Harvard Pilgrim Prescription Drug List

PREMIUM FORMULARY
FOUR-TIER DRUG LIST
BY CATEGORY

LAST UPDATED : 08/28/2015

This list is subject to change at any time.

Harvard Pilgrim Health Care

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 4-Tier Prescription Drug Program

Covered medications are categorized in one of the four 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 four-tier prescription drug list

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

1. Under "Drug," look up the name of your medication.
2. Once you find the medication, check the tier number to the right of the drug name.
   - Tier 1 ($), our lowest copayment tier, consists of low-cost generics. You pay just $5 for any prescription drug in Tier 1. Tier 1 drugs contain the same active ingredients as their brand-name counterparts.
   - Tier 2 ($$) consists primarily of higher-cost generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 2 may also include brand-name drugs that Harvard Pilgrim has determined to be more effective, less costly or to have fewer side effects than similar medications.
   - Tier 3 ($$$) consists mostly 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 3 may include generic drugs determined to be more costly than their brand-name alternatives.
   - Tier 4 ($$$$) consists of drugs that the plan has not included in Tier 1, Tier 2 or Tier 3.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
ANALGESICS			
Opiate Agonists			
Abstral	4	Max.120 tabs/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.. Prior authorization required.
acetaminophen/codeine	1		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
acetaminophen/codeine 300mg-60mg	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
acetaminophen/tramadol	2		
Actiq	4	Max. 120 lozenges/30 days.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.. Prior authorization required.
Avinza	4	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
butorphanol	2		
Butrans	3	Max. 4 patches/28-day supply	* Mail Service: Max. 30-day supply as required by State or Federal law, or benefit plan design.
codeine sulfate	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Conzip	4		
Demerol	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
dihydrocodeine/acetaminophen/ caffeine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
dihydrocodeine/aspirin/caffeine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Dilaudid	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Dolophine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Duragesic	4	Max 15 patches/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Embeda	4	Max. 3 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Endocet	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Endocet 5mg-325mg	1		
Endocet 7.5mg-325mg	1		
Exalgo	4	Max. 60 tabs/30 day-supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
fentanyl	2	Max. 15 patches/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
fentanyl citrate (lozenge)	2	Max. 120 lozenges/30-day supply.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Prior authorization required.
Fentora	4	Max. 120 lozenges/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			design.. Prior authorization required.
Hycet	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydrocodone/acetaminophen	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydrocodone/acetaminophen 5mg-500mg	1		
hydrocodone/acetaminophen 7.5mg-650mg	2		
hydrocodone/acetaminophen 7.5mg-750mg	1		
hydrocodone/acetaminophen oral solution	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydromorphone	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydromorphone (liquid)	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydromorphone tab ER 24H	2	Max. 60 tabs/30- day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Hysingla ER 20mg, 30mg	4	Max: 60 tabs/30 day-supply.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Prior authorization required.
Hysingla ER 40mg, 60mg, 80mg, 100mg, 120mg	4	Max: 30 tabs/30 day-supply.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Prior authorization required
Kadian 10mg, 20mg, 30mg, 50mg, 60mg, 80mg, 100mg	4	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
Kadian 40mg, 70mg, 130mg, 150mg, 200mg	3	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Lazanda	4	Max. 15 bottles/30-day supply Effective 1/1/15, Prior authorization required.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
levorphanol	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Lortab	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
meperidine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
methadone	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
morphine SR	2	Max. 3 tabs/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
morphine sulfate	2	Max. 3 tabs/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
morphine sulfate (Roxane) 15mg, 30mg	3	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
morphine sulfate cap ER 10mg, 20mg, 30mg, 50mg, 60mg, 80mg, 100mg	2	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
morphine sulfate ER	2	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
MS Contin	4	Max. 3 tabs/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
MSIR	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Norco	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Nucynta	3		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Nucynta ER	3	Max. 60 tabs/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Opana	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Opana ER	4	Max. 90 tabs/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
opium tincture	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Oxecta	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone hcl er	2	Max. 4 tabs/day (inclusive of all strengths)	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone/acetaminophen	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone/acetaminophen 5mg-325mg	1		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone/aspirin	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
oxycodone/ibuprofen	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Oxycontin	3	Max. 4 tabs/day (inclusive of all strengths)	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxymorphone	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxymorphone tab ER 12h	2	Max. 90 tabs/30 day-supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
pentazocine/acetaminophen	2		
pentazocine/naloxone	2		
Percocet	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Percodan	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Reprexain	2		* Not available through Mail Service. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Roxicet	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Roxicet 5mg-325mg	1		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Roxicodone	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Subsys	4	Max. 120 sprays/30-day supply Effective 1/1/15, Prior authorization required.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
Synalgos-DC	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
tramadol	2		
tramadol ER	2		
tramadol hcl er	2		
Trezix	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tylenol with Codeine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Ultracet	4		
Ultram	4		
Ultram ER	4		
Vicodin	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vicodin ES	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vicodin HP	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vicoprofen	NC		* This drug is not covered. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Xartemis XR	4	Effective 4/15/15: Max. 4 tabs/day	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Xodol	4		
Zamicet	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Zohydro ER	4	Max. 60 tabs/30-day supply	* Mail Service: Max. 30-day supply as required by state

DRUG NAME	TIER	LIMITATIONS	NOTES
			& federal law or benefit plan design.. Prior authorization required.
ANTI-EMETICS			
5HT-3 Antagonists			
Anzemet	4	50mg: Max. 6 tabs/copay; 100mg: Max. 3 tabs/copay	* Not available through Mail Service.
granisetron	2	Max. 6 tabs/copay	* Not available through Mail Service.
Granisol	2	Max. 30mL/copay	* Not available through Mail Service.
ondansetron	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay; 4mg/5mL: Max. 100mL (2 bottles)/copay	* Not available through Mail Service.
ondansetron ODT	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Not available through Mail Service.
Sancuso	4	4 patches/copay	* Not available through Mail Service.
Zofran	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay, 4mg/5mL: Max. 100mL (2 bottles)/copay	* Not available through Mail Service.
Zofran ODT	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Not available through Mail Service.
Zuplenz	4	4mg: Max. 18 films/copay; 8mg: Max. 9 films/copay	* Not available through Mail Service.
Anti-Emetics, Fixed-Dose Combination			
Akynzeo	4	Max. 1 cap/copay, Max. 3 caps/28 day-supply	* Not available through Mail Service.
Anti-Emetics, Other			
Cesamet	4	Max. 18 tabs/copay	* Not available through Mail Service. * Max. 30-day supply as

