MG TABLET	NC	
PROTONIX DR 40 MG TABLET	NC	
PROTOPIC 0.03% OINTMENT	NC	
PROTOPIC 0.1% OINTMENT	NC	
PROTRIPTYLINE HCL 10 MG TABLET	1	
PROTRIPTYLINE HCL 5 MG TABLET	1	
PROVENTIL HFA 90 MCG INHALER	NC	
PROVERA 10 MG TABLET	NC	
PROVERA 2.5 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
PROVERA 5 MG TABLET	NC	
PROVIGIL 100 MG TABLET	NC	
PROVIGIL 200 MG TABLET	NC	
PROZAC 10 MG PULVULE	NC	
PROZAC 20 MG PULVULE	NC	
PROZAC 40 MG PULVULE	NC	
PROZAC WEEKLY 90 MG CAPSULE	NC	
PRUCLAIR NONSTEROIDAL CREAM	1	
PRUDOXIN 5% CREAM	NC	
PRUMYX CREAM	1	
PRUTECT TOPICAL EMULSION	1	
PSORCON 0.05% CREAM	NC	
PULMICORT 0.25 MG/2 ML RESPUL	NC	
PULMICORT 0.5 MG/2 ML RESPULE	NC	
PULMICORT 1 MG/2 ML RESPULE	NC	
PULMICORT 180 MCG FLEXHALER	2	HSA*
PULMICORT 90 MCG FLEXHALER	2	HSA*
PULMOSAL 7% VIAL	NC	
PULMOZYME 1 MG/ML AMPUL	2	SPP*: Must use CVS Specialty
PURINETHOL 50 MG TABLET	NC	
PURIXAN 20 MG/ML ORAL SUSP	3	CH*
PUSH BUTTON SAFETY 21G LANCET	2	HSA*
PUSH BUTTON SAFETY 28G LANCET	2	HSA*
PV TRUETRACK SMART SYS STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
PYLERA CAPSULE	3	
PYRAZINAMIDE 500 MG TABLET	1	
PYRIDIUM 100 MG TABLET	NC	
PYRIDIUM 200 MG TABLET	NC	
PYRIDOSTIGMINE BR 60 MG TABLET	1	
PYRIDOSTIGMINE ER 180 MG TAB	1	
PYROGALLIC ACID 25% OINTMENT	3	

## Q

QBRELIS 1MG/ML SOLUTION	3	HSA*
QNASL 80 MCG NASAL SPRAY	3	
QNASL CHILDREN'S 40 MCG SPRAY	3	
QUALAQUIN 324 MG CAPSULE	NC	
QUARTETTE TABLET	NC	
QUASENSE 0.15-0.03 MG TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
QUAZEPAM 15 MG TABLET	1	
QUDEXY XR 100 MG CAPSULE	NC	
QUDEXY XR 150 MG CAPSULE	NC	
QUDEXY XR 200 MG CAPSULE	NC	
QUDEXY XR 25 MG CAPSULE	NC	
QUDEXY XR 50 MG CAPSULE	NC	
QUESTRAN LIGHT POWDER	NC	
QUESTRAN PACKET	NC	
QUETIAPINE ER 150 MG TABLET	2	
QUETIAPINE ER 200 MG TABLET	2	
QUETIAPINE ER 300 MG TABLET	2	
QUETIAPINE ER 400 MG TABLET	2	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
QUETIAPINE ER 50 MG TABLET	2	
QUETIAPINE FUMARATE 100 MG TAB	1	
QUETIAPINE FUMARATE 200 MG TAB	1	
QUETIAPINE FUMARATE 25 MG TAB	1	
QUETIAPINE FUMARATE 300 MG TAB	1	
QUETIAPINE FUMARATE 400 MG TAB	1	
QUETIAPINE FUMARATE 50 MG TAB	1	
QUICK RELEASE TEFLN CANNULA	MD	
QUILLICHEW ER 20 MG CHEW TAB	3	Max. 60 Days Supply
QUILLICHEW ER 30 MG CHEW TAB	3	Max. 60 Days Supply
QUILLICHEW ER 40 MG CHEW TAB	3	Max. 60 Days Supply
QUILLIVANT XR 25 MG/5 ML SUSP	3	Max. 60 Days Supply
QUINAPRIL 10 MG TABLET	1	HSA*
QUINAPRIL 20 MG TABLET	1	HSA*
QUINAPRIL 40 MG TABLET	1	HSA*
QUINAPRIL 5 MG TABLET	1	HSA*
QUINAPRIL-HCTZ 10-12.5 MG TAB	1	HSA*
QUINAPRIL-HCTZ 20-12.5 MG TAB	1	HSA*
QUINAPRIL-HCTZ 20-25 MG TAB	1	HSA*
QUINIDINE GLUC ER 324 MG TAB	1	
QUINIDINE SULF ER 300 MG TAB	1	
QUINIDINE SULFATE 200 MG TAB	1	
QUINIDINE SULFATE 300 MG TAB	1	
QUININE SULFATE 324 MG CAPSULE	1	
QUINTET AC GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
QUINTET GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
QVAR 40 MCG ORAL INHALER	2	HSA*
QVAR 80 MCG ORAL INHALER	2	HSA*

## R

RA ASPIRIN 325 MG TABLET	0	ACA*
RA E-ZJECT 26G LANCETS	2	HSA*
RA E-ZJECT 28G LANCETS	2	HSA*
RA NICOTINE 14 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
RA NICOTINE 21 MG/24HR PATCH	0	Max. 180 Days Supply;Max. 1 per day ACA*
RA NICOTINE 4 MG CHEWING GUM	0	Max. 180 Days Supply;Max. 480 in 30 days ACA*
RABAVERT RABIES VACC W-DILUENT	MD	
RABEPRAZOLE SOD DR 20 MG TAB	2	
RADIAGEL	3	
RADIAPLEXRX GEL	3	
RAGWITEK SUBLINGUAL TABLET	3	Max. 1 per day
RAJANI 28 TABLET	0	ACA*
RALOXIFENE HCL 60 MG TABLET	1	HSA*; ACA*
RAMIPRIL 1.25 MG CAPSULE	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RAMIPRIL 10 MG CAPSULE	1	HSA*
RAMIPRIL 2.5 MG CAPSULE	1	HSA*
RAMIPRIL 5 MG CAPSULE	1	HSA*
RANEXA ER 1,000 MG TABLET	2	HSA*
RANEXA ER 500 MG TABLET	2	HSA*
RANITIDINE 15 MG/ML SYRUP	1	
RANITIDINE 150 MG CAPSULE	1	
RANITIDINE 150 MG TABLET	1	
RANITIDINE 300 MG CAPSULE	1	
RANITIDINE 300 MG TABLET	1	
RAPAFLO 4 MG CAPSULE	3	
RAPAFLO 8 MG CAPSULE	3	
RAPAMUNE 0.5 MG TABLET	3	
RAPAMUNE 1 MG TABLET	3	
RAPAMUNE 1 MG/ML ORAL SOLN	3	
RAPAMUNE 2 MG TABLET	3	
RASAGILINE MESYLATE 0.5 MG TAB	2	
RASAGILINE MESYLATE 1 MG TAB	2	
RASUVO 10 MG/0.2 ML AUTOINJ	2	Max. 0.8 ML(s) in 30 days
RASUVO 12.5 MG/0.25 ML AUTOINJ	2	Max. 1 ML(s) in 30 days
RASUVO 15 MG/0.3 ML AUTOINJ	2	Max. 1.2 ML(s) in 30 days
RASUVO 17.5 MG/0.35 ML AUTOINJ	2	Max. 1.4 ML(s) in 30 days
RASUVO 20 MG/0.4 ML AUTOINJ	2	Max. 1.6 ML(s) in 30 days
RASUVO 22.5 MG/0.45 ML AUTOINJ	2	Max. 1.8 ML(s) in 30 days
RASUVO 25 MG/0.5 ML AUTOINJ	2	Max. 2 ML(s) in 30 days
RASUVO 27.5 MG/0.55 ML AUTOINJ	2	Max. 2.2 ML(s) in 30 days
RASUVO 30 MG/0.6 ML AUTOINJ	2	Max. 2.4 ML(s) in 30 days
RASUVO 7.5 MG/0.15 ML AUTOINJ	2	Max. 0.6 ML(s) in 30 days
RAVICTI 1.1 GRAM/ML LIQUID	3	SPP*: Must use CVS Specialty
RAYALDEE ER 30 MCG CAPSULE	3	Prior Authorization required;Max. 2 per day
RAYOS DR 1 MG TABLET	3	Prior Authorization required
RAYOS DR 2 MG TABLET	3	Prior Authorization required
RAYOS DR 5 MG TABLET	3	Prior Authorization required
RAZADYNE 12 MG TABLET	NC	
RAZADYNE 4 MG TABLET	NC	
RAZADYNE 4 MG/ML ORAL SOLUTION	NC	
RAZADYNE 8 MG TABLET	NC	
RAZADYNE ER 16 MG CAPSULE	NC	
RAZADYNE ER 24 MG CAPSULE	NC	
RAZADYNE ER 8 MG CAPSULE	NC	
REA LO 39 CREAM	NC	
REA LO 40 CREAM	NC	
REA LO 40 LOTION	NC	
READYLANCE 21G SAFETY LANCETS	2	HSA*
READYLANCE 23G SAFETY LANCETS	2	HSA*
READYLANCE 26G SAFETY LANCETS	2	HSA*
READYLANCE 28G SAFETY LANCETS	2	HSA*
READYLANCE 30G SAFETY LANCETS	2	HSA*
REBETOL 200 MG CAPSULE	NC	
REBETOL 40 MG/ML SOLUTION	2	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
REBIF 22 MCG/0.5 ML SYRINGE	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF 44 MCG/0.5 ML SYRINGE	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF REBIDOSE 22 MCG/0.5 ML	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF REBIDOSE 44 MCG/0.5 ML	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF REBIDOSE TITRATION PACK	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
REBIF TITRATION PACK	3	Max. 30 Days Supply SPP*: Must use CVS Specialty
RECLIPSEN 28 DAY TABLET	0	ACA*
RECOMBINATE 1,241-1,800 UNIT V	MD	SPP*: Must use CVS Specialty
RECOMBIVAX HB 10 MCG/ML SYR	MD	Not covered for members 17 and younger
RECOMBIVAX HB 10 MCG/ML VIAL	MD	
RECOMBIVAX HB 40 MCG/ML VIAL	MD	Not covered for members 17 and younger
RECOMBIVAX HB 5 MCG/0.5 ML VL	MD	Not covered for members 17 and younger
RECTACORT-HC 25 MG SUPPOSITORY	NC	
RECTIV 0.4% OINTMENT	3	
REFUAH PLUS TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
REGENECARE 2% WOUND GEL	3	
REGLAN 10 MG TABLET	NC	
REGLAN 5 MG TABLET	NC	
REGRANEX 0.01% GEL	3	Limit fills to 3 in 365 days;Max. 15 GM(s) in 30 days
RELAGARD VAGINAL GEL	3	
RELAGESIC 650-50 MG TABLET	NC	
RELENZA 5 MG DISKHALER	3	Max. quantity of 20 per fill
RELIAMED 30G LANCETS	2	HSA*
RELIAMED SAFETY 23G LANCETS	2	HSA*
RELIAMED SAFETY 28G LANCETS	2	HSA*
RELIAMED SAFETY SEAL 28G LANCT	2	HSA*
RELIAMED SAFETY SEAL 30G LANCT	2	HSA*
RELION CONFIRM-MICRO TEST STRP	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION MICRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION PRIME TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION THIN 26G LANCETS	2	HSA*
RELION ULTIMA TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RELION ULTRA THIN PLUS 33G	2	HSA*
RELION ULTRA THIN PLUS LANCETS	2	HSA*
RELISTOR 12 MG/0.6 ML SYRINGE	2	
RELISTOR 12 MG/0.6 ML VIAL	2	
RELISTOR 150 MG TABLET	3	Prior Authorization required;Max. 3 per day
RELISTOR 8 MG/0.4 ML SYRINGE	2	
RELPAK 20 MG TABLET	3	Max. quantity of 12 per fill;Step Therapy required MQC*: 12 tabs per copay
RELPAK 40 MG TABLET	3	Max. quantity of 6 per fill;Step Therapy required MQC*: 6 tabs/copay
REMERON 15 MG SOLTAB	NC	
REMERON 15 MG TABLET	NC	
REMERON 30 MG SOLTAB	NC	
REMERON 30 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
REMERON 45 MG SOLTAB	NC	
REMERON 45 MG TABLET	NC	
REMEVEN 50% CREAM	1	
RENA-VITE RX TABLET	1	
RENACIDIN IRRIGATION SOLUTION	3	
RENAGEL 400 MG TABLET	2	
RENAGEL 800 MG TABLET	2	
RENAL CAPS SOFTGEL	1	
RENEW ADVANCED MICRO-LANCETS	2	HSA*
RENO CAPS SOFTGEL	1	
REVELA 0.8 GM POWDER PACKET	2	
REVELA 2.4 GM POWDER PACKET	2	
REVELA 800 MG TABLET	2	
REPAGLINIDE 0.5 MG TABLET	1	HSA*
REPAGLINIDE 1 MG TABLET	1	HSA*
REPAGLINIDE 2 MG TABLET	1	HSA*
REPAGLINIDE-METFORMIN 1-500 MG	1	HSA*
REPAGLINIDE-METFORMIN 2-500 MG	1	HSA*
REPATHA 140 MG/ML SURECLICK	2	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
REPATHA 140 MG/ML SYRINGE	2	Prior Authorization required;Max. 2 ML(s) per 28 days SPP*: Must use CVS Specialty
REPATHA 420 MG/3.5ML PUSHTRONX	2	Prior Authorization required;Max. 3.5 ML(s) per 30 days SPP*: Must use CVS Specialty
REPREXAIN 10-200 MG TABLET	1	
REPREXAIN 2.5-200 MG TABLET	1	
REPREXAIN 5-200 MG TABLET	1	
REPRONEX 75 UNIT VIAL	2	Max. 30 Days Supply IVF*
REQUIP 0.25 MG TABLET	NC	
REQUIP 0.5 MG TABLET	NC	
REQUIP 1 MG TABLET	NC	
REQUIP 2 MG TABLET	NC	
REQUIP 3 MG TABLET	NC	
REQUIP 4 MG TABLET	NC	
REQUIP 5 MG TABLET	NC	
REQUIP XL 12 MG TABLET	NC	
REQUIP XL 2 MG TABLET	NC	
REQUIP XL 4 MG TABLET	NC	
REQUIP XL 6 MG TABLET	NC	
REQUIP XL 8 MG TABLET	NC	
RESCRIPTOR 100 MG TABLET	2	
RESCRIPTOR 200 MG TABLET	2	
RESCULA 0.15% EYE DROPS	3	
RESERPINE 0.1 MG TABLET	1	HSA*
RESERPINE 0.25 MG TABLET	1	HSA*
RESPA A.R. TABLET SA	1	
RESTASIS 0.05% EYE EMULSION	2	Max. 2 per day
RESTASIS MULTIDOSE 0.05% EYE	2	Max. 2 ML(s) per day
RESTIZAN GEL	3	
RESTORIL 15 MG CAPSULE	NC	
RESTORIL 22.5 MG CAPSULE	NC	
RESTORIL 30 MG CAPSULE	NC	
RESTORIL 7.5 MG CAPSULE	NC	
RETIN-A 0.01% GEL	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RETIN-A 0.025% CREAM	NC	
RETIN-A 0.025% GEL	NC	
RETIN-A 0.05% CREAM	NC	
RETIN-A 0.1% CREAM	NC	
RETIN-A MICRO 0.04% GEL	NC	
RETIN-A MICRO 0.1% GEL	NC	
RETIN-A MICRO PUMP 0.08% GEL	3	Prior Authorization required for members 30 and older
RETROVIR 10 MG/ML SYRUP	NC	
RETROVIR 100 MG CAPSULE	NC	
REVATIO 10 MG/ML ORAL SUSP	3	Prior Authorization required SPP*: Must use CVS Specialty
REVATIO 20 MG TABLET	NC	
REVEAL TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
REVIA 50 MG TABLET	NC	
REVLIMID 10 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 15 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 2.5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 20 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 25 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REVLIMID 5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
REXULTI 0.25 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 0.5 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 1 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 2 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 3 MG TABLET	3	Max. 1 per day;Step Therapy required
REXULTI 4 MG TABLET	3	Max. 1 per day;Step Therapy required
REYATAZ 150 MG CAPSULE	2	
REYATAZ 200 MG CAPSULE	2	
REYATAZ 300 MG CAPSULE	2	
REYATAZ 50 MG POWDER PACKET	2	
REZIRA SOLUTION	3	
RHEUMATREX 2.5 MG TABLET	2	
RHINOCORT AQUA NASAL SPRAY	NC	
RHINOFLEX-650 TABLET	1	
RHOFADE 1% CREAM	NC	
RHOGAM ULTRA-FILTERED PLUS SYR	MD	SPP*: Must use CVS Specialty
RIASTAP VIAL	MD	SPP*: Must use CVS Specialty
RIBASPHERE 200 MG CAPSULE	1	SPP*: Must use CVS Specialty
RIBASPHERE 200 MG TABLET	1	SPP*: Must use CVS Specialty
RIBASPHERE 400 MG TABLET	1	SPP*: Must use CVS Specialty
RIBASPHERE 600 MG TABLET	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 200-400 MG	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 400-400 MG	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 600-400 MG	1	SPP*: Must use CVS Specialty
RIBASPHERE RIBAPAK 600-600 MG	3	SPP*: Must use CVS Specialty
RIBATAB 400-400 MG DOSEPACK	NC	
RIBATAB 400-600 MG DOSEPACK	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RIBAVIRIN 200 MG CAPSULE	1	SPP*: Must use CVS Specialty
RIBAVIRIN 200 MG TABLET	1	SPP*: Must use CVS Specialty
RIBAVIRIN 6 GM INHALATION VIAL	2	
RIDAURA 3 MG CAPSULE	3	
RIFABUTIN 150 MG CAPSULE	1	
RIFADIN 150 MG CAPSULE	NC	
RIFADIN 300 MG CAPSULE	NC	
RIFAMATE CAPSULE	3	
RIFAMPIN 150 MG CAPSULE	1	
RIFAMPIN 300 MG CAPSULE	1	
RIFATER TABLET	3	
RIGHTEST GL300 30G LANCETS	2	HSA*
RIGHTEST GS100 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS250S TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS260 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS300 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RIGHTEST GS550 TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
RILUTEK 50 MG TABLET	NC	
RILUZOLE 50 MG TABLET	1	
RIMANTADINE HCL 100 MG TABLET	1	
RIOMET 500 MG/5 ML SOLUTION	3	HSA*
RISEDRONATE SOD DR 35 MG TAB	1	Max. 4 per 28 days HSA*
RISEDRONATE SODIUM 150 MG TAB	1	Max. 1 in 30 days HSA*
RISEDRONATE SODIUM 30 MG TAB	1	Max. 1 per day HSA*
RISEDRONATE SODIUM 35 MG TAB	1	Max. 4 per 28 days HSA*
RISEDRONATE SODIUM 5 MG TABLET	1	Max. 1 per day HSA*
RISPERDAL 0.25 MG TABLET	NC	
RISPERDAL 0.5 MG TABLET	NC	
RISPERDAL 1 MG TABLET	NC	
RISPERDAL 1 MG/ML SOLUTION	NC	
RISPERDAL 2 MG TABLET	NC	
RISPERDAL 3 MG TABLET	NC	
RISPERDAL 4 MG TABLET	NC	
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	NC	
RISPERDAL M-TAB 1 MG ODT	NC	
RISPERDAL M-TAB 2 MG ODT	NC	
RISPERDAL M-TAB 3 MG ODT	NC	
RISPERDAL M-TAB 4 MG ODT	NC	
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	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
RISPERIDONE 1 MG TABLET	1	
RISPERIDONE 1 MG/ML SOLUTION	1	
RISPERIDONE 2 MG ODT	1	
RISPERIDONE 2 MG TABLET	1	
RISPERIDONE 3 MG ODT	1	
RISPERIDONE 3 MG TABLET	1	
RISPERIDONE 4 MG ODT	1	
RISPERIDONE 4 MG TABLET	1	
RITALIN 10 MG TABLET	NC	
RITALIN 20 MG TABLET	NC	
RITALIN 5 MG TABLET	NC	
RITALIN LA 10 MG CAPSULE	2	Max. 60 Days Supply
RITALIN LA 20 MG CAPSULE	NC	
RITALIN LA 30 MG CAPSULE	NC	
RITALIN LA 40 MG CAPSULE	NC	
RITALIN LA 60 MG CAPSULE	NC	
RITALIN SR 20 MG TABLET	NC	
RITEFLO SPACER	MD	
RIVASTIGMINE 1.5 MG CAPSULE	1	
RIVASTIGMINE 13.3 MG/24HR PTCH	1	
RIVASTIGMINE 3 MG CAPSULE	1	
RIVASTIGMINE 4.5 MG CAPSULE	1	
RIVASTIGMINE 4.6 MG/24HR PATCH	1	
RIVASTIGMINE 6 MG CAPSULE	1	
RIVASTIGMINE 9.5 MG/24HR PATCH	1	
RIVELSA TABLET	0	Max. 91 Days Supply;Max. 1 per day ACA*
RIXUBIS 250 UNIT NOMINAL	MD	SPP*: Must use CVS Specialty
RIZATRIPTAN 10 MG ODT	1	Max. quantity of 9 per fill MQC*: 9 tabs/copay
RIZATRIPTAN 10 MG TABLET	1	Max. quantity of 9 per fill MQC*: 9 tabs/copay
RIZATRIPTAN 5 MG ODT	1	Max. quantity of 18 per fill MQC*: 4 patches/copay
RIZATRIPTAN 5 MG TABLET	1	Max. quantity of 18 per fill MQC*: 18 tabs/copay
ROBAXIN 500 MG TABLET	NC	
ROBAXIN-750 TABLET	NC	
ROBINUL 1 MG TABLET	NC	
ROBINUL FORTE 2 MG TABLET	NC	
ROCALTROL 0.25 MCG CAPSULE	NC	
ROCALTROL 0.5 MCG CAPSULE	NC	
ROCALTROL 1 MCG/ML ORAL SOLN	NC	
ROPINIROLE HCL 0.25 MG TABLET	1	
ROPINIROLE HCL 0.5 MG TABLET	1	
ROPINIROLE HCL 1 MG TABLET	1	
ROPINIROLE HCL 2 MG TABLET	1	
ROPINIROLE HCL 3 MG TABLET	1	
ROPINIROLE HCL 4 MG TABLET	1	
ROPINIROLE HCL 5 MG TABLET	1	
ROPINIROLE HCL ER 12 MG TABLET	1	
ROPINIROLE HCL ER 2 MG TABLET	1	
ROPINIROLE HCL ER 4 MG TABLET	1	
ROPINIROLE HCL ER 6 MG TABLET	1	
ROPINIROLE HCL ER 8 MG TABLET	1	
ROSADAN 0.75% CREAM	1	
ROSADAN 0.75% CREAM KIT	3	
ROSADAN 0.75% GEL	NC	
ROSANIL CLEANSER LOTION	2	
ROSULA 10%-5% CLOTHS	NC	