DRUG NAME	TIER	LIMITATIONS	NOTES
			required by state & federal law or benefit plan design.
Compazine	4		
Diclegis	4		
dronabinol	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Marinol	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
prochlorperazine	1		
prochlorperazine (suppository)	2		
promethazine	2		
Transderm-Scop	3	Max. 1 box (4 patches)/ copay	* Not available through Mail Service.
NK1 Receptor Antagonists			
Emend	4	40mg: Max. 4 caps/copay, 80mg: Max. 2 caps/copay, 125mg: Max. 1 cap/copay, Tri-Pack: Max. 1 pack/copay	* Not available through Mail Service.
ANTI-INFLAMMATORY AGENTS			
Antirheumatic Agents			
Arava	4		
hydroxychloroquine	2		
Kineret	4		* Prior authorization required. Sole Source Pharmacy: Omnicare/RX Crossroads, 866-547-0644
leflunomide	2		
Plaquenil	4		
Ridaura	4		
Non-Steroidal Anti-Inflammatory Drugs (NSAID)			
Anaprox	4		
Anaprox DS	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Arthrotec	4		
Cambia	4		
Cataflam	4		
Celebrex	4		
celecoxib	2		
Clinoril	4		
Daypro	4		
diclofenac	2		
diclofenac sodium drops	2		
diflunisal	2		
Duexis	4		* Effective 10/1/15: Prior authorization required.
EC-Naprosyn	4		
etodolac	2		
Feldene	4		
Flector	3		
flurbiprofen	2		
ibuprofen	2		
ibuprofen 100mg/5mL (suspension)	2		
Indocin	4		
Indocin Rectal Suppository	3		
indomethacin	2		
KETOPROFEN	2		
ketoprofen 50mg caps	1		
ketorolac, oral	2	Max. 5-days supply / 20 tabs per fill	* Not available through Mail Service.
meclofenamate	2		
mefenamic acid	2		
meloxicam	1		
misoprostol/diclofenac	2		
Mobic	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Motrin	4		
nabumetone	2		
Nalfon	4		
Naprelan	4		
Naprosyn	4		
naproxen	1		
naproxen 550mg	2		
NAPROXEN SODIUM	2		
NAPROXEN SODIUM 275 MG TAB	1		
naproxen sodium cr	2		
oxaprozin	2		
Pennsaid	4		
piroxicam	2		
Ponstel	4		
salsalate	2		
Sprix	4	Max. 5 bottles/fill	* Not available through Mail Service.
Sulfamylon	4		
sulindac	2		
Tivorbex	4		
tolmetin	2		
Vimovo	4		* Effective 10/1/15: Prior authorization required.
Voltaren	4		
Voltaren Gel	4		
Voltaren XR	4		
Zipsor	4		
Zorvolex	3		

ANTIBACTERIALS

Antibacterials, Other

DRUG NAME	TIER	LIMITATIONS	NOTES
Cayston	4		* Not available through Mail Service.
Cleocin	4		
clindamycin	2		
Dapsone	2		
Flagyl	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Flagyl ER	4		
Furadantin	4		
Hiprex	4		
linezolid	2		* Prior authorization required.
Lithostat	4		
Macrobid	4		
Macrodantin	4		
Macrodantin 25mg	3		
methenamine hippurate	2		
metronidazole	2		
metronidazole 250mg & 500mg (tablet)	1		
Monurol	4		
Nebupent	4		
neomycin sulfate	2		
nitrofurantoin	2		
nitrofurantoin, macro	2		
Primsol	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Sivextro	4	Max. 6 tabs/copay	* Not available through Mail Service. *
trimethoprim	2		
Vancocin	4		
vancomycin	2		
Vandazole	4		
Xifaxan 200mg	4	Max. 9 tabs/copay	* Not available through Mail Service.
Xifaxan 550mg	3		
Zyvox	4		* Prior authorization required
Cephalosporins			
Cedax (capsule)	4		
Cedax (suspension)	4		
cefaclor	2		
cefadroxil	2		
cefdinir	2		
cefditoren pivoxil	2		
cefixime	2		
cefpodoxime	2		
cefprozil	2		
ceftibuten	2		
Ceftin (suspension)	4		
Ceftin (tablet)	4		
cefuroxime axetil	2		
cephalexin	2		
Keflex	4		
Spectracef	4		
Suprax	4		
Macrolides			
azithromycin	2		
Biaxin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Biaxin XL	4		
clarithromycin	2		
Dificid	4	Max. 20 tabs/copay	* Not available through Mail Service.
Ery-Tab	2		
Ery-Tab 333mg	3		
Eryped	3		
erythromycin base, filmtab	2		
erythromycin ethylsuccinate	2		
erythromycin ethylsuccinate 200mg suspension	2		
erythromycin ethylsuccinate/ sulfisoxazole	2		
Ketek	4		
PCE	4		
Zithromax Tabs/Susp/Tri-Pack/Z-Pack	4		

Penicillins

amoxicillin	2		
amoxicillin (chewable)	2		
amoxicillin 200mg/5mL (suspension)	2		
amoxicillin 500mg (tablet)	2		
amoxicillin trihydrate ER	2		
amoxicillin trihydrate/clavulanic acid ES 600mg (suspension)	2		
amoxicillin trihydrate/clavulanic acid suspension	2		
amoxicillin trihydrate/clavulanic acid tabs	2		
amoxicillin trihydrate/clavulanic acid tabs XR	2		
ampicillin	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Augmentin (suspension)	4		
Augmentin (tablets)	4		
Augmentin 125-31.25mg (suspension)	3		
Augmentin ES 600mg (suspension)	4		
Augmentin XR	4		
dicloxacillin sodium	2		
Moxatag	4		
penicillin v potassium	1		
Trimox 250mg (capsule)	1		
Trimox 250mg/mL (suspension)	1		

Quinolones

Avelox	4		
Cipro	4		
Cipro XR	4		
ciprofloxacin 100mg (tablet)	2		
ciprofloxacin 250mg, 500mg, 750mg (tablets)	1		
ciprofloxacin ER	2		
Factive	4		
Levaquin	4		
levofloxacin	2		
LEVOFLOXACIN 250mg, 500mg	1		
moxifloxacin	2		
Noroxin	4		

Sulfonamides

Bactrim	4		
Bactrim DS	4		
Septra	4		
Septra DS	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
trimethoprim/sulfamethoxazole	1		
trimethoprim/sulfamethoxazole DS	1		
Tetracyclines			
Acticlate	4		
Adoxa	4		
Benoxyldoxy	4		
demeclocycline	2		
Doryx	4		
doxycycline hyclate	2		
doxycycline hyclate 20mg & 75mg	2		
doxycycline hyclate 50mg & 100mg	2		
doxycycline monohydrate	2		
doxycycline monohydrate 40mg	2		
Dynacin	4		
Minocin	4		
minocycline	2		
Monodox	4		
Ocudox	4		
Oracea	4		
Periostat	4		
Solodyn	4		* Prior authorization required
tetracycline	1		
Vibramycin (tablet)	4		
Vibramycin Oral Suspension	4		
Vibramycin Syrup	4		
ANTICONVULSANTS			
Anticonvulsants, Other			
Fycompa	4		
Keppra	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Keppra XR	4		
levetiracetam	2		
levetiracetam XR	2		
Onfi	3	Prior authorization required for members 18 and older	
Potiga	4		
Sabril	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Vimpat	3		
Calcium Channel Modifying Agents			
Celontin	3		
ethosuximide	2		
Lyrica	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Zarontin	4		
Zonegran	4		
zonisamide	2		
GABA Augmenting Agents			
Depakene	4		
Depakote	4		
Depakote ER	4		
Depakote Sprinkle	4		
divalproex sodium	2		
divalproex sodium 125mg (sprinkle)	2		
divalproex sodium ER	2		
gabapentin	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Gabitril	4		
Gralise	4		
Neurontin	4		
Stavzor	4		
tiagabine	2		
valproic acid	2		

Glutamate Reducing Agents

felbamate	2		
Felbatol	4		
Lamictal	4		
Lamictal ODT	4		
Lamictal Starter Kit	3		
Lamictal Starter Kit 25mg	4		
Lamictal XR	4		
lamotrigine	1		
lamotrigine ODT	2		
lamotrigine starter kit 25mg	2		
lamotrigine tab er 24	2		
Qudexy XR	4		
Topamax	4		
topiramate	2		
topiramate ER	2		
Trokendi XR	4		

Sodium Channel Inhibitors

Aptiom	4		
Banzel	3		
carbamazepine	2		
carbamazepine ER	2		
Carbatrol	4		
Dilantin	4		
Dilantin Infatab	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Equetro	4		
oxcarbazepine	2		
oxcarbazepine suspension	2		
Oxtellar XR	4		
Peganone	4		
Phenytek	4		
phenytoin	2		
phenytoin sodium ER	2		
phenytoin tab chew	2		
Tegretol	4		
Tegretol XR	4		
Trileptal	4		
Trileptal Suspension	4		
ANTIDEMENTIA			
Antidementia Agents, Other			
Ergoloid	2		
Namzaric	4		
Cholinesterase Inhibitors			
Aricept	4		
Aricept ODT	4		
donepezil	2		
donepezil ODT	2		
Exelon	4		
Exelon Patch	3		
galantamine	2		
galantamine ER	2		
Razadyne	4		
Razadyne ER	4		
rivastigmine	2		
Glutamate Pathway Modifiers			

DRUG NAME	TIER	LIMITATIONS	NOTES
memantine	2		
Namenda	4		
Namenda XR	4		
ANTIDEPRESSANTS			
Antidepressants, Other			
Aplenzin	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
budeprion SR	2		
budeprion XL	2		
bupropion	2		
bupropion SR	2		
bupropion XL	2		
Forfivo XL	3		
maprotiline	2		
mirtazapine	2		
mirtazapine 15mg	1		
nefazodone	2		
olanzapine/fluoxetine	2		
Oleptro ER	4		
Remeron	4		
Symbyax	4		
trazodone	1		
trazodone 150mg & 300mg	2		
Viibryd	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Wellbutrin	4		* Step Therapy: First level drug treatment required before

DRUG NAME	TIER	LIMITATIONS	NOTES
			coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Wellbutrin SR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Wellbutrin XL	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over
Monoamine Oxidase Inhibitors			
EMSAM	4		
Marplan	4		
Nardil	4		
Parnate	4		
phenelzine	2		
tranylcypromine	2		
Serotonin/Norepinephrine Reuptake Inhibitors			
Brintellix	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Celexa	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
citalopram hydrobromide tabs	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cymbalta	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
desvenlafaxine ER	2		
desvenlafaxine ER	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
desvenlafaxine fumarate ER	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy for members 18 years and over.
duloxetine	2		
duloxetine hcl 40mg	2		
Effexor XR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
escitalopram	2		
Fetzima	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
fluoxetine	1		
fluoxetine (oral solution)	2		
fluoxetine 20mg (tablet)	2		
fluoxetine 40mg (capsule)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Fluoxetine 60mg tabs	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
fluoxetine 90mg (weekly)	2		
fluvoxamine	2		
fluvoxamine er 24h	2		
Irenka	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Khedezla	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Lexapro	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Luvox CR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
paroxetine	2		
Paxil	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Paxil (liquid)	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Paxil CR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Paxil CR 37.5mg	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Pexeva	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Pristiq	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Prozac	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Prozac Weekly	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Sarafem	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			is required. * Step Therapy: For members 18 and over.
Savella	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
sertraline	1		
venlafaxine (tablet)	2		
venlafaxine ER (capsules)	2		
venlafaxine ER (tablets)	2		
Venlafaxine ER (tablets) (Brand)	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Venlafaxine ER (tablets) 225mg	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Zoloft	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.

Tricyclics

amitriptyline	1		
Anafranil	4		
clomipramine	2		
desipramine	2		
doxepin	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
doxepin 10mg/mL (oral concentrate)	2		
doxepin 150mg (capsule)	2		
imipramine	2		
imipramine pamoate	2		
Norpramin	4		
nortriptyline	2		
Pamelor	4		
protriptyline	2		
Surmontil	4		
Tofranil	4		
Tofranil PM	4		
Vivactil	4		
ANTIDOTES, DETERRENTS AND TOXICOLOGIC AGENTS			
Antidotes			
Adrenaclick	4	Max. 2 units/copay	* Not available through Mail Service.
Auvi-Q	4	Max. 2 units/copay	* Not available through Mail Service.
Chemet	3		
Epipen	3	Max. 2 units/copay	* Not available through Mail Service.
Epipen Jr.	3	Max. 2 units/copay	* Not available through Mail Service.
Evzio	4	Max. 2 units/copay; Max.4 units/30-day supply	* Not available through Mail Service.
Exjade	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Ferriprox	4		* Not available through Mail Service. * Sole source through Centric Health.
Jadenu	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Kayexalate	4		
leucovorin	2		
Mesnex	4		
sodium polystyrene sulfonate	2		
sodium polystyrene sulfonate enema	2		
SPS Rectal Enema	4		
Deterrents			
acamprosate calcium	2		
Antabuse	4		
Bunavail	4	2.1mg/0.3mg, 4.2mg/0.7mg: Max. 90 doses/30-day supply; 6.3mg/1mg: Max: 60 doses/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
buprenorphine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
buprenorphine/naloxone	2		* Max. 30-day supply as required by state & federal law or benefit plan design
Campral calcium	4		
disulfiram	2		
naltrexone	2		
Revia	4		
Suboxone Film	3		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Subutex	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vivitrol	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through mail service.
Zubsolv	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Smoking Cessation			
Buproban	2	Annual Limit: Max. 360 tabs/180 days.	* Not available through Mail Service.
bupropion, smoking cessation	2	Annual Limit: Max. 360 tabs/180-day supply	* Not available through Mail Service.
Chantix	3	Annual limit of 26 weeks	* Not available through Mail Service.
Nicotrol Inhaler	4	Max. 168 units/fill; Limit 180-day supply per year	* Not available through Mail Service.
Nicotrol NS	4	Max. 4 units/fill; Limit 180 day-supply per year	* Not available through Mail Service.
Zyban	4	Max. 60 tabs/fill; Max 360 tabs/year	* Not available through Mail Service.
ANTIFUNGALS			
Antifungals - Oral			
Ancobon	4		
clotrimazole (troche)	2		
Cresemba	4		* Not available through Mail Service.
Diflucan	4		
fluconazole	1		
flucytosine	2		
Grifulvin V	4		
Gris-Peg	4		
griseofulvin	2		
griseofulvin ultramicro	2		
itraconazole	2	Max. 168 caps/year	* Not available through Mail Service. * Prior authorization required