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*
ROWASA 4 GM/60 ML ENEMA KIT	NC	
ROWEEPRA 1,000 MG TABLET	NC	
ROWEEPRA 500 MG TABLET	NC	
ROWEEPRA 750 MG TABLET	NC	
ROXICET 5-325 ORAL SOLUTION	1	
ROXICET 5-325 TABLET	1	
ROXICODONE 15 MG TABLET	NC	
ROXICODONE 30 MG TABLET	NC	
ROXICODONE 5 MG TABLET	NC	
ROZEREM 8 MG TABLET	3	Step Therapy required STA*: 18 and older
RUBRACA 200 MG TABLET	3	CH*; SPP*: CVS Specialty
RUBRACA 250 MG TABLET	3	CH*; SPP*: CVS Specialty
RUBRACA 300 MG TABLET	3	CH*; SPP*: CVS Specialty
RYDAPT 25 MG CAPSULE	3	Prior Authorization required;Max. 8 per day PA NTM*; CH*; SPP*: CVS Specialty
RYTARY ER 23.75 MG-95 MG CAP	3	Step Therapy required
RYTARY ER 36.25 MG-145 MG CAP	3	Step Therapy required
RYTARY ER 48.75 MG-195 MG CAP	3	Step Therapy required
RYTARY ER 61.25 MG-245 MG CAP	3	Step Therapy required
RYTHMOL 150 MG TABLET	NC	
RYTHMOL 225 MG TABLET	NC	
RYTHMOL SR 225 MG CAPSULE	NC	
RYTHMOL SR 325 MG CAPSULE	NC	
RYTHMOL SR 425 MG CAPSULE	NC	
RYVENT 6 MG TABLET	3	

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SABRIL 500 MG POWDER PACKET	3	SPP*: Must use CVS Specialty
SABRIL 500 MG TABLET	2	SPP*: Must use CVS Specialty
SACCHARIN POWDER	3	
SAFESNAP ALLERGY SYRINGE 1 ML	3	
SAFESNAP SYRINGE 10 ML	3	
SAFESNAP SYRINGE 10 ML	3	
SAFESNAP SYRINGE 3 ML	3	
SAFESNAP SYRINGE 3 ML	3	
SAFESNAP SYRINGE 5 ML	3	
SAFESNAP SYRINGE 5 ML	3	
SAFESNAP TUBERCULIN SYR 1 ML	3	
SAFETY 21G LANCETS	2	HSA*
SAFETY 28G LANCETS	2	HSA*
SAFETY LANCETS 26G	2	HSA*
SAFETY SEAL 28G LANCETS	2	HSA*
SAFETY SEAL 30G LANCETS	2	HSA*



DRUG NAME	TIER	LIMITATIONS/ * NOTES
SAFETY SYRINGE W-SHIELD 3 ML	3	
SAFETY-LET 30G LANCETS	2	HSA*
SAFETY-LOK 1 ML TB SYRINGE	3	
SAFETY-LOK 10 ML SYRINGE	3	
SAFETY-LOK 10 ML SYRINGE	3	
SAFETY-LOK 3 ML SYRINGE	3	
SAFETY-LOK 3 ML SYRINGE	3	
SAFETY-LOK 3 ML SYRINGE	3	
SAFETY-LOK 5 ML SYRINGE	3	
SAFETY-LOK 5 ML SYRINGE	3	
SAFYRAL TABLET	0	ACA*
SAIZEN 5 MG VIAL	NC	
SAIZEN 8.8 MG CLICK.EASY CARTG	NC	
SAIZEN 8.8 MG VIAL	NC	
SALACYN 6% CREAM	NC	
SALACYN 6% LOTION	1	
SALAGEN 5 MG TABLET	NC	
SALAGEN 7.5 MG TABLET	NC	
SALEX 6% CREAM KIT	NC	
SALEX 6% LOTION KIT	NC	
SALEX 6% SHAMPOO	NC	
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	
SALIVAMAX POWDER PACKET	3	
SALSALATE 500 MG TABLET	1	
SALSALATE 750 MG TABLET	1	
SAMSCA 15 MG TABLET	3	
SAMSCA 30 MG TABLET	3	
SANCTURA 20 MG TABLET	NC	
SANCTURA XR 60 MG CAPSULE	NC	
SANCUSO 3.1 MG/24 HR PATCH	3	Max. quantity of 4 per fill MQC*: 4 patches/copy
SANDIMMUNE 100 MG CAPSULE	3	
SANDIMMUNE 100 MG/ML SOLN	2	
SANDIMMUNE 25 MG CAPSULE	3	
SANDOSTATIN 0.05 MG/ML AMPUL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 0.1 MG/ML AMPUL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 0.2 MG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 0.5 MG/ML AMPUL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN 1 MG/ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SANDOSTATIN LAR DEPOT 10 MG VL	MD	Prior Authorization required;Max. 1 per 28 days SPP*: Must use CVS Specialty
SANDOSTATIN LAR DEPOT 20 MG KT	MD	Prior Authorization required;Max. 1 per 28 days SPP*: Must use CVS Specialty
SANDOSTATIN LAR DEPOT 30 MG KT	MD	Prior Authorization required;Max. 1 per 28 days SPP*: Must use CVS Specialty
SANTYL OINTMENT	2	
SAPHRIS 10 MG TAB SL BLK CHERY	3	
SAPHRIS 2.5 MG TAB SL BLK CHRY	3	
SAPHRIS 5 MG TAB SL BLK CHERRY	3	
SARAFEM 10 MG TABLET	2	Step Therapy required STA*: 18 and older