DRUG NAME	TIER	LIMITATIONS	NOTES
ketoconazole	2		
Lamisil	4	Max. 28 tabs/fill; Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required
Lamisil Granules	4	Max. 28 packets/fill; Max. 84 packets/year	* Not available through Mail Service. * Prior authorization required.
Noxafil (suspension)	4		
Noxafil (tablets)	4		
nystatin	2		
nystatin (cream)	1		
nystatin (ointment)	1		
Onmel	4	Max. 28 tabs/28-day supply; Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required.
Oravig	4		
Sporanox	4	Max. 168 caps/year	* Not available through Mail Service. * Prior authorization required.
Sporanox (solution)	4		
terbinafine	2	Max. 28 tabs/fill, Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required
Vfend	4		
voriconazole	2		
ANTIGOUT			
Antigout Agents			
allopurinol	1		
colchicine (capsule)	2		
colchicine (tablet)	2		
Colcrys	4		
Ixinity	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo or Caremark. * Not available through Mail Service.
Mitigare	4		
probenecid	2		
probenecid/colchicine	2		
Uloric	3		
Zyloprim	4		
ANTIMIGRAINE AGENTS			
Abortive			
almotriptan malate	2	6.25mg: Max. 12 tabs/copay; 12.5mg: Max. 6 tabs/copay	* Not available through Mail Service. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Alsuma	4	Max. 6 injections/copay	* Not available through Mail Service.
Amerge	4	1mg: Max. 15 tabs/copay; 2.5mg: Max. 6 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Axert	4	6.25mg: Max. 12 tabs/copay; 12.5mg: Max. 6 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
D.H.E. 45	3		
dihydroergotamine mesylate nasal spray	2		
Ergomar	3		
Frova	4	Max. 9 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first

DRUG NAME	TIER	LIMITATIONS	NOTES
			level drug is not tried, prior authorization is required.
Imitrex (injection)	4	Max. 3 boxes (6 inj)/copay	* Not available through Mail Service.
Imitrex (nasal spray)	4	Max. 6 sprays/copay	* Not available through Mail Service.
Imitrex (tablets)	4	25mg: Max. 24 tabs/copay; 50mg: Max. 12 tabs/copay, 100mg: Max. 6 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
isometheptene, dichloralphenazone, acetaminophen	2		
Maxalt	4	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Maxalt MLT	4	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Migranal Nasal Spray	3		
naratriptan	2	1mg: Max. 15 tabs/copay; 2.5mg: Max. 6 tabs/copay	* Not available through Mail Service.
Relpax	3	20mg: Max. 12 tabs/copay; 40mg: Max. 6 tabs/copay	* Not available through Mail Service.
rizatriptan	2	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	* Not available through Mail Service.
rizatriptan; oral-disintegrating tablet	2	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	* Not available through Mail Service.
sumatriptan (injection)	2	Max. 3 boxes (6 inj)/copay	* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
sumatriptan (nasal spray)	2	Max. 6 sprays/copay	* Not available through Mail Service.
sumatriptan (tablets)	2	25mg: Max. 24 tabs/copay; 50mg: Max. 12 tabs/copay; 100mg: Max. 6 tabs/copay	* Not available through Mail Service.
Sumavel Dosepro	4	Max. 6 pens/copay	* Not available through Mail Service.
Treximet	3	Max. 9 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
zolmitriptan	2	5mg: Max. 6 tabs/copay, 2.5mg: Max. 12 tabs/copay	* Not available through Mail Service.
zolmitriptan ODT	2	5mg: Max. 6 tabs/copay; 2.5mg: Max. 12 tabs/copay	* Not available through Mail Service.
Zomig	4	2.5mg: Max. 12 tabs/copay; 5mg: Max. 6 tabs/copay; Nasal Spray: Max. 6 sprays/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Zomig ZMT	4	2.5mg: Max. 12 tabs/copay; 5mg: Max. 6 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.

Antimigraine, Other

acetaminophen/butalbital	2		
acetaminophen/caffeine/butalbital	2		
Alagesic LQ	2		
aspirin/butalbital/caffeine	2		
Butalbital Compound w/codeine	2		* Mail Service: Max. 30-day supply as required by State

DRUG NAME	TIER	LIMITATIONS	NOTES
			or Federal law, or benefit plan design.
butalbital, aspirin, caffeine	2		* Mail Service: Max. 30-day supply as required by State or Federal law, or benefit plan design.
butalbital/acetaminophen/ caffeine/codeine	2		* Mail Service: Max. 30-day supply as required by State or Federal law, or benefit plan design.
Cafergot	4		
Esgic	4		
Esgic Plus	4		
Fioricet	4		
Fioricet w/Codeine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Fiorinal	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Fiorinal with Codeine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
ANTIMYASTHENIC AGENTS			
Parasympathomimetics			
Mestinon tabs	4		
Mestinon Timespan	4		
pyridostigmine	2		
pyridostigmine SR	2		
ANTIMYCOBACTERIALS			
Antimycobacterials, Other			
Mycobutin	4		
rifabutin	2		
Antituberculars			

DRUG NAME	TIER	LIMITATIONS	NOTES
ethambutol	2		
isoniazid	1		
isoniazid (syrup)	2		
Myambutol	4		
pyrazinamide	2		
Rifadin	4		
Rifamate	4		
rifampin	2		
Rifater	4		
Sirturo	4		* Packaged as a 6-month (180 day) supply. Member pays 6 copays at retail pharmacy.
ANTINEOPLASTICS, ORAL			
Antineoplastics, Oral			
Afinitor	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Afinitor Disperz	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Alkeran	4		
anastrozole	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Arimidex	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Aromasin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
bicalutamide	2		
Bosulif	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
capecitabine	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Caprelsa	4		* Not available through Mail Service.
Casodex	4		
CEENU	4		
Cometriq	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
cyclophosphamide	2		
cyclophosphamide capsules (Roxane)	3		
Emcyt	3		
Erivedge	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
etoposide	2		
exemestane	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fareston	4		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Farydak	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Femara	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
flutamide	2		
Gilotrif	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Gleevec	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Gleostine	4		
Hexalen	3		
Hycamtin	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Hydrea	4		
hydroxyurea	2		
Ibrance	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Imbruvica	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
Inlyta	4		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through mail service.
Jakafi	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Lenvima	4		* This medication is eligible for a $0 co-pay under certain benefit plans. * Covered through Specialty Pharmacy Program. Use Accredo. * This medication is eligible for a $0 co-pay under certain benefit plans.Not available through Mail Service.
letrozole	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Leukeran	3		
lomustine	2		
Lynparza	4		* Not available through Mail Service.
Lysodren	3		
Matulane	3		* Sole source through Walgreens Specialty Pharmacy.
Megace	4		
Megace ES	4		
megestrol acetate	2		
megestrol acetate ES	2		
Mekinist	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
mercaptopurine	2		
Myleran	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Nexavar	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Nilandron	3		
Purinethol	4		
Purixan	4		
Sprycel	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Stivarga	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Sutent	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Tafinlar	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
tamoxifen	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tarceva	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Targretin	4		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
Tasigna	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Temodar	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
temozolomide	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Thioguanine	3		
Tykerb	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Votrient	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Xalkori	4	Max. 60 caps/30-day supply	* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service
Xeloda	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Xtandi	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Zelboraf	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service
Zolinza	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Zydelig	4		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Zykadia	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Zytiga	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service
ANTIPARASITICS			
Anthelmintics			
Albenza	3		
Biltricide	4		
ivermectin	2		
mebendazole	2		
Stromectol	4		
Antiprotozoals			
Alinia	4		
Aralen	4		
atovaquone	2		
atovaquone/proguanil	2		
chloroquine phosphate	2		
Coartem	4	Max. 24 tabs/copay	* Not available through Mail Service.
Daraprim	3		
Malarone	4		
mefloquine	2		
Mepron	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
paromomycin	2		
Primaquine	4		
Qualaquin	4		
quinine sulfate	2		
Tindamax	4		
tinidazole	2		
Yodoxin	3		
Scabicides and Pediculicides			
Eurax	3		
lindane	2		
Lycelle	4		
malathion	2		
Natroba	4		* Not available through Mail Service.
Ovide	4		
permethrin	2		
Sklice	4		
spinosad	2		* Not available through Mail Service.
Ulesfia	4		
ANTIPARKINSONS			
Antiparkinson Agents			
Apokyn	4		* Not available through Mail Service.
Azilect	3		
benztropine 0.5mg, 1mg tab	1		
benztropine 2mg tab	2		
benztropine mesylate	2		
bromocriptine mesylate	2		
carbidopa	2		
carbidopa/levodopa	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
carbidopa/levodopa (rapid dissolve tab)	2		
carbidopa/levodopa SR	2		
carbidopa/levodopa/entacapone	2		
Comtan	4		
Duopa	4	Max. 2800ml/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo.
Eldepryl	4		
entacopone	2		
Lodosyn	4		
Mirapex	4		
Mirapex ER	4		
Neupro	4		
Parlodel	4		
pramipexole	2		
pramipexole er	2		
Requip	4		
Requip XL	4		
ropinirole	2		
ropinirole hcl tab er 24hr	2		
ropinirole XL	2		
Rytary	4		
selegiline	2		
Sinemet	4		
Sinemet CR	4		
Stalevo	4		
Tasmar	4		
tolcapone	2		
trihexyphenidyl	2		
Zelapar ODT	4		
ANTIPSYCHOTICS			

DRUG NAME	TIER	LIMITATIONS	NOTES
Atypical Antipsychotics			
Abilify	4		
Abilify Discmelt	4		
aripiprazole	2		
clozapine	2		* Not available through Mail Service.
clozapine ODT	2		
Clozaril	4		* Not available through Mail Service.
Fanapt	4		
Fazaclo	4		* Not available through Mail Service.
Geodon	4		
Invega	4		
Invega Sustenna	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Latuda	3		
olanzapine	2		
olanzapine ODT	2		* Covered through Specialty Pharmacy Program. Use Accredo.
quetiapine	2		
Rexulti	4	Max. 30 tabs/30-day supply	
Risperdal	4		
Risperdal Consta	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Risperdal M-TAB	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
risperidone	2		
risperidone M-Tab ODT	2		
Saphris	4		
Seroquel	4		
Seroquel XR	3		
Versacloz	4		* Not available through Mail Service.
ziprasidone	2		
Zyprexa	4		
Zyprexa IM	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Zyprexa Zydis	4		

Conventional Antipsychotics

chlorpromazine	2		
fluphenazine	2		
FLUPHENAZINE 1mg tab	1		
haloperidol	2		
loxapine	2		
Loxitane	4		
Navane	4		
Orap	3		
perphenazine	2		
thioridazine	2		
thiothixene	2		
trifluoperazine	2		

ANTIVIRALS

Anti-HIV, Misc.

Atripla	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Complera	4		
Epzicom	3		
Evotaz	4		
Fuzeon	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Isentress	3		
Prezcobix	4		
Selzentry	3		
Stribild	4		
Tivicay	4		
Truvada	3		
Tybost	4		
Viread	3		
Vitekta	4		

Anti-HIV, NNRTI

Edurant	4		
Intelence	4		
nevirapine	2		
nevirapine ER 400mg	2		
Rescriptor	3		
Sustiva	3		
Viramune	4		
Viramune XR 100mg	3		
Viramune XR 400mg	4		

Anti-HIV, NRTI

abacavir	2		
abacavir/lamivudine/zidovudine	2		
Combivir	4		
didanosine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Emtriva	4		
Epivir (solution)	4		
Epivir (tablet)	4		
Epivir HBV (solution)	4		
Epivir HBV (tablet)	4		
lamivudine (solution)	2		
lamivudine (tabs)	2		
lamivudine/zidovudine	2		
stavudine	2		
Triumeq	4		
Trizivir	4		
Videx EC	4		
Zerit	4		
Ziagen (tablet)	4		
zidovudine	2		

Anti-HIV, Protease Inhibitors

Aptivus	4		
Crixivan	3		
Invirase	3		
Kaletra	3		
Lexiva	3		
Norvir	3		
Prezista	3		
Reyataz	3		
Viracept	3		