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SARAFEM 20 MG TABLET	3	Step Therapy required STA*: 18 and older
SAVAYSA 15 MG TABLET	3	HSA*
SAVAYSA 30 MG TABLET	3	HSA*
SAVAYSA 60 MG TABLET	3	HSA*
SAVELLA 100 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA 12.5 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA 25 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA 50 MG TABLET	2	Step Therapy required STA*: 18 and older
SAVELLA TITRATION PACK	2	Step Therapy required STA*: 18 and older
SB LANCETS THIN 28G	2	HSA*
SB LANCETS ULTRA THIN 30G	2	HSA*
SCALACORT 2% LOTION	NC	
SCOPOLAMINE 1 MG/3 DAY PATCH	2	Max. quantity of 4 per fill MQC*: 1 box (4 patches)/copay
SEASONIQUE 0.15-0.03-0.01 TAB	NC	
SEB-PREV 10% WASH	1	
SECONAL SODIUM 100 MG CAPSULE	3	
SECTRAL 200 MG CAPSULE	NC	
SECTRAL 400 MG CAPSULE	NC	
SEEBRI NEOHALER 15.6 MCG INHAL	3	Max. 2 per day HSA*
SELEGILINE HCL 5 MG CAPSULE	1	
SELEGILINE HCL 5 MG TABLET	1	
SELENIUM SULFIDE 2.25% SHAMPOO	1	
SELENIUM SULFIDE 2.5% LOTION	1	
SELZENTRY 150 MG TABLET	2	
SELZENTRY 20 MG/ML ORAL SOLN	2	
SELZENTRY 25 MG TABLET	2	
SELZENTRY 300 MG TABLET	2	
SELZENTRY 75 MG TABLET	2	
SEMPREX-D 8 MG-60 MG CAPSULE	3	
SENSIPAR 30 MG TABLET	3	SPP*: Must use CVS Specialty
SENSIPAR 60 MG TABLET	3	SPP*: Must use CVS Specialty
SENSIPAR 90 MG TABLET	3	SPP*: Must use CVS Specialty
SEREVENT DISKUS 50 MCG	2	Max. 60 in 30 days HSA*
SERNIVO 0.05% SPRAY	3	Max. 4 ML(s) per day
SEROPHENE 50 MG TABLET	NC	
SEROQUEL 100 MG TABLET	NC	
SEROQUEL 200 MG TABLET	NC	
SEROQUEL 25 MG TABLET	NC	
SEROQUEL 300 MG TABLET	NC	
SEROQUEL 400 MG TABLET	NC	
SEROQUEL 50 MG TABLET	NC	
SEROQUEL XR 150 MG TABLET	NC	
SEROQUEL XR 200 MG TABLET	NC	
SEROQUEL XR 300 MG TABLET	NC	
SEROQUEL XR 400 MG TABLET	NC	
SEROQUEL XR 50 MG TABLET	NC	
SEROQUEL XR SAMPLE KIT	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SEROSTIM 4 MG VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
SEROSTIM 5 MG VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
SEROSTIM 6 MG VIAL	2	Prior Authorization required SPP*: Must use CVS Specialty
SERTRALINE 20 MG/ML ORAL CONC	1	
SERTRALINE HCL 100 MG TABLET	1	
SERTRALINE HCL 25 MG TABLET	1	
SERTRALINE HCL 50 MG TABLET	1	
SETLAKIN 0.15 MG-0.03 MG TAB	0	Max. 91 Days Supply;Max. 1 per day ACA*
SEVELAMER 0.8 GM POWDER PACKET	2	
SEVELAMER 2.4 GM POWDER PACKET	2	
SEVELAMER CARBONATE 800 MG TAB	1	
SF 5000 PLUS CREAM	1	
SHAROBEL 0.35 MG TABLET	0	ACA*
SHOHL'S MODIFIED SOLUTION	3	
SIDEROL LIQUID	1	
SIDESTREAM PEDIATRIC FACE MASK	MD	
SIGNIFOR 0.3 MG/ML AMPULE	3	LDD*: Accredo (866) 815-4717
SIGNIFOR 0.6 MG/ML AMPULE	3	LDD*: Accredo (866) 815-4717
SIGNIFOR 0.9 MG/ML AMPULE	3	LDD*: Accredo (866) 815-4717
SILDENAFIL 20 MG TABLET	1	Prior Authorization required SPP*: Must use CVS Specialty
SILENOR 3 MG TABLET	3	Step Therapy required STA*: 18 and older
SILENOR 6 MG TABLET	3	Step Therapy required STA*: 18 and older
SILHOUETTE INFUSION SET 43"	MD	
SILICONE MASK-INFANT	MD	
SILICONE MASK-PEDIATRIC	MD	
SILIQ 210 MG/1.5 ML SYRINGE	3	Prior Authorization required SPP*: Must use CVS Specialty; PA NTM*
SILVADENE 1% CREAM	NC	
SILVER NITRATE 0.5% SOLN	1	
SILVER NITRATE 10% OINTMENT	1	
SILVER NITRATE 10% SOLUTION	1	
SILVER NITRATE 25% SOLUTION	1	
SILVER NITRATE 50% SOLUTION	1	
SILVER NITRATE APPLICATOR	1	
SILVER SULFADIAZINE 1% CREAM	1	
SILVRSTAT DRESSING GEL	3	
SIMBRINZA 1%-0.2% EYE DROPS	2	
SIMCOR 1,000-20 MG TABLET	2	HSA*
SIMCOR 1,000-40 MG TABLET	2	HSA*
SIMCOR 500-20 MG TABLET	2	HSA*
SIMCOR 500-40 MG TABLET	2	HSA*
SIMCOR 750-20 MG TABLET	2	HSA*
SIMPONI 100 MG/ML PEN INJECTOR	3	Prior Authorization required;Max. 1 ML(s) per 30 days SPP*: Must use CVS Specialty
SIMPONI 100 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) per 30 days SPP*: Must use CVS Specialty
SIMPONI 50 MG/0.5 ML PEN INJEC	3	Prior Authorization required;Max. 0.5 ML(s) per 30 days SPP*: Must use CVS Specialty
SIMPONI 50 MG/0.5 ML SYRINGE	3	Prior Authorization required;Max. 0.5 ML(s) per 30 days SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SIMVASTATIN 10 MG TABLET	0	ACA*
SIMVASTATIN 20 MG TABLET	0	ACA*
SIMVASTATIN 40 MG TABLET	0	ACA*
SIMVASTATIN 5 MG TABLET	0	ACA*
SIMVASTATIN 80 MG TABLET	0	ACA*
SINEMET 10-100 MG TABLET	NC	
SINEMET 25-100 MG TABLET	NC	
SINEMET 25-250 MG TABLET	NC	
SINEMET CR 25-100 TABLET	NC	
SINEMET CR 50-200 TABLET	NC	
SINGLE-LET LANCETS	2	HSA*
SINGULAIR 10 MG TABLET	NC	
SINGULAIR 4 MG GRANULES	NC	
SINGULAIR 4 MG TABLET CHEW	NC	
SINGULAIR 5 MG TABLET CHEW	NC	
SIROLIMUS 0.5 MG TABLET	1	
SIROLIMUS 1 MG TABLET	1	
SIROLIMUS 2 MG TABLET	1	
SIRTURO 100 MG TABLET	3	Max. quantity of 32 per fill
SITAVIG 50 MG BUCCAL TABLET	3	Max. quantity of 1 per fill;Max. 2 in 30 days MQC*: 1 tab/per copay. Max. 2 tabs/30 days
SIVEXTRO 200 MG TABLET	3	Max. quantity of 6 per fill MQC*: 6 tabs/copay
SKELAXIN 800 MG TABLET	NC	
SKLICE 0.5% LOTION	3	
SM BUFF ASPIRIN 325 MG TAB	0	ACA*
SM COLOR LANCETS 21G	2	HSA*
SM LANCETS 21G	2	HSA*
SM THIN LANCETS 26G	2	HSA*
SMART CARESENS N TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMART SENSE COLOR 33G LANCETS	2	HSA*
SMART SENSE STANDARD 21G	2	HSA*
SMART SENSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMART SENSE THIN 26G LANCETS	2	HSA*
SMARTDIABETES VANTAGE 30G	2	HSA*
SMARTDIABETES XPRES TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMARTTEST LANCET	2	HSA*
SMARTTEST TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SMARTRX GABA-V KIT	3	
SOD CITRATE-CITRIC ACID SOLN	1	
SOD POLYSTYREN SULF 15 G/60 ML	1	
SOD SULFACE-SULF 9.8-4.8% CLSR	1	
SOD SULFACE-SULFUR 10-5% CLOTH	1	
SOD SULFACET-SULFUR 10-2% CLSR	3	
SOD SULFACET-SULFUR 10-5% CLSR	1	
SOD SULFACETAMIDE 10% SHAMPOO	1	
SOD SULFACETAMIDE-SULFUR LOTN	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SODIUM CHLORIDE 0.9% INHAL VL	1	
SODIUM CHLORIDE 0.9% IRRIG.	1	
SODIUM CHLORIDE 10% VIAL	1	
SODIUM CHLORIDE 3% VIAL	1	
SODIUM CHLORIDE 7% VIAL	1	
SODIUM CITRATE 4% SOLN	1	
SODIUM FLUORIDE 0.5 MG/ML DROP	1	ACA*: Children through age 5; HSA
SODIUM PHENYLBUTYRATE 500MG TB	2	
SODIUM PHENYLBUTYRATE POWDER	1	
SODIUM SUCCINATE POWDER	3	
SODIUM SULFACETAMIDE 10% WASH	1	
SOF-SET MICRO INFUSION SET	MD	
SOF-SET ULTIMATE QR SET	MD	
SOFT TOUCH LANCETS	2	HSA*
SOLARAZE 3% GEL	NC	
SOLIQUA 100 UNIT-33 MCG/ML PEN	3	Prior Authorization required HSA*
SOLODYN ER 105 MG TABLET	3	Prior Authorization required
SOLODYN ER 115 MG TABLET	3	Prior Authorization required
SOLODYN ER 45 MG TABLET	NC	
SOLODYN ER 55 MG TABLET	3	Prior Authorization required
SOLODYN ER 65 MG TABLET	3	Prior Authorization required
SOLODYN ER 80 MG TABLET	3	Prior Authorization required
SOLTAMOX 10 MG/5 ML SOLN	3	CH*; HSA*
SOLUS V2 28G LANCETS	2	HSA*
SOLUS V2 30G TWIST LANCETS	2	HSA*
SOLUS V2 AUDIBLE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SOMA 250 MG TABLET	NC	
SOMA 350 MG TABLET	NC	
SOMATULINE DEPOT 120 MG/0.5 ML	2	Prior Authorization required;Max. 0.5 ML(s) per 28 days SPP*: Must use CVS Specialty
SOMATULINE DEPOT 60 MG/0.2 ML	2	Prior Authorization required;Max. 0.2 ML(s) per 28 days SPP*: Must use CVS Specialty
SOMATULINE DEPOT 90 MG/0.3 ML	2	Prior Authorization required;Max. 0.3 ML(s) per 28 days SPP*: Must use CVS Specialty
SOMAVERT 10 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 15 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 20 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 25 MG VIAL	3	SPP*: Must use CVS Specialty
SOMAVERT 30 MG VIAL	3	SPP*: Must use CVS Specialty
SONAFINE TOPICAL EMULSION	1	
SONATA 10 MG CAPSULE	NC	
SONATA 5 MG CAPSULE	NC	
SOOLANTRA 1% CREAM	3	
SORBITOL 70% SOLUTION	3	
SORIATANE 10 MG CAPSULE	NC	
SORIATANE 17.5 MG CAPSULE	NC	
SORIATANE 25 MG CAPSULE	NC	
SORILUX 0.005% FOAM	3	
SORINE 120 MG TABLET	1	HSA*
SORINE 160 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SORINE 240 MG TABLET	1	HSA*
SORINE 80 MG TABLET	1	HSA*
SOTALOL 120 MG TABLET	1	HSA*
SOTALOL 160 MG TABLET	1	HSA*
SOTALOL 240 MG TABLET	1	HSA*
SOTALOL 80 MG TABLET	1	HSA*
SOTYLIZE 5 MG/ML ORAL SOLUTION	2	HSA*
SOVALDI 400 MG TABLET	2	Prior Authorization required;Max. 1 per day SPP*: Must use CVS Specialty
SPACE CHAMBER PLUS	MD	
SPECTRACEF 400 MG DOSE PACK TB	NC	
SPINOSAD 0.9% TOPICAL SUSP	1	
SPIRIVA 18 MCG CP-HANDIHALER	2	Max. 1 per day HSA*; Max 1 inhaler/30 days supply
SPIRIVA RESPIMAT 1.25 MCG INH	2	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
SPIRIVA RESPIMAT 2.5 MCG INH	2	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
SPIRONOLACTONE 100 MG TABLET	1	HSA*
SPIRONOLACTONE 25 MG TABLET	1	HSA*
SPIRONOLACTONE 50 MG TABLET	1	HSA*
SPIRONOLACTONE-HCTZ 25-25 TAB	1	HSA*
SPORANOX 10 MG/ML SOLUTION	3	
SPORANOX 100 MG CAPSULE	NC	
SPRAY AND STRETCH SPRAY	3	
SPRINTEC 28 DAY TABLET	0	ACA*
SPRITAM 1,000 MG TABLET	3	
SPRITAM 250 MG TABLET	3	
SPRITAM 500 MG TABLET	3	
SPRITAM 750 MG TABLET	3	
SPRIX 15.75 MG NASAL SPRAY	3	Max. quantity of 5 per fill
SPRYCEL 100 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 140 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 20 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 50 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 70 MG TABLET	2	CH*; SPP*: CVS Specialty
SPRYCEL 80 MG TABLET	2	CH*; SPP*: CVS Specialty
SPS 15 GM/60 ML SUSPENSION	1	
SPS 30 GM/120 ML ENEMA	1	
SRONYX 0.10-0.02 MG TABLET	0	ACA*
SSD 1% CREAM	1	
SSKI 1 GM/ML SOLUTION	1	
ST. JOSEPH ASPIRIN 81 MG CHEW	0	ACA*
ST. JOSEPH ASPIRIN EC 81 MG TB	0	ACA*
STALEVO 100 TABLET	NC	
STALEVO 125 TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
STALEVO 150 TABLET	NC	
STALEVO 200 TABLET	NC	
STALEVO 50 TABLET	NC	
STALEVO 75 TABLET	NC	
STANNOUS FLUOR 0.63% RINSE	1	
STARLIX 120 MG TABLET	NC	
STARLIX 60 MG TABLET	NC	
STAVUDINE 1 MG/ML SOLUTION	1	
STAVUDINE 15 MG CAPSULE	1	
STAVUDINE 20 MG CAPSULE	1	
STAVUDINE 30 MG CAPSULE	1	
STAVUDINE 40 MG CAPSULE	1	
STAVZOR DR 125 MG CAPSULE	3	
STAVZOR DR 250 MG CAPSULE	3	
STAVZOR DR 500 MG CAPSULE	3	
STAXYN 10 MG ODT	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STELARA 45 MG/0.5 ML SYRINGE	MD	Prior Authorization required SPP*: Must use CVS Specialty
STELARA 90 MG/ML SYRINGE	MD	Prior Authorization required SPP*: Must use CVS Specialty
STENDRA 100 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STENDRA 200 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STENDRA 50 MG TABLET	3	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
STERILANCE TL TWIST 30G LANCET	2	HSA*
STERILANCE TL TWIST 32G LANCET	2	HSA*
STIMATE 1.5 MG/ML NASAL SPRAY	2	
STIOLTO RESPIMAT INHAL SPRAY	3	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
STIVARGA 40 MG TABLET	3	CH*; SPP*: CVS Specialty
STRATTERA 10 MG CAPSULE	NC	
STRATTERA 100 MG CAPSULE	NC	
STRATTERA 18 MG CAPSULE	NC	
STRATTERA 25 MG CAPSULE	NC	
STRATTERA 40 MG CAPSULE	NC	
STRATTERA 60 MG CAPSULE	NC	
STRATTERA 80 MG CAPSULE	NC	
STRENSIQ 18 MG/0.45 ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRENSIQ 28 MG/0.7 ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRENSIQ 40 MG/ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRENSIQ 80 MG/0.8 ML VIAL	3	LDD*: Pantherx Specialty Pharmacy 1-855-726-8479
STRIANT 30 MG MUCOADHESIVE	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 2 per day
STRIBILD TABLET	3	
STRIVERDI RESPIMAT INHAL SPRAY	3	Max. 4 GM(s) per 30 days HSA*; Max 1 inhaler/30 days supply
STROMEKTOL 3 MG TABLET	NC	
STRONG IODINE SOLUTION	1	
STROVITE FORTE CAPLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
STROVITE ONE CAPLET	3	
STROVITE PLUS CAPLET	1	
STROVITE TABLET	1	
SUBOXONE 12 MG-3 MG SL FILM	2	
SUBOXONE 2 MG-0.5 MG SL FILM	2	
SUBOXONE 4 MG-1 MG SL FILM	2	
SUBOXONE 8 MG-2 MG SL FILM	2	
SUBSYS 1,200 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 1,600 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 100 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 200 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 400 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 600 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUBSYS 800 MCG SPRAY	3	Prior Authorization required;Max. 120 per 30 days
SUCLEAR BOWEL PREP KIT	3	
SUCRAID 8,500 UNITS/ML SOLN	3	
		LDD*: Accredo (866) 815-4717
SUCRALFATE 1 GM TABLET	1	
SULAR ER 17 MG TABLET	NC	
SULAR ER 34 MG TABLET	NC	
SULAR ER 8.5 MG TABLET	NC	
SULF-PRED 10-0.23% EYE DROPS	1	
SULFACETAMIDE 10% EYE DROPS	1	
SULFACETAMIDE 10% EYE OINTMENT	1	
SULFACETAMIDE SOD 10% TOP SUSP	1	
SULFACETAMIDE-SULFUR 10-2% CRM	1	
SULFACETAMIDE-SULFUR 10-5% CRM	1	
SULFADIAZINE 500 MG TABLET	1	
SULFAMETHOXAZOLE-TMP DS TABLET	1	
SULFAMETHOXAZOLE-TMP SS TABLET	1	
SULFAMETHOXAZOLE-TMP SUSP	1	
SULFAMYLON 8.5% CREAM	3	
SULFAMYLON POWDER PACKET	3	
SULFASALAZINE 500 MG TABLET	1	
SULFASALAZINE DR 500 MG TAB	1	
SULFATRIM PEDIATRIC SUSPENSION	1	
SULINDAC 150 MG TABLET	1	
SULINDAC 200 MG TABLET	1	
SUMATRIPTAN 20 MG NASAL SPRAY	1	Max. quantity of 6 per fill MQC*: 6 sprays/copay
SUMATRIPTAN 4 MG/0.5 ML CART	1	Max. quantity of 3 per fill
SUMATRIPTAN 4 MG/0.5 ML INJECT	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 5 MG NASAL SPRAY	1	Max. quantity of 6 per fill MQC*: 6 sprays/copay
SUMATRIPTAN 6 MG/0.5 ML INJECT	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 6 MG/0.5 ML REFILL	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 6 MG/0.5 ML SYRNG	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN 6 MG/0.5 ML VIAL	1	Max. quantity of 3 per fill MQC*: 3 boxes (6 inj)/copay
SUMATRIPTAN SUCC 100 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
SUMATRIPTAN SUCC 25 MG TABLET	1	Max. quantity of 6 per fill MQC*: 24 tabs/copay
SUMATRIPTAN SUCC 50 MG TABLET	1	MQC*: 12 tabs/copay
SUMAVEL DOSEPRO 4 MG/0.5 ML	3	Max. 3 ML(s) per day;Max. quantity of 3 per fill MQC*: 6 pens/copay
SUMAVEL DOSEPRO 6 MG/0.5 ML	3	Max. 10 ML(s) per day;Max. quantity of 3 per fill MQC*: 6 pens/copay