Anti-Influenza Agents

amantadine	2		
Flumadine	4		
Relenza	4	Max. 1 package per fill	
rimantadine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Tamiflu	3	30mg: Max. 20 caps/180-day supply; 45mg: Max. 20 caps/180-day supply; 75mg: Max 10 caps/180-day supply; 6mg/mL susp: Max. 240ml/180-day supply	* Not available through Mail Service.
Antiherpetic			
acyclovir	2		
acyclovir (ointment)	2		
acyclovir (suspension)	2		
Denavir	4		
famciclovir	2		
Famvir	4		
Sitavig	4	Max. 1 tab/per copay. Max 2 tabs/30 days.	* Not available through Mail Service.
valacyclovir	2		
Valtrex	4		
Xerese	4		
Zovirax	4		
Zovirax (Cream)	4		
Zovirax (ointment)	4		
Zovirax (Suspension)	4		
Antivirals, Other			
adefovir	2		
Baraclude (tablet)	4		
Copegus	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
entecavir	2		
Harvoni	3	Max. 28 tabs/28 day-supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			required. Not available through mail service.
Hepsera	4		
Olysio	4	Max. 28 tabs/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Rebetol (capsule)	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Rebetol (Solution)	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Ribapak	2		
Ribasphere	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Ribatab	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
ribavirin	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Sovaldi	3	Max. 28 tabs/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Technivie	4	Max. 56 tabs/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Tyzeka	4		
Viekira Pak	4	Maximum 1 pak per 28-days.	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
CMV Agents			
ganciclovir	2		
Valcyte	4		
valganciclovir	2		
ANXIOLYTICS			
Anxiolytics, Other			
buspirone	2		
buspirone 5mg tab	1		
meprobamate	2		
Benzodiazepines			
alprazolam	1		
alprazolam (rapid dissolve tablet)	2		
alprazolam ER	2		
alprazolam Intensol	4		
Ativan	4		
chlordiazepoxide	1		
chlordiazepoxide/amitriptyline	2		
clonazepam	1		
clonazepam (rapid dissolve)	2		
clorazepate	2		
Diastat Acudial 5-7, 5-10mg	3		
Diastat Acudial, 12.5mg, 15mg, 20mg	4		
diazepam	1		
diazepam (solution) (concentrate)	2		
diazepam rectal gel 12.5mg, 15mg, 20mg	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Doral	4		
estazolam	2		
flurazepam	1		
Halcion	4		
Klonopin	4		
lorazepam	2		
oxazepam	2		
quazepam	2		
Restoril	4		
temazepam	2		
temazepam 15mg & 30mg	1		
Tranxene T-Tabs	4		
triazolam	2		
Valium	4		
Xanax	4		
Xanax XR	4		
BIPOLAR AGENTS			
Bipolar Agents			
Eskalith	4		
lithium carbonate	2		
lithium carbonate SR	2		
lithium citrate	2		
Lithobid	4		
BLOOD GLUCOSE REGULATORS			
Alpha Glucosidase Inhibitors			
acarbose	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glyset	4		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Precose	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Amylinomimetics			
SymlinPen	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Antiglycemic agent, Misc			
Cycloset	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Korlym	4		* Covered through Specialty Pharmacy Program. Must use Centric Health Resource.
Biguanides			
Fortamet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glucophage	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Glucophage XR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glumetza	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metformin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metformin ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Riomet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
DPP-4 inhibitor			
Januvia	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Nesina	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Onglyza	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tradjenta	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fixed-Dose Combination Agents			
Actoplus Met	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Actoplus Met XR	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Avandamet	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avandaryl	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Duetact	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
glipizide/metformin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glucovance	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
glyburide/metformin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glyxambi	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Invokamet	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Janumet	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Janumet XR	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Jentadueto	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Kazano	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Kombiglyze XR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Oseni	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone/glimepiride	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone/metformin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prandimet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prestalia	4	Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Xigduo XR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

Glycemic Agents

DRUG NAME	TIER	LIMITATIONS	NOTES
Glucagon Emergency Kit	3		* Not available through Mail Service. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Proglycem (suspension)	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Incretin Mimetics			
Bydureon	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Byetta	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tanzeum	4	Max. 4 pens/28-day supply	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the

DRUG NAME	TIER	LIMITATIONS	NOTES
			Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Trulicity	4	Max. 4 pens/28-day supply	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Victoza	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Insulins			
Afrezza	4	4 & 8 unit single strength kits, Max. 180 cartridges/30-day supply. 4 & 8 unit combo product, Max. 450 cartridges/30-day supply.	* Not available through Mail Service. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required.
Apidra	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Humalog	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humalog Mix	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humulin 70/30	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humulin N	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humulin N Kwikpen	3		
Humulin R	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lantus	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be

DRUG NAME	TIER	LIMITATIONS	NOTES
			subject to your plan deductible. Applicable copayment will apply.
Levemir	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Novolin 70/30	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Novolin N	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Novolin R	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Novolog	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Novolog Mix	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Toujeo Solostar	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Meglitinides			
nateglinide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prandin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
repaglinide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Starlix	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
SGLT2 Inhibitors			
Farxiga	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Invokana	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Jardiance	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Sulfonylureas			
Amaryl	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
chlorpropamide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Diabeta	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
glimepiride	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
glipizide	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
glipizide extended-release	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glucotrol	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glucotrol XL	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
glyburide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
glyburide 1.25mg	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
glyburide, micronized	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Glynase	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
tolazamide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Thiazolidinediones			
Actos	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avandia	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS			
Anticoagulants			
Arixtra	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Coumadin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Eliquis	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
enoxaparin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
fondaparinux	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service
Fragmin	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
heparin	2		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Iprivask	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Must use Accredo.
Jantoven	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lovenox	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Pradaxa	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Savaysa	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
warfarin	2		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Xarelto	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Antihemophilia			
Advate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alphanate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alphanine SD	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alprolix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Benefix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo or Caremark. * Not available through Mail Service.
Corifact	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Caremark.
Eloctate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Feiba VH Immuno	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Helixate FS	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Caremark or Accredo. * Not available through Mail Service.
Hemofil-M	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Humate-P	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Koate-DVI	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo or Caremark. * Not available through Mail Service.
Kogenate FS	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Monoclate-P	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Mononine	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Novoeight	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark.
Novoseven	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Novoseven RT	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Profilnine SD	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Caremark or Accredo. * Not available through Mail Service.
Recombinate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Caremark or Accredo. * Not available through Mail Service.
RiaSTAP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Caremark. * Not available through mail service
Rixubis	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Tretten	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Wilate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Caremark. * Not available through mail service
Xyntha	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.

Blood Formation Products

DRUG NAME	TIER	LIMITATIONS	NOTES
Aranesp	4	Max. 4 vials or syringes/fill	* Covered through Specialty Pharmacy Program. Use Magellan Health (formerly known as ICORE) or Accredo. * Not available through Mail Service. Prior authorization required.
Epogen	3	2,000U/3,000U/4,000U/10,000U: Max. 12 vials/fill; 20,000U/40,000U: Max. 4 vials/fill	* Covered through Specialty Pharmacy Program. Use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.Prior authorization required.
Granix	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Mircera	4		* Not available through Mail Service.
Mozobil	3	Max. 4 vials/copay	* Covered through Specialty Pharmacy Program. Must use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Neulasta	3		* Covered through Specialty Pharmacy Program. Use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Neumega	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Neupogen	3		* Covered through Specialty Pharmacy Program. Use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Neupogen (syringe)	4		* Covered through Specialty Pharmacy Program. Use Accredo or Magellan Health (formerly