DRUG NAME	TIER	LIMITATIONS/ * NOTES
SUPER THIN 28G LANCETS	2	HSA*
SUPER THIN 33G LANCETS	2	HSA*
SUPERVITE LIQUID	3	
SUPRAX 100 MG TABLET CHEWABLE	3	
SUPRAX 100 MG/5 ML SUSPENSION	NC	
SUPRAX 200 MG TABLET CHEWABLE	3	
SUPRAX 200 MG/5 ML SUSPENSION	NC	
SUPRAX 400 MG CAPSULE	3	
SUPRAX 400 MG TABLET	2	
SUPRAX 500 MG/5 ML SUSPENSION	3	
SUPREP BOWEL PREP KIT	3	
SURE COMFORT 18G LANCETS	2	HSA*
SURE COMFORT 21G LANCETS	2	HSA*
SURE COMFORT 23G LANCETS	2	HSA*
SURE COMFORT 28G LANCETS	2	HSA*
SURE COMFORT 30G LANCETS	2	HSA*
SURE EDGE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURE RESULT DSS PREMIUM PACK	NC	
SURE-LANCE 26G LANCETS	2	HSA*
SURE-LANCE FLAT LANCETS	2	HSA*
SURE-LANCE THIN 28G LANCETS	2	HSA*
SURE-LANCE ULTRA THIN 30G	2	HSA*
SURE-T PARADIGM 23" SET	MD	
SURE-TEST EASYPLUS MINI STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURE-TOUCH LANCET	2	HSA*
SURECHEK TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURESTEP PRO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
SURMONTIL 100 MG CAPSULE	NC	
SURMONTIL 25 MG CAPSULE	NC	
SURMONTIL 50 MG CAPSULE	NC	
SURVANTA 25 MG/ML VIAL	3	
SUSTIVA 200 MG CAPSULE	2	
SUSTIVA 50 MG CAPSULE	2	
SUSTIVA 600 MG TABLET	2	
SUTENT 12.5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SUTENT 25 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SUTENT 37.5 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SUTENT 50 MG CAPSULE	3	CH*; SPP*: CVS Specialty
SYEDA 28 TABLET	0	ACA*
SYLATRON 200 MCG KIT	3	SPP*: Must use CVS Specialty
SYLATRON 300 MCG KIT	3	SPP*: Must use CVS Specialty
SYLATRON 600 MCG KIT	3	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SYMBICORT 160-4.5 MCG INHALER	2	Max. 10.2 GM(s) in 30 days HSA*
SYMBICORT 80-4.5 MCG INHALER	2	Max. 10.2 GM(s) in 30 days HSA*
SYMBYAX 12-25 MG CAPSULE	NC	
SYMBYAX 12-50 MG CAPSULE	NC	
SYMBYAX 3-25 MG CAPSULE	NC	
SYMBYAX 6-25 MG CAPSULE	NC	
SYMBYAX 6-50 MG CAPSULE	NC	
SYMLINPEN 120 PEN INJECTOR	2	HSA*
SYMLINPEN 60 PEN INJECTOR	2	HSA*
SYMPROIC 0.2 MG TABLET	3	Prior Authorization required PA NTM*
SYNAGIS 100 MG/1 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SYNAGIS 50 MG/0.5 ML VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
SYNALAR 0.01% SOLUTION	NC	
SYNALAR 0.025% CREAM	NC	
SYNALAR 0.025% CREAM KIT	3	
SYNALAR 0.025% OINTMENT	NC	
SYNALAR 0.025% OINTMENT KIT	3	
SYNALAR TS 0.01% KIT	3	
SYNALGOS-DC CAPSULE	NC	
SYNAREL 2 MG/ML NASAL SPRAY	2	Max. 30 Days Supply IVF*
SYNDROS 5 MG/ML SOLUTION	3	
SYNERA PATCH	3	
SYNJARDY 12.5-1,000 MG TABLET	3	HSA*
SYNJARDY 12.5-500 MG TABLET	3	HSA*
SYNJARDY 5-1,000 MG TABLET	3	HSA*
SYNJARDY 5-500 MG TABLET	3	HSA*
SYNJARDY XR 10-1,000 MG TABLET	3	HSA*
SYNJARDY XR 12.5-1,000 MG TAB	3	HSA*
SYNJARDY XR 25-1,000 MG TABLET	3	HSA*
SYNJARDY XR 5-1,000 MG TABLET	3	HSA*
SYNTHROID 100 MCG TABLET	2	
SYNTHROID 112 MCG TABLET	2	
SYNTHROID 125 MCG TABLET	2	
SYNTHROID 137 MCG TABLET	2	
SYNTHROID 150 MCG TABLET	2	
SYNTHROID 175 MCG TABLET	2	
SYNTHROID 200 MCG TABLET	2	
SYNTHROID 25 MCG TABLET	2	
SYNTHROID 300 MCG TABLET	2	
SYNTHROID 50 MCG TABLET	2	
SYNTHROID 75 MCG TABLET	2	
SYNTHROID 88 MCG TABLET	2	
SYPRINE 250 MG CAPSULE	3	Prior Authorization required
SYRINGE 35 ML	3	
SYRINGE W-NEEDLE 1 ML 25X1"	3	
SYRINGE W-O NDL 12 ML-NON-STRL	3	
SYRINGE W-O NDL 20 ML-NON-STRL	3	
SYRINGE W-O NDL 35 ML-NON-STRL	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
SYRINGE W-O NDL 6 ML NON-STRL	3	
SYRINGE W-O NEEDLE 140 ML	3	
SYRINGE W-O NEEDLE 60 ML	3	
SYRINGE W-O NEEDLE 60 ML	3	

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TABLOID 40 MG TABLET	2	CH*
TACLONEX 0.005%-0.064% SUSPENS	3	
TACLONEX OINTMENT	NC	
TACROLIMUS 0.03% OINTMENT	1	Prior Authorization required
TACROLIMUS 0.1% OINTMENT	1	Prior Authorization required
TACROLIMUS 0.5 MG CAPSULE	1	
TACROLIMUS 1 MG CAPSULE	1	
TACROLIMUS 5 MG CAPSULE	1	
TAFINLAR 50 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TAFINLAR 75 MG CAPSULE	3	CH*; SPP*: CVS Specialty
TAGRISSO 40 MG TABLET	3	CH*; SPP*: CVS Specialty
TAGRISSO 80 MG TABLET	3	CH*; SPP*: CVS Specialty
TAKE ACTION 1.5 MG TABLET	NC	
TALTZ 80 MG/ML AUTOINJECTOR	3	Prior Authorization required;Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
TALTZ 80 MG/ML SYRINGE	3	Prior Authorization required;Max. 1 ML(s) per 28 days SPP*: Must use CVS Specialty
TAMIFLU 30 MG CAPSULE	NC	
TAMIFLU 45 MG CAPSULE	NC	
TAMIFLU 6 MG/ML SUSPENSION	2	Max. 240 ML(s) in 180 days
TAMIFLU 75 MG CAPSULE	NC	
TAMOXIFEN 10 MG TABLET	1	CH*; HSA*
TAMOXIFEN 20 MG TABLET	1	CH*; HSA*
TAMSULOSIN HCL 0.4 MG CAPSULE	1	
TANZEUM 30 MG PEN INJECT	3	Max. 4 per 28 days;Step Therapy required HSA*
TANZEUM 50 MG PEN INJECT	3	Max. 4 per 28 days;Step Therapy required HSA*
TAPAZOLE 10 MG TABLET	NC	
TAPAZOLE 5 MG TABLET	NC	
TARCEVA 100 MG TABLET	2	CH*; SPP*: CVS Specialty
TARCEVA 150 MG TABLET	2	CH*; SPP*: CVS Specialty
TARCEVA 25 MG TABLET	2	CH*; SPP*: CVS Specialty
TARGADOX 50 MG TABLET	3	Max. 2 per day
TARGRETIN 1% GEL	3	HSA*
TARGRETIN 75 MG CAPSULE	NC	
TARINA FE 1-20 TABLET	0	ACA*
TARKA ER 1-240 MG TABLET	NC	
TARKA ER 2-180 MG TABLET	NC	
TARKA ER 2-240 MG TABLET	NC	
TARKA ER 4-240 MG TABLET	NC	
TASIGNA 150 MG CAPSULE	2	CH*; SPP*: CVS Specialty
TASIGNA 200 MG CAPSULE	2	CH*; SPP*: CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TASMAR 100 MG TABLET	NC	
TAYTULLA 1 MG-20 MCG CAPSULE	0	ACA*
TAZAROTENE 0.1% CREAM	2	Prior Authorization required for members 30 and older
TAZORAC 0.05% CREAM	3	Prior Authorization required for members 30 and older
TAZORAC 0.05% GEL	3	Prior Authorization required for members 30 and older
TAZORAC 0.1% CREAM	NC	
TAZORAC 0.1% GEL	3	Prior Authorization required for members 30 and older
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*
TAZTIA XT 360 MG CAPSULE	1	HSA*
TD GOLD TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TECFIDERA DR 120 MG CAPSULE	2	SPP*: Must use CVS Specialty
TECFIDERA DR 240 MG CAPSULE	2	SPP*: Must use CVS Specialty
TECFIDERA STARTER PACK	2	SPP*: Must use CVS Specialty
TECHLITE 28G LANCETS	2	HSA*
TECHLITE 30G LANCETS	2	HSA*
TECHNIVIE DOSE PACK	3	Prior Authorization required;Max. 56 per 28 days Max 56 tabs/28 days supply; SPP*: Must use CVS Specialty
TEGRETOL 100 MG/5 ML SUSP	3	
TEGRETOL 200 MG TABLET	3	
TEGRETOL XR 100 MG TABLET	3	
TEGRETOL XR 200 MG TABLET	3	
TEGRETOL XR 400 MG TABLET	3	
TEKAMLO 150 MG-10 MG TABLET	2	Max. 1.5 per day HSA*
TEKAMLO 150 MG-5 MG TABLET	2	Max. 1.5 per day HSA*
TEKAMLO 300 MG-10 MG TABLET	2	Max. 1 per day HSA*
TEKAMLO 300 MG-5 MG TABLET	2	Max. 1 per day HSA*
TEKTURNA 150 MG TABLET	2	Max. 1.5 per day HSA*
TEKTURNA 300 MG TABLET	2	Max. 1 per day HSA*
TEKTURNA HCT 150-12.5 MG TAB	2	Max. 45 in 30 days HSA*
TEKTURNA HCT 150-25 MG TABLET	2	Max. 45 in 30 days HSA*
TEKTURNA HCT 300-12.5 MG TAB	2	Max. 30 in 30 days HSA*
TEKTURNA HCT 300-25 MG TABLET	2	Max. 30 in 30 days HSA*
TELCARE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
TELCARE ULTRA THIN 30G LANCETS	2	HSA*
TELMISARTAN 20 MG TABLET	1	HSA*
TELMISARTAN 40 MG TABLET	1	HSA*
TELMISARTAN 80 MG TABLET	1	HSA*

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TERCONAZOLE 80 MG SUPPOSITORY	1	
TERSI 2.25% FOAM	3	
TERUMO ALLERGY 1 ML 27GX1/2"	3	
TERUMO HYPODERMIC NDL-SYRIN	3	
TERUMO SURGUARD2 SYR 20G-10 ML	3	
TERUMO SURGUARD2 SYR 20G-3 ML	3	
TERUMO SURGUARD2 SYR 20G-5 ML	3	
TERUMO SURGUARD2 SYR 21G 3 ML	3	
TERUMO SURGUARD2 SYR 21G-10 ML	3	
TERUMO SURGUARD2 SYR 21G-3 ML	3	
TERUMO SURGUARD2 SYR 21G-5 ML	3	
TERUMO SURGUARD2 SYR 22G 3 ML	3	
TERUMO SURGUARD2 SYR 23G 3 ML	3	
TERUMO SURGUARD2 SYR 25G 3 ML	3	
TERUMO SURGUARD2 SYR 25G-1 ML	3	
TERUMO SURGUARD2 SYR 26G-1 ML	3	
TERUMO SURGUARD2 SYR 27G-1 ML	3	
TERUMO SYRINGE 3 ML	3	
TERUMO SYRINGE 30 ML	3	
TESSALON PERLE 100 MG CAP	NC	
TEST N'GO GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TESTIM 1% (50MG) GEL	NC	
TESTONE CIK KIT	3	Max. 2 per 15 days
TESTOSTERON CYP 1,000 MG/10 ML	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 ML(s) in 30 days
TESTOSTERON ENAN 1,000 MG/5 ML	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 5 ML(s) in 30 days
TESTOSTERONE 10 MG GEL PUMP	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 120 GM(s) in 30 days
TESTOSTERONE 12.5 MG/1.25 GRAM	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 300 GM(s) in 30 days
TESTOSTERONE 25 MG/2.5 GM PKT	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 2.5 GM(s) per day
TESTOSTERONE 30 MG/1.5 ML PUMP	2	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 180 ML(s) in 30 days
TESTOSTERONE 50 MG/5 GRAM GEL	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 GM(s) per day
TESTOSTERONE 50 MG/5 GRAM PKT	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 10 GM(s) per day
TESTOSTERONE CYP 200 MG/ML	1	Max. 30 Days Supply;Prior Authorization required for members 18 and older;Max. 4 ML(s) in 30 days
TESTRED 10 MG CAPSULE	NC	
TETCAINE 0.5% EYE DROPS	NC	
TETRABENAZINE 12.5 MG TABLET	1	SPP*: Must use CVS Specialty
TETRABENAZINE 25 MG TABLET	1	SPP*: Must use CVS Specialty
TETRACAINE 0.5% EYE DROPS	1	
TETRACYCLINE 250 MG CAPSULE	1	
TETRACYCLINE 500 MG CAPSULE	1	
TETRAVISC 0.5% EYE DROPS	NC	
TETRIX CREAM	3	
TETRIX CREAM KIT	NC	
TEVETEN 600 MG TABLET	NC	
TEVETEN HCT 600-12.5 MG TAB	3	HSA*
TEVETEN HCT 600-25 MG TAB	3	HSA*
TEXACORT 2.5% SOLUTION	3	
TEXAVITE LQ DROPS	3	
THALOMID 100 MG CAPSULE	2	CH*; SPP*: CVS Specialty

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

TIAZAC ER 240 MG CAPSULE	NC	
TIAZAC ER 300 MG CAPSULE	NC	
TIAZAC ER 360 MG CAPSULE	NC	
TIAZAC ER 420 MG CAPSULE	NC	
TICLOPIDINE 250 MG TABLET	1	HSA*
TIGAN 300 MG CAPSULE	NC	
TIKOSYN 125 MCG CAPSULE	NC	
TIKOSYN 250 MCG CAPSULE	NC	
TIKOSYN 500 MCG CAPSULE	NC	
TILIA FE 28 TABLET	0	ACA*
TIMOLOL 0.25% EYE DROPS	1	
TIMOLOL 0.25% GFS GEL-SOLUTION	1	
TIMOLOL 0.5% EYE DROPS	1	
TIMOLOL 0.5% GFS GEL-SOLUTION	1	
TIMOLOL MALEATE 10 MG TABLET	1	HSA*
TIMOLOL MALEATE 20 MG TABLET	1	HSA*
TIMOLOL MALEATE 5 MG TABLET	1	HSA*
TIMOPTIC 0.25% OCUDOSE DROP	3	
TIMOPTIC 0.5% OCUDOSE DROP	3	
TIMOPTIC-XE 0.25% EYE SOLN	NC	
TIMOPTIC-XE 0.5% EYE SOLN	NC	
TINDAMAX 250 MG TABLET	NC	
TINDAMAX 500 MG TABLET	NC	
TINIDAZOLE 250 MG TABLET	1	
TINIDAZOLE 500 MG TABLET	1	
TIROSINT 100 MCG CAPSULE	3	
TIROSINT 112 MCG CAPSULE	3	
TIROSINT 125 MCG CAPSULE	3	
TIROSINT 13 MCG CAPSULE	3	
TIROSINT 137 MCG CAPSULE	3	
TIROSINT 150 MCG CAPSULE	3	
TIROSINT 25 MCG CAPSULE	3	
TIROSINT 50 MCG CAPSULE	3	
TIROSINT 75 MCG CAPSULE	3	
TIROSINT 88 MCG CAPSULE	3	
TISSEEL VHSD 2 ML KIT	3	
TIVICAY 10 MG TABLET	3	
TIVICAY 25 MG TABLET	3	
TIVICAY 50 MG TABLET	3	
TIVORBEX 20 MG CAPSULE	3	
TIVORBEX 40 MG CAPSULE	3	
TIZANIDINE HCL 2 MG CAPSULE	1	
TIZANIDINE HCL 2 MG TABLET	1	
TIZANIDINE HCL 4 MG CAPSULE	1	
TIZANIDINE HCL 4 MG TABLET	1	
TIZANIDINE HCL 6 MG CAPSULE	1	
TL G-FOL OS TABLET	1	
TL GARD RX TABLET	1	
TL ICON CAPSULE	1	
TL-FOL 500 CAPLET	1	
TOBI 300 MG/5 ML SOLUTION	NC	
TOBI PODHALER 28 MG INHALE CAP	2	SPP*: Must use CVS Specialty
TOBRADEX EYE DROPS	NC	
TOBRADEX EYE OINTMENT	2	
TOBRADEX ST EYE DROPS	3	
TOBRAMYCIN 0.3% EYE DROPS	1	
TOBRAMYCIN 300 MG/5 ML AMPULE	1	SPP*: Must use CVS Specialty



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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TOPROL XL 200 MG TABLET	NC	
TOPROL XL 25 MG TABLET	NC	
TOPROL XL 50 MG TABLET	NC	
TORSEMIDE 10 MG TABLET	1	HSA*
TORSEMIDE 100 MG TABLET	1	HSA*
TORSEMIDE 20 MG TABLET	1	HSA*
TORSEMIDE 5 MG TABLET	1	HSA*
TOUJEO SOLOSTAR 300 UNITS/ML	2	HSA*
TOVIAZ ER 4 MG TABLET	2	
TOVIAZ ER 8 MG TABLET	2	
TRACLEER 125 MG TABLET	2	SPP*: Must use CVS Specialty
TRACLEER 62.5 MG TABLET	2	SPP*: Must use CVS Specialty
TRADJENTA 5 MG TABLET	2	HSA*
TRAMADOL HCL 50 MG TABLET	1	
TRAMADOL HCL ER 100 MG CAPSULE	1	
TRAMADOL HCL ER 100 MG TABLET	1	
TRAMADOL HCL ER 150 MG CAPSULE	1	
TRAMADOL HCL ER 200 MG CAPSULE	1	
TRAMADOL HCL ER 200 MG TABLET	1	
TRAMADOL HCL ER 300 MG CAPSULE	1	
TRAMADOL HCL ER 300 MG TABLET	1	
TRAMADOL-ACETAMINOPHN 37.5-325	1	
TRANDATE 100 MG TABLET	NC	
TRANDATE 200 MG TABLET	NC	
TRANDATE 300 MG TABLET	NC	
TRANDOLAPR-VERAPAM ER 1-240 MG	1	HSA*
TRANDOLAPR-VERAPAM ER 2-180 MG	1	HSA*
TRANDOLAPR-VERAPAM ER 2-240 MG	1	HSA*
TRANDOLAPR-VERAPAM ER 4-240 MG	1	HSA*
TRANDOLAPRIL 1 MG TABLET	1	HSA*
TRANDOLAPRIL 2 MG TABLET	1	HSA*
TRANDOLAPRIL 4 MG TABLET	1	HSA*
TRANEXAMIC ACID 650 MG TABLET	1	Max. 30 in 30 days
TRANSDERM-SCOP 1.5 MG/3 DAY	3	Max. quantity of 4 per fill MQC*: 1 box (4 patches)/copay
TRANXENE T-TAB 15 MG	NC	
TRANXENE T-TAB 3.75 MG	NC	
TRANXENE T-TAB 7.5 MG	NC	
TRANLYCYPROMINE SULF 10 MG TAB	1	
TRAVATAN Z 0.004% EYE DROP	2	
TRAVOPROST 0.004% EYE DROP	1	
TRAZODONE 100 MG TABLET	1	
TRAZODONE 150 MG TABLET	1	
TRAZODONE 300 MG TABLET	1	
TRAZODONE 50 MG TABLET	1	
TRECATOR 250 MG TABLET	3	
TRELEGY ELLIPTA 100-62.5-25	3	Prior Authorization required;Max. 60 in 30 days HSA*; PA NTM*
TREMFYA 100 MG/ML SYRINGE	3	Prior Authorization required PA NTM*; SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRESIBA FLEXTOUCH 100 UNITS/ML	3	Prior Authorization required HSA*
TRESIBA FLEXTOUCH 200 UNITS/ML	3	Prior Authorization required HSA*
TRETIN-X 0.025% CREAM COMB PCK	3	Prior Authorization required for members 30 and older
TRETIN-X 0.0375% CREAM	3	Prior Authorization required for members 30 and older
TRETIN-X 0.075% CREAM	3	Prior Authorization required for members 30 and older
TRETIN-X 0.1% COMBO PACK	3	Prior Authorization required for members 30 and older
TRETINOIN 0.01% GEL	1	Prior Authorization required for members 30 and older
TRETINOIN 0.025% CREAM	1	Prior Authorization required for members 30 and older
TRETINOIN 0.025% GEL	1	Prior Authorization required for members 30 and older
TRETINOIN 0.05% CREAM	1	Prior Authorization required for members 30 and older
TRETINOIN 0.05% GEL	1	Prior Authorization required for members 30 and older
TRETINOIN 0.1% CREAM	1	Prior Authorization required for members 30 and older
TRETINOIN 10 MG CAPSULE	1	CH*
TRETINOIN GEL MICRO 0.04% TUBE	1	Prior Authorization required for members 30 and older
TRETINOIN GEL MICRO 0.1% TUBE	1	Prior Authorization required for members 30 and older
TRETEN 2,500 UNIT VIAL	MD	SPP*: Must use CVS Specialty
TREXALL 10 MG TABLET	3	
TREXALL 15 MG TABLET	3	
TREXALL 5 MG TABLET	3	
TREXALL 7.5 MG TABLET	3	
TREXIMET 10-60 MG TABLET	2	Max. quantity of 9 per fill; Step Therapy required MQC*: 9 tabs/copay
TREXIMET 85-500 MG TABLET	2	Max. quantity of 9 per fill; Step Therapy required MQC*: 9 tabs/copay
TREZIX 16-320.5-30 MG CAPSULE	NC	
TREZIX CAPSULE	1	
TRI FEMYNOR 28 TABLET	0	ACA*
TRI-BUFFERED ASPIRIN 325 MG TB	0	ACA*
TRI-ESTARYLLA TABLET	0	ACA*
TRI-LEGEST FE-28 DAY TABLET	0	ACA*
TRI-LINYAH TABLET	0	ACA*
TRI-LO-ESTARYLLA TABLET	0	ACA*
TRI-LO-MARZIA TABLET	0	ACA*
TRI-LO-SPRINTEC TABLET	0	ACA*
TRI-NORINYL 28 TABLET	NC	
TRI-PREVIFEM TABLET	0	ACA*
TRI-SPRINTEC TABLET	0	ACA*
TRIAMCINOLONE 0.025% CREAM	1	
TRIAMCINOLONE 0.025% LOTION	1	
TRIAMCINOLONE 0.025% OINT	1	
TRIAMCINOLONE 0.1% CREAM	1	
TRIAMCINOLONE 0.1% LOTION	1	
TRIAMCINOLONE 0.1% OINTMENT	1	
TRIAMCINOLONE 0.1% PASTE	1	
TRIAMCINOLONE 0.147 MG/G SPRAY	1	
TRIAMCINOLONE 0.5% CREAM	1	
TRIAMCINOLONE 0.5% OINTMENT	1	
TRIAMCINOLONE 55 MCG NASAL SPR	1	
TRIAMTERENE-HCTZ 37.5-25 MG CP	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TRIAMTERENE-HCTZ 37.5-25 MG TB	1	HSA*
TRIAMTERENE-HCTZ 50-25 MG CAP	1	HSA*
TRIAMTERENE-HCTZ 75-50 MG TAB	1	HSA*
TRIANEX 0.05% OINTMENT	1	
TRIAZOLAM 0.125 MG TABLET	1	
TRIAZOLAM 0.25 MG TABLET	1	
TRIBENZOR 20-5-12.5 MG TABLET	NC	
TRIBENZOR 40-10-12.5 MG TABLET	NC	
TRIBENZOR 40-10-25 MG TABLET	NC	
TRIBENZOR 40-5-12.5 MG TABLET	NC	
TRIBENZOR 40-5-25 MG TABLET	NC	
TRICITRATES ORAL SOLUTION	1	
TRICON CAPSULE	1	
TRICOR 145 MG TABLET	NC	
TRICOR 48 MG TABLET	NC	
TRIDERM 0.1% CREAM	1	
TRIDERM 0.5% CREAM	1	
TRIDESILON 0.05% CREAM	1	
TRIFLUOPERAZINE 1 MG TABLET	1	
TRIFLUOPERAZINE 10 MG TABLET	1	
TRIFLUOPERAZINE 2 MG TABLET	1	
TRIFLUOPERAZINE 5 MG TABLET	1	
TRIFLURIDINE 1% EYE DROPS	1	
TRIGELS-F FORTE SOFTGEL	1	
TRIGLIDE 160 MG TABLET	2	HSA*
TRIHXYPHENIDYL 2 MG TABLET	1	
TRIHXYPHENIDYL 2 MG/5 ML ELX	1	
TRIHXYPHENIDYL 5 MG TABLET	1	
TRILEPTAL 150 MG TABLET	3	
TRILEPTAL 300 MG TABLET	3	
TRILEPTAL 300 MG/5 ML SUSP	3	
TRILEPTAL 600 MG TABLET	3	
TRILIPIX DR 135 MG CAPSULE	NC	
TRILIPIX DR 45 MG CAPSULE	NC	
TRILYTE WITH FLAVOR PACKETS	0	ACA*
TRIMETHOBENZAMIDE 300 MG CAP	1	
TRIMETHOPRIM 100 MG TABLET	1	
TRIMIPRAMINE MALEATE 100 MG CP	1	
TRIMIPRAMINE MALEATE 25 MG CAP	1	
TRIMIPRAMINE MALEATE 50 MG CAP	1	
TRIMPEX 50 MG/5 ML ORAL SOLN	3	
TRINESSA LO TABLET	0	ACA*
TRINESSA TABLET	0	ACA*
TRINTELLIX 10 MG TABLET	3	Step Therapy required STA*: 18 and older
TRINTELLIX 20 MG TABLET	3	Step Therapy required STA*: 18 and older
TRINTELLIX 5 MG TABLET	3	Step Therapy required STA*: 18 and older
TRIPHROCAPS SOFTGEL	1	
TRIPLE DYE SWAB	1	
TRIUMEQ TABLET	3	
TRIVORA-28 TABLET	0	ACA*
TRIZIVIR TABLET	NC	
TROKENDI XR 100 MG CAPSULE	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TROKENDI XR 200 MG CAPSULE	3	
TROKENDI XR 25 MG CAPSULE	3	
TROKENDI XR 50 MG CAPSULE	3	
TROPAZONE LOTION	3	
TROPICAMIDE 0.5% EYE DROPS	1	
TROPICAMIDE 1% EYE DROPS	1	
TROSPIUM CHLORIDE 20 MG TABLET	1	
TROSPIUM CHLORIDE ER 60 MG CAP	1	
TRUE METRIX GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
TRUEPLUS 26G LANCETS	2	HSA*
TRUEPLUS 33G LANCETS	2	HSA*
TRUEPLUS KETONE TEST STRIPS	2	
TRUEPLUS SAFETY 28G LANCETS	2	
TRUEPLUS SUPER THIN 28G LANCET	2	HSA*
TRUEPLUS ULTRA THIN 30G LANCET	2	HSA*
TRUETEST GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
TRUETRACK GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
TRULANCE 3 MG TABLET	3	Prior Authorization required
TRULICITY 0.75 MG/0.5 ML PEN	2	Max. 2 ML(s) per 28 days;Step Therapy required HSA*
TRULICITY 1.5 MG/0.5 ML PEN	2	Max. 2 ML(s) per 28 days;Step Therapy required HSA*
TRUSOPT 2% EYE DROPS	NC	
TRUVADA 100 MG-150 MG TABLET	2	
TRUVADA 133 MG-200 MG TABLET	2	
TRUVADA 167 MG-250 MG TABLET	2	
TRUVADA 200 MG-300 MG TABLET	2	
TRUZONE PEAK FLOW METER	MD	
TUBERCULIN 1 ML SYRINGE	3	
TUBERCULIN SYRINGE	3	
TUBERCULIN SYRINGES	3	
TUDORZA PRESSAIR 400 MCG INH	2	Max. 1 in 30 days HSA*
TUSNEL C SYRUP	NC	
TUSNEL PEDIATRIC LIQUID	NC	
TUSSICAPS 10 MG-8 MG CAPSULE	NC	
TUSSICAPS 5 MG-4 MG CAPSULE	NC	
TUSSIGON 5-1.5 MG TABLET	NC	
TUSSIONEX PENNKINETIC SUSP	NC	
TUZISTRA XR 14.7-2.8 MG/5 ML	3	
TWINRIX VACCINE SYRINGE	MD	Not covered for members 17 and younger
TWINRIX VACCINE VIAL	MD	Not covered for members 17 and younger
TWYNSTA 40-10 MG TABLET	NC	
TWYNSTA 40-5 MG TABLET	NC	
TWYNSTA 80-10 MG TABLET	NC	
TWYNSTA 80-5 MG TABLET	NC	
TYBOST 150 MG TABLET	3	
TYKERB 250 MG TABLET	2	CH*; SPP*: CVS Specialty
TYLENOL WITH CODEINE #3 TABLET	NC	
TYLENOL WITH CODEINE #4 TABLET	NC	
TYMLOS 80 MCG DOSE PEN INJECTR	2	Prior Authorization required;Max. 1.56 ML(s) in 30 days HSA*; SPP*: Must use CVS Specialty
TYVASO 1.74 MG/2.9 ML SOLUTION	2	SPP*: Must use CVS Specialty