DRUG NAME	TIER	LIMITATIONS	NOTES
			known as ICORE). * Not available through Mail Service.
Nplate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Procrit	3	2,000U/3,000U/4,000U/10,000U: Max. 12 vials/fill; 20,000U/40,000U: Max. 4 vials/fill	* Covered through Specialty Pharmacy Program. Use Accredo or Magellan Health (formerly known as ICORE). * Not available through mail servicePrior authorization required
Promacta	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Coagulants			
aminocaproic acid	2		
Lysteda	4	Max. 30 tabs/30-day supply	
tranexamic acid	2	Max. 30 tabs/30-day supply	
Platelet Aggregation Inhibitors			
Aggrenox	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Agrylin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
anagrelide	2		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Brilinta	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
cilostazol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
clopidogrel	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
clopidogrel 75mg	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
dipyridamole	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
dipyridamole/aspirin	2		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Effient	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Plavix	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Pletal	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ticlopidine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Zontivity	4		
CARDIOVASCULAR			
ACE Inhibitors			
Accupril	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Aceon	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Altace (Capsules)	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
benazepril	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
captopril	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
captopril 100mg	2		
enalapril	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Epaned	4		
fosinopril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
lisinopril	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Lotensin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Mavik	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
moexipril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Monopril	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
perindopril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prinivil	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
quinapril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
ramipril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
trandolapril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Univasc	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vasotec	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Zestril	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Alpha Adrenergic Agonists			
Catapres	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Catapres TTS	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
clonidine	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
clonidine transdermal	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
GUANFACINE 1mg	1		
guanfacine HCl	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
methyldopa	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
midodrine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tenex	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Alpha Adrenergic Blocking Agents			
Cardura	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cardura XL	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dibenzyline	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
doxazosin mesylate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
doxazosin mesylate 1mg	2		
doxazosin mesylate 2mg	2		
Minipress	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
phenoxybenzamine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
prazosin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
terazosin 10mg	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
terazosin 1mg, 2mg, 5mg	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Angiotensin II Receptor Antagonists			
Atacand	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avapro	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Benicar	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
candesartan	2		
Cozaar	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Diovan	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Edarbi	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
eprosartan	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
irbesartan	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
losartan	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Micardis	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
telmisartan	2		
Teveten	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
valsartan	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

Anti-Arrhythmics

amiodarone	2		
Betapace	4		
Betapace AF	4		
Cordarone	4		
disopyramide	2		
flecainide acetate	2		
mexiletine	2		
Multaq	3		
Norpace	4		
Norpace CR	4		
Pacerone	2		
propafenone	2		
quinidine gluconate SR	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
quinidine sulfate	2		
Rythmol	4		
Rythmol SR	4		
Sorine	2		
sotalol	2		
sotalol AF	2		
Sotylize	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tikosyn	4		* Manufacturer sponsored Tikosyn Program. Members or physicians should call 1-877-TIKOSYN (845-6796) for dispensing information.
Beta Adrenergic Blocking Agents			
acebutolol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
atenolol	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
betaxolol, oral	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
bisoprolol fumarate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Bystolic	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
carvedilol	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Coreg	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Coreg CR	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Corgard	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Hemangeol	4		* Not available through Mail Service.
Inderal LA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Inderal XL	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Innopran XL	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Kerlone	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
labetalol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Levatol	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lopressor	4		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metoprolol succinate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metoprolol tartrate	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nadolol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pindolol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
propranolol	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
propranolol (oral solution)	2		
propranolol 24hr SA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
propranolol 60mg	2		
Sectral	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tenormin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Toprol XL	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Trandate	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Zebeta	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

Calcium Channel Blockers

Adalat CC	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
amlodipine	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Calan	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Calan SR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cardene SR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cardizem	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cardizem CD	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cardizem LA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Cartia XT	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dilacor XR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dilt-XR	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem 24hr ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem CD	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem SR	2		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
felodipine ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
isradipine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Matzim LA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nicardipine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nifedical XL	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nifedipine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
nifedipine SR	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nimodipine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nimotop	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nisoldipine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Norvasc	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nymalize	4		
Procardia	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Procardia XL	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Sular	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Taztia XT	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tiazac	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
verapamil	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
verapamil ER PM	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
verapamil SR	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Verelan	4		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Verelan PM	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cardiovascular, Other			
Corlanor	4	Max. 60 tabs/30-day supply	* Prior authorization required.
digoxin	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
digoxin (solution)	3		
eplerenone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Inspra	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lanoxin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Northera	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
pentoxifylline	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
reserpine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vecamyl	4		
Diuretics			
acetazolamide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
acetazolamide capsule ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Aldactazide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Aldactone	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
amiloride	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amiloride/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
bumetanide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
chlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
chlorthalidone	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Demadex	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Diamox Sequels	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Dyazide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dyrenium	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Edecrin	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
furosemide	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
furosemide (oral solution)	2		
hydrochlorothiazide	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
indapamide	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Lasix	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Maxzide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
methazolamide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metolazone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Microzide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Naturetin-5	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
spironolactone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
spironolactone/ hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
torsemide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
triamterene/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
triamterene/hydrochlorothiazide 50mg-25mg	2		
Zaroxolyn	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dyslipidemics, Fibrates			
Antara	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
fenofibrate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
fenofibrate 120mg	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
fenofibric acid	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fenoglide 120mg	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fenoglide 40 mg	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fibricor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
gemfibrozil	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Lipofen	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
LoFibra	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lopid	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
TriCor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Triglide	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Trilipix	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

Dyslipidemics, Other

DRUG NAME	TIER	LIMITATIONS	NOTES
cholestyramine/aspartame	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
cholestyramine/sucrose	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Colestid	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
colestipol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
colestipol granules	2		
fenofibrate, micronized	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Juxtapid	4		* Not available through Mail Service. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply. * Sole source through Centric Health.
Kynamro	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Lovaza	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
niacin er	2		
Niacor	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Niaspan	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
omega 3 acids ethyl esters	2		
Praluent	4	Max. 2 pens/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Prevalite	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Questran	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Questran Light	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vascepa	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vytorin	4	Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Welchol (tablets)	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Welchol Powder Pack	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Zetia	3	Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

Dyslipidemics, Statins

DRUG NAME	TIER	LIMITATIONS	NOTES
Altoprev	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
atorvastatin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Crestor	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
fluvastatin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lescol	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lescol XL	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lipitor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Livalo	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
lovastatin	2		
lovastatin 20mg, 40mg	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Mevacor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Pravachol	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pravastatin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
simvastatin	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zocor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fixed-Dose Combination Agents - Cardiovascular			
Accuretic	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Advicor	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amlodipine/atorvastatin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amlodipine/benazepril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amlodipine/valsartan	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amlodipine/valsartan/hctz	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Amturnide	3	150mg: Max. 45 tabs/30-day supply; 300mg: Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Atacand HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
atenolol/chlorthalidone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avalide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Azor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
benazepril/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Benicar HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
bisoprolol/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Caduet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
candesartan/HCTZ	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
captopril/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Corzide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Diovan HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Dutoprol	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Edarbyclor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
enalapril/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Entresto	4	Max. 60 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required.
Exforge	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Exforge HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
fosinopril/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Hyzaar	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
irbesartan/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
lisinopril/hydrochlorothiazide	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lopressor HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
losartan/hydrochlorothiazide	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lotensin HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lotrel	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
metoprolol/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Micardis HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
moexipril/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nadolol-bendroflumethiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Simcor	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tarka	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tekamlo	3	150mg/5mg & 150mg/10mg: Max. 45	* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
		tabs/30 days; 300mg/5mg & 300mg/10mg: Max. 30 tabs/30 days	Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tekturna HCT	3	150mg: Max. 45 tabs/30-day supply; 300mg: Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
telmisartan/amlodipine	2	Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
telmisartan/hctz	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tenoretic	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Teveten HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tribenzor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Twynsta	4	Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
valsartan/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vaseretic	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
verapamil/trandolapril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Zestoretic	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Ziac	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Renin Inhibitor, Direct			
Tekturna	3	150mg: Max. 45 tabs/30-day supply; 300mg: Max. 30 tabs/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vasodilators			
BiDil	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
hydralazine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Imdur	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Isordil	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Isordil 40mg	3		
isosorbide dinitrate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
isosorbide dinitrate 30mg	2		
isosorbide mononitrate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Minitran	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
minoxidil	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Monoket	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nitro-Dur	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nitroglycerin (patch)	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nitroglycerin spray	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Nitrolingual Pump Spray	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nitromist	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nitrostat	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Ranexa	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
CENTRAL NERVOUS SYSTEM AGENTS			
Barbiturates			
Mysoline	4		
phenobarbital	1		
phenobarbital 20mg/5mL (elixir)	2		
primidone	2		
Seconal	1		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
CNS, Misc. Agents			