DRUG NAME	TIER	LIMITATIONS/ * NOTES
TYVASO INHALATION REFILL KIT	2	SPP*: Must use CVS Specialty
TYVASO INHALATION STARTER KIT	2	SPP*: Must use CVS Specialty
TYZEKA 600 MG TABLET	3	
TYZINE 0.1% NOSE DROPS	3	
TYZINE 0.1% NOSE SPRAY	3	

## U

U-CORT 1% CREAM	1	
UCERIS 2 MG RECTAL FOAM	3	
UCERIS 9 MG ER TABLET	3	
ULESFIA 5% LOTION	3	
ULORIC 40 MG TABLET	2	
ULORIC 80 MG TABLET	2	
ULTICARE SAFETY 3 ML 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	
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*
ULTRACET TABLET	NC	
ULTRAFOAM 2X6.25X7CM SPONGE	3	
ULTRALANCE 26G LANCETS	2	HSA*
ULTRALANCE 28G LANCETS	2	HSA*
ULTRAM 50 MG TABLET	NC	
ULTRAM ER 100 MG TABLET	NC	
ULTRAM ER 200 MG TABLET	NC	
ULTRAM ER 300 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ULTRATLC LANCETS	2	HSA*
ULTRATRAK TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
ULTRATRAK ULTIMATE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
ULTRAVATE 0.05% CREAM	NC	
ULTRAVATE 0.05% LOTION	3	
ULTRAVATE 0.05% OINTMENT	NC	
ULTRAVATE PAC OINTMENT KIT	NC	
ULTRAVATE X OINTMENT COMBO PAC	3	
ULTRESA DR 13,800 UNIT CAPSULE	3	
ULTRESA DR 20,700 UNIT CAPSULE	3	
ULTRESA DR 23,000 UNIT CAPSULE	3	
UMECTA 40% EMULSION	3	
UMECTA PD 40% EMULSION	3	
UNILET COMFORTOUCH 26G LANCETS	2	HSA*
UNILET COMFORTOUCH LANCET	2	HSA*
UNILET EXCELITE II LANCET	2	HSA*
UNILET EXCELITE LANCET	2	HSA*
UNILET GP LANCET	2	HSA*
UNILET LANCET SUPERLITE	2	HSA*
UNILET MICRO THIN 33G LANCETS	2	HSA*
UNILET SUPER THIN 30G LANCETS	2	HSA*
UNILET ULTRA THIN 28G LANCETS	2	HSA*
UNIRETIC 15-12.5 TABLET	NC	
UNIRETIC 15-25 MG TABLET	NC	
UNIRETIC 7.5-12.5 MG TABLET	NC	
UNISTIK 3 COMFORT LANCET	2	HSA*
UNISTIK 3 EXTRA 21G LANCETS	2	HSA*
UNISTIK 3 GENTLE ON-THE-GO 30G	2	HSA*
UNISTIK 3 NORMAL 23G LANCETS	2	HSA*
UNISTIK 3 SAFETY 21G LANCETS	2	HSA*
UNISTIK CZT COMFORT 28G LANCET	2	HSA*
UNISTIK CZT NORMAL 23G LANCETS	2	HSA*
UNISTIK SAFETY 28G LANCET	2	HSA*
UNISTIK SAFETY 30G LANCETS	2	HSA*
UNISTIK TOUCH 21G LANCETS	2	HSA*
UNISTIK TOUCH 23G LANCETS	2	HSA*
UNISTIK TOUCH 28G LANCETS	2	HSA*
UNISTIK TOUCH 30G LANCETS	2	HSA*
UNISTRIP1 GLUCOSE TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
UNITHROID 100 MCG TABLET	1	
UNITHROID 112 MCG TABLET	1	
UNITHROID 125 MCG TABLET	1	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
UNITHROID 137 MCG TABLET	1	
UNITHROID 150 MCG TABLET	1	
UNITHROID 175 MCG TABLET	1	
UNITHROID 200 MCG TABLET	1	
UNITHROID 25 MCG TABLET	1	
UNITHROID 300 MCG TABLET	1	
UNITHROID 50 MCG TABLET	1	
UNITHROID 75 MCG TABLET	1	
UNITHROID 88 MCG TABLET	1	
UNIVASC 15 MG TABLET	NC	
UNIVASC 7.5 MG TABLET	NC	
UNIVERSAL 1 33G LANCETS	2	
UPTRAVI 1,000 MCG TABLET	3	HSA* Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 1,200 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 1,400 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 1,600 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 200 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 200-800 TITRATION PACK	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 400 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 600 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
UPTRAVI 800 MCG TABLET	3	Prior Authorization required SPP*: Must use CVS Specialty
URE-K 50% CREAM	NC	
UREA 39% CREAM	1	
UREA 40% CREAM	1	
UREA 40% GEL	1	
UREA 40% LOTION	1	
UREA 50% NAIL STICK	1	
URECHOLINE 10 MG TABLET	NC	
URECHOLINE 25 MG TABLET	NC	
URECHOLINE 5 MG TABLET	NC	
URECHOLINE 50 MG TABLET	NC	
URISTIX 4 REAGENT STRIPS	2	
URISTIX REAGENT STRIPS	2	
UROCIT-K ER 15 MEQ TABLET	NC	
UROCIT-K SR 10 MEQ TABLET	NC	
UROCIT-K SR 5 MEQ TABLET	NC	
UROQID-ACID NO.2 500-500 TB	3	
UROXATRAL 10 MG TABLET	NC	
URSO 250 MG TABLET	NC	
URSO FORTE 500 MG TABLET	NC	
URSODIOL 250 MG TABLET	1	
URSODIOL 300 MG CAPSULE	1	
URSODIOL 500 MG TABLET	1	
UTIBRON NEOHALER 27.5-15.6 MCG	3	Max. 2 per day HSA*

## V

V-C FORTE CAPSULE	1	
VAGIFEM 10 MCG VAGINAL TAB	NC	
VALACYCLOVIR HCL 1 GRAM TABLET	1	
VALACYCLOVIR HCL 500 MG TABLET	1	



DRUG NAME	TIER	LIMITATIONS/ * NOTES
VALCHLOR 0.016% GEL	3	Max. 60 GM(s) in 30 days LDD*: Dohmen Life Sciences 1-800-305-7881
VALCYTE 450 MG TABLET	NC	
VALCYTE 50 MG/ML SOLUTION	NC	
VALGANCICLOVIR 450 MG TABLET	1	
VALGANCICLOVIR HCL 50 MG/ML	1	
VALIUM 10 MG TABLET	NC	
VALIUM 2 MG TABLET	NC	
VALIUM 5 MG TABLET	NC	
VALPROIC ACID 250 MG CAPSULE	1	
VALPROIC ACID 250 MG/5 ML SOLN	1	
VALSARTAN 160 MG TABLET	1	HSA*
VALSARTAN 320 MG TABLET	1	HSA*
VALSARTAN 40 MG TABLET	1	HSA*
VALSARTAN 80 MG TABLET	1	HSA*
VALSARTAN-HCTZ 160-12.5 MG TAB	1	HSA*
VALSARTAN-HCTZ 160-25 MG TAB	1	HSA*
VALSARTAN-HCTZ 320-12.5 MG TAB	1	HSA*
VALSARTAN-HCTZ 320-25 MG TAB	1	HSA*
VALSARTAN-HCTZ 80-12.5 MG TAB	1	HSA*
VALTREX 1 GM CAPLET	NC	
VALTREX 500 MG CAPLET	NC	
VANATOL LQ ORAL SOLUTION	3	
VANOCIN HCL 125 MG CAPSULE	NC	
VANOCIN HCL 250 MG CAPSULE	NC	
VANCOMYCIN HCL 10 GM VIAL	1	Not covered for members 18 and older
VANCOMYCIN HCL 125 MG CAPSULE	1	
VANCOMYCIN HCL 250 MG CAPSULE	1	
VANCOMYCIN HCL 5 GM VIAL	1	
VANAZOLE VAGINAL 0.75% GEL	2	
VANISHPOINT 1 ML TB SYR 25X5/8	3	
VANISHPOINT 1 ML TB SYR 27X1/2	3	
VANISHPOINT 10 ML 21GX1-1/2"	3	
VANISHPOINT 20GX1" 3 ML SYRING	3	
VANISHPOINT 21GX1" 5 ML SYRING	3	
VANISHPOINT 21GX1.5" 3 ML SYR	3	
VANISHPOINT 22GX1" 3 ML SYR	3	
VANISHPOINT 22GX1-1/2" 5 ML SY	3	
VANISHPOINT 23GX1" 3 ML SYRING	3	
VANISHPOINT 23GX1-1/2 3 ML SYR	3	
VANISHPOINT 25GX1" 3 ML SYRING	3	
VANISHPOINT 25GX5/8" 3 ML SYR	3	
VANISHPOINT 3 ML 21GX1" SYRING	3	
VANISHPOINT 3 ML 22GX1.5" SYRG	3	
VANISHPOINT 5 ML 21GX1-1/2"	3	
VANISHPOINT SYRINGE 1 ML 25X1"	3	
VANOS 0.1% CREAM	NC	
VANOXIDE-HC LOTION	3	
VAQTA 25 UNITS/0.5 ML SYRINGE	MD	Not covered for members 17 and younger
VAQTA 50 UNITS/ML SYRINGE	MD	Not covered for members 17 and younger
VAQTA 50 UNITS/ML VIAL	MD	Not covered for members 17 and younger
VARUBI 90 MG TABLET	3	Max. quantity of 2 per fill MQC*: 2 tabs/copy

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VASCEPA 0.5 GM CAPSULE	2	HSA*
VASCEPA 1 GM CAPSULE	2	HSA*
VASERETIC 10-25 MG TABLET	NC	
VASOLEX OINTMENT	1	
VASOTEC 10 MG TABLET	NC	
VASOTEC 2.5 MG TABLET	NC	
VASOTEC 20 MG TABLET	NC	
VASOTEC 5 MG TABLET	NC	
VCF CONTRACEPTIVE FILM	0	ACA*
VCF CONTRACEPTIVE FOAM	0	ACA*
VCF CONTRACEPTIVE GEL	0	ACA*
VECAMYL 2.5 MG TABLET	3	
VECTICAL 3 MCG/G OINTMENT	NC	
VEHICLE-N MILD SOLUTION	3	
VEHICLE-N SOLUTION	3	
VELIVET 28 DAY TABLET	0	ACA*
VELPHORO 500 MG CHEWABLE TAB	3	
VELTASSA 16.8 GM POWDER PACKET	3	LDD*: Walgreens Specialty (800) 424-9002
VELTASSA 25.2 GM POWDER PACKET	3	LDD*: Walgreens Specialty (800) 424-9002
VELTASSA 8.4 GM POWDER PACKET	3	LDD*: Walgreens Specialty (800) 424-9002
VELTIN 1.2%-0.025% GEL	NC	
VEMLIDY 25 MG TABLET	3	
VENCLEXTA 10 MG TABLET	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENCLEXTA 100 MG TABLET	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENCLEXTA 50 MG TABLET	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENCLEXTA STARTING PACK	3	CH*; LDD*: Diplomat Pharmacy 1-877-977-9118 or Onco360 Pharmacy 1-877-662-6633
VENELEX OINTMENT	3	
VENLAFAXINE HCL 100 MG TABLET	1	
VENLAFAXINE HCL 25 MG TABLET	1	
VENLAFAXINE HCL 37.5 MG TABLET	1	
VENLAFAXINE HCL 50 MG TABLET	1	
VENLAFAXINE HCL 75 MG TABLET	1	
VENLAFAXINE HCL ER 150 MG CAP	1	
VENLAFAXINE HCL ER 150 MG TAB	3	
VENLAFAXINE HCL ER 225 MG TAB	3	
VENLAFAXINE HCL ER 37.5 MG CAP	1	
VENLAFAXINE HCL ER 37.5 MG TAB	3	
VENLAFAXINE HCL ER 75 MG CAP	1	
VENLAFAXINE HCL ER 75 MG TAB	3	
VENTAVIS 10 MCG/1 ML SOLUTION	3	SPP*: Must use CVS Specialty
VENTAVIS 20 MCG/1 ML SOLUTION	3	SPP*: Must use CVS Specialty
VENTOLIN HFA 90 MCG INHALER	2	HSA*
VERAMYST 27.5 MCG NASAL SPRAY	NC	
VERAPAMIL 120 MG TABLET	1	HSA*

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VERAPAMIL 360 MG CAP PELLETT	1	HSA*
VERAPAMIL 40 MG TABLET	1	HSA*
VERAPAMIL 80 MG TABLET	1	HSA*
VERAPAMIL ER 120 MG CAPSULE	1	HSA*
VERAPAMIL ER 120 MG TABLET	1	HSA*
VERAPAMIL ER 180 MG CAPSULE	1	HSA*
VERAPAMIL ER 180 MG TABLET	1	HSA*
VERAPAMIL ER 240 MG CAPSULE	1	HSA*
VERAPAMIL ER 240 MG TABLET	1	HSA*
VERAPAMIL ER PM 100 MG CAPSULE	1	HSA*
VERAPAMIL ER PM 200 MG CAPSULE	1	HSA*
VERAPAMIL ER PM 300 MG CAPSULE	1	HSA*
VERDESO 0.05% FOAM	3	
VERDROCET 2.5-325 MG TABLET	NC	
VEREGEN 15% OINTMENT	2	
VERELAN 120 MG CAP PELLETT	NC	
VERELAN 180 MG CAP PELLETT	NC	
VERELAN 240 MG CAP PELLETT	NC	
VERELAN 360 MG CAP PELLETT	NC	
VERELAN PM 100 MG CAP PELLETT	NC	
VERELAN PM 200 MG CAP PELLETT	NC	
VERELAN PM 300 MG CAP PELLETT	NC	
VERIPRED 20 20 MG/5 ML SOLN	NC	
VERSACLOZ 50 MG/ML SUSPENSION	3	Max. 28 Days Supply
VERZENIO 100 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VERZENIO 150 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VERZENIO 200 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VERZENIO 50 MG TABLET	3	Prior Authorization required CH*; PA NTM*; SPP*: CVS Specialty
VESICARE 10 MG TABLET	2	
VESICARE 5 MG TABLET	2	
VESTURA 3 MG-0.02 MG TABLET	0	ACA*
VEXOL 1% EYE DROPS	3	
VFEND 200 MG TABLET	NC	
VFEND 40 MG/ML SUSPENSION	NC	
VFEND 50 MG TABLET	NC	
VGO 40 DISPOSABLE DEVICE	2	Max. 1 per day HSA*
VIAGRA 100 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
VIAGRA 25 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
VIAGRA 50 MG TABLET	2	Covered for males only;Not covered for members 17 and younger; Max. 4 in 30 days PAQ*: If greater than 4 tabs/30 days
VIBERZI 100 MG TABLET	2	
VIBERZI 75 MG TABLET	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VIBRAMYCIN 100 MG CAPSULE	NC	
VIBRAMYCIN 25 MG/5 ML SUSP	NC	
VIBRAMYCIN 50 MG/5 ML SYRUP	3	
VIC-FORTE CAPSULE	1	
VICODIN 5-300 MG TABLET	1	
VICODIN ES 7.5-300 MG TABLET	1	
VICODIN HP 10-300 MG TABLET	1	
VICOPROFEN 7.5-200 MG TABLET	NC	
VICTORY GLUCOSE TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
VICTOZA 3-PAK 18 MG/3 ML PEN	2	Max. 9 ML(s) per 30 days;Step Therapy required HSA*
VIDEX 2 GM PEDIATRIC SOLN	2	
VIDEX EC 125 MG CAPSULE	NC	
VIDEX EC 200 MG CAPSULE	NC	
VIDEX EC 250 MG CAPSULE	NC	
VIDEX EC 400 MG CAPSULE	NC	
VIEKIRA PAK	3	Prior Authorization required;Max. 84 per 28 days SPP*: Must use CVS Specialty
VIEKIRA XR TABLET	3	Prior Authorization required;Max. 84 per 28 days SPP*: Must use CVS Specialty
VIENVA-28 TABLET	0	ACA*
VIGABATRIN 500 MG POWDER PACKT	2	SPP*: Must use CVS Specialty
VIGAMOX 0.5% EYE DROPS	3	
VIIBRYD 10 MG TABLET	3	Step Therapy required STA*: 18 and older
VIIBRYD 10-20 MG STARTER PACK	3	Step Therapy required STA*: 18 and older
VIIBRYD 10-20-40 MG STARTER PK	3	Step Therapy required STA*: 18 and older
VIIBRYD 20 MG TABLET	3	Step Therapy required STA*: 18 and older
VIIBRYD 40 MG TABLET	3	Step Therapy required STA*: 18 and older
VIMOVO DR 375-20 MG TABLET	NC	
VIMOVO DR 500-20 MG TABLET	NC	
VIMPAT 10 MG/ML SOLUTION	2	
VIMPAT 100 MG TABLET	2	
VIMPAT 150 MG TABLET	2	
VIMPAT 200 MG TABLET	2	
VIMPAT 50 MG TABLET	2	
VINATE DHA GELCAP	1	HSA*
VIOKACE 10,440-39,150 UNITS TB	3	
VIOKACE 20,880-78,300 UNITS TB	3	
VIORELE 28 DAY TABLET	0	ACA*
VIRACEPT 250 MG TABLET	2	
VIRACEPT 625 MG TABLET	2	
VIRAMUNE 200 MG TABLET	NC	
VIRAMUNE 50 MG/5 ML SUSP	NC	
VIRAMUNE XR 100 MG TABLET	NC	
VIRAMUNE XR 400 MG TABLET	NC	
VIRASAL ANTIVIRAL WART REMOVER	NC	
VIRAZOLE 6 GM VIAL	NC	
VIREAD 150 MG TABLET	2	
VIREAD 200 MG TABLET	2	
VIREAD 250 MG TABLET	2	
VIREAD 300 MG TABLET	2	
VIREAD POWDER	2	
VIROPTIC 1% EYE DROPS	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VIRT-CAPS SOFTGEL	1	
VIRT-GARD TABLET	1	
VIRT-PHOS 250 NEUTRAL TABLET	1	
VIRTUSSIN AC LIQUID	1	
VISTARIL 25 MG CAPSULE	NC	
VISTARIL 50 MG CAPSULE	NC	
VISTOGARD 10 GRAM PACKET	3	
VIT D2 1.25 MG (50,000 UNIT)	1	
VITAFOL CAPLET	1	HSA*
VITAFOL FE+ DOCUSATE COMBO PCK	3	HSA*
VITAMIN D 400 UNIT TABLET	0	ACA*
VITAMIN D-400 TABLET	0	Not covered for members 64 and younger ACA*
VITAMIN D2 400 UNIT TABLET	0	ACA*
VITAMIN D3 400 UNIT SOFTGEL	NC	
VITAMIN D3 400 UNIT TAB CHEW	3	
VITAMIN D3 400 UNIT TABLET	0	Not covered for members 64 and younger ACA*
VITEKTA 150 MG TABLET	3	
VITEKTA 85 MG TABLET	3	
VITUZ SOLUTION	3	
VIVACTIL 10 MG TABLET	NC	
VIVACTIL 5 MG TABLET	NC	
VIVELLE-DOT 0.025 MG PATCH	NC	
VIVELLE-DOT 0.0375 MG PATCH	NC	
VIVELLE-DOT 0.05 MG PATCH	NC	
VIVELLE-DOT 0.075 MG PATCH	NC	
VIVELLE-DOT 0.1 MG PATCH	NC	
VIVITROL 380 MG VIAL + DILUENT	MD	SPP*: Must use CVS Specialty
VIVLODEX 10 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
VIVLODEX 5 MG CAPSULE	3	Prior Authorization required;Max. 1 per day
VIVOTIF EC CAPSULE	3	
VOCAL POINT TEST STRIP	3	Prior Authorization required;Max. 204 per 30 days HSA*
VOGELXO 12.5 MG/1.25 GRAM PUMP	NC	
VOGELXO 50 MG/5 GRAM GEL	NC	
VOL-CARE RX TABLET	1	
VOLTAREN 1% GEL	NC	
VOLTAREN-XR 100 MG TABLET	NC	
VONVENDI 1,300 UNIT VIAL	MD	SPP*: Must use CVS Specialty
VORICONAZOLE 200 MG TABLET	1	
VORICONAZOLE 40 MG/ML SUSP	1	
VORICONAZOLE 50 MG TABLET	1	
VORTEX ADULT MASK	MD	
VORTEX FROG CHILD MASK	MD	
VORTEX HOLDING CHAMBER	MD	
VORTEX LADYBUG TODDLER MASK	MD	
VORTEX VHC FROG CHILD MASK	MD	
VOSEVI 400-100-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
VOSOL HC EAR DROPS	NC	
VOSPIRE ER 4 MG TABLET	NC	
VOSPIRE ER 8 MG TABLET	NC	
VOTRIENT 200 MG TABLET	3	CH*; SPP*: CVS Specialty
VP-VITE RX TABLET	1	
VRAYLAR 1.5 MG CAPSULE	3	Max. 1 per day;Step Therapy required

DRUG NAME	TIER	LIMITATIONS/ * NOTES
VRAYLAR 1.5 MG-3 MG PACK	3	Max. 1 per day;Step Therapy required
VRAYLAR 3 MG CAPSULE	3	Max. 1 per day;Step Therapy required
VRAYLAR 4.5 MG CAPSULE	3	Max. 1 per day;Step Therapy required
VRAYLAR 6 MG CAPSULE	3	Max. 1 per day;Step Therapy required
VUSION OINTMENT	3	
VYFEMLA 28 TABLET	0	ACA*
VYTORIN 10-10 MG TABLET	NC	
VYTORIN 10-20 MG TABLET	NC	
VYTORIN 10-40 MG TABLET	NC	
VYTORIN 10-80 MG TABLET	NC	
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

## W

WALGREENS ULTRA THIN LANCETS	2	HSA*
WARFARIN SODIUM 1 MG TABLET	1	HSA*
WARFARIN SODIUM 10 MG TABLET	1	HSA*
WARFARIN SODIUM 2 MG TABLET	1	HSA*
WARFARIN SODIUM 2.5 MG TABLET	1	HSA*
WARFARIN SODIUM 3 MG TABLET	1	HSA*
WARFARIN SODIUM 4 MG TABLET	1	HSA*
WARFARIN SODIUM 5 MG TABLET	1	HSA*
WARFARIN SODIUM 6 MG TABLET	1	HSA*
WARFARIN SODIUM 7.5 MG TABLET	1	HSA*
WATCHHALER SPACER	MD	
WATER FOR INJECTION VIAL	1	
WAVESENSE JAZZ TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
WAVESENSE PRESTO TEST STRIPS	3	Prior Authorization required;Max. 204 per 30 days HSA*
WELCHOL 3.75G PACKET	2	HSA*
WELCHOL 625 MG TABLET	2	HSA*
WELLBUTRIN 100 MG TABLET	NC	
WELLBUTRIN 75 MG TABLET	NC	
WELLBUTRIN SR 100 MG TABLET	NC	
WELLBUTRIN SR 150 MG TABLET	NC	
WELLBUTRIN SR 200 MG TABLET	NC	
WELLBUTRIN XL 150 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
WELLBUTRIN XL 300 MG TABLET	NC	
WERA 0.5/0.035 MG 28 TABLET	0	ACA*
WESTCORT 0.2% OINTMENT	NC	
WESTHROID 130 MG TABLET	1	
WESTHROID 16.25 MG TABLET	1	
WESTHROID 195 MG TABLET	1	
WESTHROID 32.5 MG TABLET	1	
WESTHROID 48.75 MG TABLET	1	
WESTHROID 65 MG TABLET	1	
WESTHROID 97.5 MG TABLET	1	
WIDE SEAL DIAPHRAGM 70MM	0	ACA*
WILATE 1,000-1,000 UNIT VIAL	MD	SPP*: Must use CVS Specialty
WINDMILL TRAINER	MD	
WP THYROID 113.75 MG TABLET	1	
WP THYROID 130 MG TABLET	1	
WP THYROID 16.25 MG TABLET	1	
WP THYROID 32.5 MG TABLET	1	
WP THYROID 48.75 MG TABLET	1	
WP THYROID 65 MG TABLET	1	
WP THYROID 81.25 MG TABLET	1	
WP THYROID 97.5 MG TABLET	1	
WYMZYA FE CHEWABLE TABLET	0	ACA*

## X

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
XELODA 500 MG TABLET	NC	
XENAZINE 12.5 MG TABLET	NC	
XENAZINE 25 MG TABLET	NC	
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
XERESE 5%-1% CREAM	NC	
XERMELO 250 MG TABLET	3	Prior Authorization required;Max. 3 per day LDD*: Diplomat Pharmacy (877) 977-9118
XGEVA 120 MG/1.7 ML VIAL	MD	Prior Authorization required;Max. 1.7 ML(s) in 28 days SPP*: Must use CVS Specialty
XIAFLEX 0.9 MG VIAL	MD	
XIFAXAN 200 MG TABLET	3	Max. quantity of 9 per fill MQC*: 9 tabs/copay
XIFAXAN 550 MG TABLET	2	
XIGDUO XR 10 MG-1,000 MG TAB	3	HSA*
XIGDUO XR 10 MG-500 MG TABLET	3	HSA*
XIGDUO XR 5 MG-1,000 MG TABLET	3	HSA*
XIGDUO XR 5 MG-500 MG TABLET	3	HSA*
XIIDRA 5% EYE DROPS	2	Max. 2 per day
XODOL 10-300 TABLET	NC	
XODOL 5-300 TABLET	NC	
XODOL 7.5-300 MG TABLET	NC	
XOLAIR 150 MG VIAL	MD	Prior Authorization required SPP*: Must use CVS Specialty
XOLEGEL 2% GEL	NC	
XOLOX 10-500 MG TABLET	NC	
XOPENEX 0.31 MG/3 ML SOLUTION	NC	
XOPENEX 0.63 MG/3 ML SOLUTION	NC	
XOPENEX 1.25 MG/3 ML SOLUTION	NC	
XOPENEX CONC 1.25 MG/0.5 ML	NC	
XOPENEX HFA 45 MCG INHALER	NC	
XRYLIX 1.5% KIT	3	
XTAMPZA ER 13.5 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 18 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 27 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 36 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTAMPZA ER 9 MG CAPSULE	3	Prior Authorization required;Max. 2 per day
XTANDI 40 MG CAPSULE	2	CH*; SPP*: CVS Specialty
XULANE PATCH	0	ACA*
XULTOPHY 100 UNIT-3.6MG/ML PEN	3	Prior Authorization required HSA*
XURIDEN GRANULE PACKET	3	
XYLON 10-200 MG TABLET	1	
XYNTHA 500 UNIT KIT	MD	SPP*: Must use CVS Specialty
XYNTHA SOLOFUSE 1,000 UNIT KIT	MD	SPP*: Must use CVS Specialty
XYREM 500 MG/ML ORAL SOLUTION	3	Prior Authorization required LDD*: Express Scripts. 866-997-3688 x66247.
XYZAL 2.5 MG/5 ML SOLUTION	NC	
XYZAL 5 MG TABLET	NC	

## Y



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

## Z

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

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZEGERID 40 MG PACKET	NC	
ZEJULA 100 MG CAPSULE	3	Prior Authorization required;Max. 3 per day CH*; PA NTM*; LDD*: Diplomat Pharmacy (877) 977-9118
ZELAPAR 1.25 MG ODT TABLET	NC	
ZELBORAF 240 MG TABLET	3	CH*; SPP*: CVS Specialty
ZEMAIRA 1,000 MG VIAL	MD	Prior Authorization required LDD*: Accredo (866) 815-4717
ZEMBRACE SYMTOUCH 3 MG/0.5 ML	3	Prior Authorization required;Max. quantity of 2 per fill MQC*: 4 injections/copay
ZEMPLAR 1 MCG CAPSULE	NC	
ZEMPLAR 2 MCG CAPSULE	NC	
ZEMPLAR 4 MCG CAPSULE	NC	
ZENATANE 10 MG CAPSULE	1	
ZENATANE 20 MG CAPSULE	1	
ZENATANE 30 MG CAPSULE	1	
ZENATANE 40 MG CAPSULE	1	
ZENCHENT 0.4 MG-35 MCG TABLET	0	ACA*
ZENCHENT FE TABLET CHEWABLE	0	ACA*
ZENPEP DR 10,000 UNITS CAPSULE	2	
ZENPEP DR 15,000 UNITS CAPSULE	2	
ZENPEP DR 20,000 UNITS CAPSULE	2	
ZENPEP DR 25,000 UNITS CAPSULE	2	
ZENPEP DR 3,000 UNITS CAPSULE	2	
ZENPEP DR 40,000 UNITS CAPSULE	2	
ZENPEP DR 5,000 UNITS CAPSULE	2	
ZENZEDI 10 MG TABLET	1	Max. 60 Days Supply
ZENZEDI 15 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 2.5 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 20 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 30 MG TABLET	3	Max. 60 Days Supply
ZENZEDI 5 MG TABLET	1	Max. 60 Days Supply
ZENZEDI 7.5 MG TABLET	3	Max. 60 Days Supply
ZEOSA CHEWABLE TABLET	0	ACA*
ZEPATIER 50-100 MG TABLET	2	Prior Authorization required;Max. 28 per 28 days SPP*: Must use CVS Specialty
ZERIT 1 MG/ML SOLUTION	3	
ZERIT 15 MG CAPSULE	NC	
ZERIT 20 MG CAPSULE	NC	
ZERIT 30 MG CAPSULE	NC	
ZERIT 40 MG CAPSULE	NC	
ZESTORETIC 10-12.5 MG TABLET	NC	
ZESTORETIC 20-12.5 MG TABLET	NC	
ZESTORETIC 20-25 MG TABLET	NC	
ZESTRIL 10 MG TABLET	NC	
ZESTRIL 2.5 MG TABLET	NC	
ZESTRIL 20 MG TABLET	NC	
ZESTRIL 30 MG TABLET	NC	
ZESTRIL 40 MG TABLET	NC	
ZESTRIL 5 MG TABLET	NC	
ZETIA 10 MG TABLET	NC	
ZETONNA 37 MCG NASAL SPRAY	NC	
ZFLEX TABLET	1	
ZGESIC TABLET	3	
ZIAC 10-6.25 MG TABLET	NC	
ZIAC 2.5-6.25 MG TABLET	NC	
ZIAC 5-6.25 MG TABLET	NC	
ZIAGEN 20 MG/ML SOLUTION	3	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZIAGEN 300 MG TABLET	NC	
ZIANA GEL	NC	
ZIDOVUDINE 100 MG CAPSULE	1	
ZIDOVUDINE 300 MG TABLET	1	
ZIDOVUDINE 50 MG/5 ML SYRUP	1	
ZILEUTON ER 600 MG TABLET	2	
ZINBRYTA 150 MG/ML SYRINGE	3	HSA* Prior Authorization required;Max. 1 ML(s) in 30 days SPP*: Must use CVS Specialty
ZINC SULFATE 220 MG CAPSULE	1	
ZIOPTAN 0.0015% EYE DROPS	3	
ZIPRASIDONE HCL 20 MG CAPSULE	1	
ZIPRASIDONE HCL 40 MG CAPSULE	1	
ZIPRASIDONE HCL 60 MG CAPSULE	1	
ZIPRASIDONE HCL 80 MG CAPSULE	1	
ZIPSOR 25 MG CAPSULE	3	
ZIRGAN 0.15% OPHTHALMIC GEL	3	
ZITHROMAX 1 GM POWDER PACKET	NC	
ZITHROMAX 100 MG/5 ML SUSP	NC	
ZITHROMAX 200 MG/5 ML SUSP	NC	
ZITHROMAX 250 MG TABLET	NC	
ZITHROMAX 250 MG Z-PAK TABLET	NC	
ZITHROMAX 500 MG TABLET	NC	
ZITHROMAX 600 MG TABLET	NC	
ZITHROMAX TRI-PAK 500 MG TAB	NC	
ZMAX 2 G/60 ML ORAL SUSPENSION	3	
ZOCOR 10 MG TABLET	NC	
ZOCOR 20 MG TABLET	NC	
ZOCOR 40 MG TABLET	NC	
ZOCOR 5 MG TABLET	NC	
ZOCOR 80 MG TABLET	NC	
ZODEX 12 DAY 1.5 MG TABLET	3	Prior Authorization required PA NTM*
ZODEX 6 DAY 1.5 MG TABLET	3	Prior Authorization required PA NTM*
ZODRYL AC 25 SUSPENSION	3	
ZODRYL AC 30 SUSPENSION	3	
ZODRYL AC 35 SUSPENSION	3	
ZODRYL AC 40 SUSPENSION	3	
ZODRYL AC 50 SUSPENSION	3	
ZODRYL AC 60 SUSPENSION	3	
ZODRYL AC 80 SUSPENSION	3	
ZODRYL DAC 25 SUSPENSION	3	
ZODRYL DAC 30 SUSPENSION	3	
ZODRYL DAC 35 SUSPENSION	3	
ZODRYL DAC 40 SUSPENSION	3	
ZODRYL DAC 50 SUSPENSION	3	
ZODRYL DAC 60 SUSPENSION	3	
ZODRYL DAC 80 SUSPENSION	3	
ZODRYL DEC 25 SUSPENSION	3	
ZODRYL DEC 30 SUSPENSION	3	
ZODRYL DEC 35 SUSPENSION	3	
ZODRYL DEC 40 SUSPENSION	3	
ZODRYL DEC 50 SUSPENSION	3	
ZODRYL DEC 60 SUSPENSION	3	
ZODRYL DEC 80 SUSPENSION	3	
ZOFRAN 4 MG TABLET	NC	
ZOFRAN 4 MG/5 ML ORAL SOLN	NC	
ZOFRAN 8 MG TABLET	NC	
ZOFRAN ODT 4 MG TABLET	NC	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZOFRAN ODT 8 MG TABLET	NC	
ZOHYDRO ER 10 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 15 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 20 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 30 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 40 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOHYDRO ER 50 MG CAPSULE	3	Max. 30 Days Supply;Prior Authorization required;Max. 2 per day
ZOLEDRONIC ACID 5 MG/100 ML	MD	Prior Authorization required;Max. 100 ML(s) in 365 days SPP*: Must use CVS Specialty
ZOLINZA 100 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ZOLMITRIPTAN 2.5 MG ODT	1	Max. quantity of 12 per fill MQC*: 12 tabs/copay
ZOLMITRIPTAN 2.5 MG TABLET	1	Max. quantity of 12 per fill MQC*: 12 tabs/copay
ZOLMITRIPTAN 5 MG ODT	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ZOLMITRIPTAN 5 MG TABLET	1	Max. quantity of 6 per fill MQC*: 6 tabs/copay
ZOLOFT 100 MG TABLET	NC	
ZOLOFT 20 MG/ML ORAL CONC	NC	
ZOLOFT 25 MG TABLET	NC	
ZOLOFT 50 MG TABLET	NC	
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
ZOLVIT 10 MG-300 MG/15 ML SOLN	1	
ZOMACTON 10 MG VIAL	NC	
ZOMACTON 5 MG VIAL	NC	
ZOMIG 2.5 MG NASAL SPRAY	3	Max. quantity of 12 per fill MQC*: 6 sprays/copay
ZOMIG 2.5 MG TABLET	NC	
ZOMIG 5 MG NASAL SPRAY	3	Max. quantity of 6 per fill MQC*: 6 sprays/copay
ZOMIG 5 MG TABLET	NC	
ZOMIG ZMT 2.5 MG TABLET	NC	
ZOMIG ZMT 5 MG TABLET	NC	
ZONACORT 11 DAY 1.5 MG TABLET	NC	
ZONACORT 7 DAY 1.5 MG TABLET	NC	
ZONALON 5% CREAM	NC	
ZONATUSS 150 MG CAPSULE	NC	
ZONEGRAN 100 MG CAPSULE	3	
ZONEGRAN 25 MG CAPSULE	3	
ZONISAMIDE 100 MG CAPSULE	1	
ZONISAMIDE 25 MG CAPSULE	1	
ZONISAMIDE 50 MG CAPSULE	1	
ZONTIVITY 2.08 MG TABLET	3	HSA*
ZORBTIVE 8.8 MG VIAL	3	Prior Authorization required SPP*: Must use CVS Specialty
ZORTRESS 0.25 MG TABLET	3	
ZORTRESS 0.5 MG TABLET	3	
ZORTRESS 0.75 MG TABLET	3	
ZORVOLEX 18 MG CAPSULE	2	

DRUG NAME	TIER	LIMITATIONS/ * NOTES
ZORVOLEX 35 MG CAPSULE	3	
ZOSTAVAX VIAL	0	Not covered for members 49 and younger ACA*, SPP*: CVS/Specialty, Covered ages 50 and older
ZOVIA 1-35E TABLET	0	ACA*
ZOVIA 1-50E TABLET	0	ACA*
ZOVIRAX 200 MG CAPSULE	NC	
ZOVIRAX 200 MG/5 ML SUSP	NC	
ZOVIRAX 400 MG TABLET	NC	
ZOVIRAX 5% CREAM	3	Max. 5 GM(s) in 30 days
ZOVIRAX 5% OINTMENT	NC	
ZOVIRAX 800 MG TABLET	NC	
ZUBSOLV 0.7-0.18 MG TABLET SL	3	
ZUBSOLV 1.4-0.36 MG TABLET SL	3	
ZUBSOLV 11.4-2.9 MG TABLET SL	3	
ZUBSOLV 2.9-0.71 MG TABLET SL	3	
ZUBSOLV 5.7-1.4 MG TABLET SL	3	
ZUBSOLV 8.6-2.1 MG TABLET SL	3	
ZUPLENZ 4 MG SOLUBLE FILM	3	Max. quantity of 18 per fill MQC*: 18 films/copay
ZUPLENZ 8 MG SOLUBLE FILM	3	Max. quantity of 9 per fill MQC*: 9 films/copay
ZURAMPIC 200 MG TABLET	3	Prior Authorization required;Max. 1 per day
ZUTRIPRO SOLUTION	NC	
ZYBAN SR 150 MG TABLET	NC	
ZYCLARA 2.5% CREAM PUMP	3	
ZYCLARA 3.75% CREAM PUMP	3	
ZYDELIG 100 MG TABLET	3	CH*; LDD*: Onco360 Pharmacy 1-877-662-6633
ZYDELIG 150 MG TABLET	3	CH*; LDD*: Onco360 Pharmacy 1-877-662-6633
ZYDONE 10-400 MG TABLET	3	
ZYDONE 5-400 MG TABLET	3	
ZYDONE 7.5-400 MG TABLET	3	
ZYFLO 600 MG FILMTAB	3	HSA*
ZYFLO CR 600 MG TABLET	NC	
ZYKADIA 150 MG CAPSULE	3	CH*; SPP*: CVS Specialty
ZYLET EYE DROPS	2	
ZYLOPRIM 100 MG TABLET	NC	
ZYLOPRIM 300 MG TABLET	NC	
ZYMAXID 0.5% EYE DROPS	NC	
ZYPREXA 10 MG TABLET	NC	
ZYPREXA 10 MG VIAL	MD	SPP*: Must use CVS Specialty
ZYPREXA 15 MG TABLET	NC	
ZYPREXA 2.5 MG TABLET	NC	
ZYPREXA 20 MG TABLET	NC	
ZYPREXA 5 MG TABLET	NC	
ZYPREXA 7.5 MG TABLET	NC	
ZYPREXA ZYDIS 10 MG TABLET	NC	
ZYPREXA ZYDIS 15 MG TABLET	NC	
ZYPREXA ZYDIS 20 MG TABLET	NC	
ZYPREXA ZYDIS 5 MG TABLET	NC	
ZYTIGA 250 MG TABLET	2	CH*; SPP*: CVS Specialty
ZYTIGA 500 MG TABLET	2	CH*; SPP*: CVS Specialty
ZYVOX 100 MG/5 ML SUSPENSION	NC	
ZYVOX 600 MG TABLET	NC	

## Glossary of Notes \*

### Keyword Description

<b>HSA</b>	<b>HSA Preventive Drug.</b> 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.
<b>ACA</b>	<b>Affordable Care Act.</b> 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.
<b>CH</b>	<b>Oral Chemotherapy Mandate.</b> This includes oral chemotherapy (anti-cancer) medications used to treat cancer. These drugs may be eligible for a \$0 copayment under certain benefit plans.
<b>SPP</b>	<b>Specialty Pharmacy Medications.</b> 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.
<b>IVF</b>	<b>IVF/Fertility Pharmacy Medications.</b> These medications must be obtained from one of our designated IVF Pharmacy vendors - Freedom Drug (877)585-4603 or Village Pharmacy (866)890-8930.
<b>LDD</b>	<b>Limited Distribution Drug.</b> 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.
<b>PAQ</b>	<b>Prior Authorization for Quantity Limit Exceeded.</b> Some medications require Prior Authorization only when the quantity requested for treatment exceeds the standard quantity limit.
<b>MQC</b>	<b>Maximum Quantity per Copay.</b> 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.
<b>STA</b>	<b>Step Therapy/Age.</b> 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.
<b>PA NTM</b>	<b>Prior Authorization for New-to-Market Drugs.</b> 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.