DRUG NAME	TIER	LIMITATIONS	NOTES
cevimeline	2		
clonidine ER	2		
Evoxac	4		
guanfacine ER	2		
Horizant	4		
Intuniv	4		
Kapvay	4		
Nuedexta	3		
Rilutek	4		
riluzole	2		
Xenazine	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Xyrem	4		* Not available through Mail Service. * Available through Express Scripts Only, 866-997-3688 x66247
Stimulants, Amphetamines			
Adderall	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Adderall XR	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
amphetamine/ dextroamphetamine	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy,

DRUG NAME	TIER	LIMITATIONS	NOTES
			max 60-day supply allowed through mail service and Maine pharmacies.
amphetamine/ dextroamphetamine SR	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Desoxyn	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Dexedrine Spansule	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
dextroamphetamine	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
dextroamphetamine sulfate solution	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Evekeo	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity

DRUG NAME	TIER	LIMITATIONS	NOTES
			Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
methamphetamine	3		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Vyvanse	3		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Zenzedi	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Stimulants, Non-Amphetamines			
Aptensio XR	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Concerta	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.

DRUG NAME	TIER	LIMITATIONS	NOTES
Daytrana	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
dexmethylphenidate	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
dexmethylphenidate XR	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
dexmethylphenidate XR 5mg, 15mg, 30mg, 40mg	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Focalin	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Focalin XR 10mg, 20mg	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed

DRUG NAME	TIER	LIMITATIONS	NOTES
			through mail service and Maine pharmacies.
Focalin XR 25mg, 35mg	3		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Focalin XR 5mg, 15mg, 30mg, 40mg	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Metadate CD	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Metadate ER	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Methylin	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Methylin (chew tab)	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy,

DRUG NAME	TIER	LIMITATIONS	NOTES
			max 60-day supply allowed through mail service and Maine pharmacies.
Methylin ER	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Methylin Solution	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service.
methylphenidate	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
methylphenidate (chew tab)	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
methylphenidate 24-hr ER tab	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
methylphenidate CD	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy,

DRUG NAME	TIER	LIMITATIONS	NOTES
			max 60-day supply allowed through mail service and Maine pharmacies.
methylphenidate er	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
methylphenidate long-acting	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
methylphenidate solution	1		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
methylphenidate SR	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
modafinil	4	Max. 30 tabs/30-day supply	* Prior authorization required.
Nuvigil	3	Max. 30 tabs/30-day supply	* Prior authorization required
Provigil	4	Max. 30 tabs/30-day supply	* Prior authorization required
Quillivant XR	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed

DRUG NAME	TIER	LIMITATIONS	NOTES
			through mail service and Maine Pharmacies.
Ritalin	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine Pharmacies.
Ritalin LA	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine Pharmacies.
Strattera	3		
DENTAL/ORAL AGENTS			
Dental/Oral Agents			
Caphosol	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
chlorhexidine gluconate	2		
Episil	3		
Ethedent	1		
Ethedent 1.1%	2		
Floriva	4		
Gel-Kam	4		
Gelclair	3		
lidocaine viscous	2		
Mugard	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Neutrasal	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Orafate	NC		* This drug is not covered.
Peridex	4		
PerioGard Oral Rinse	2		
Phos-Flur	3		
pilocarpine (oral)	2		
Prevident	3		
Prevident 5000	4		
Prevident 5000 Booster Paste	4		
Prevident 5000 Plus Cream	4		
Prevident 5000 Sensitive	4		
Prothelial	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
ReNaf	1		
Salagen	4		
sodium fluoride (drops) (chewable tablets)	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
DERMATOLOGICAL/TOPICAL AGENTS			
Acne Treatments			
Absorica	4		* Not available through Mail Service.
Acanya	3		* Not available through Mail Service.
Aczone	4		
adapalene	2	Prior authorization required for members 30 and older	
Akne-Mycin	3		
Amnesteem	2		* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Azelex	3		
Benzaclin	4		* Not available through Mail Service.
Benzamycin	4		* Not available through Mail Service.
Claravis	2		* Not available through Mail Service.
Cleocin T	4		
Clindacin Pac	4		
clindamycin phosphate	2		
clindamycin phosphate 1% foam	2		
clindamycin/benzoyl peroxide	2		* Not available through Mail Service.
Differin	4	Prior authorization required for members 30 and older	
Duac	4		* Not available through Mail Service.
Epiduo	4	Prior authorization required for members 30 and older	
Epiduo Forte	4	Prior authorization required for members 30 and over.	
Erygel	4		
erythromycin/benzoyl peroxide	2		* Not available through Mail Service.
Evoclin	4		
Fabior	4	Prior authorization required for members 30 and older	
Finacea	3		
Finacea Plus	3		
Myorisan	2		* Not available through Mail Service.
Neuac	4		* Not available through Mail Service.
Onexton	4		* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Tazorac	4	Prior authorization required for members 30 and older	
Veltin	4	Prior authorization required for members 30 and older	
Zenatane	2		* Not available through Mail Service.
Ziana	4	Prior authorization required for members 30 and older	

Antipruritics

Alevicyn	4

Corticosteroids - High Potency

amcinonide	2
betamethasone dipropionate	2
betamethasone valerate	2
betamethasone valerate 0.1% (lotion)	2
betamethasone valerate foam	2
desoximetasone	2
diflorasone diacetate	2
Diprosone	4
fluocinonide	2
Halog	4
Luxiq	4
Topicort	4

Corticosteroids - Low Potency

alclometasone dipropionate	2
Aqua Glycolic HC	4
Dermasorb HC	4
desonide	2
DesOwen	4
Desowen Kit	4

DRUG NAME	TIER	LIMITATIONS	NOTES
hydrocortisone butyrate	2		
Locoid	4		
Pandel	4		
Texacort	4		
Verdeso	4		

Corticosteroids - Medium Potency

clocortolone pivalate	2		
Cloderm	4		
Cutivate	4		
Derma-Smoothe FS	4		
Dermasorb TA	4		
Dermatop	4		
Elocon	4		
fluocinolone acetonide	2		
fluocinolone acetonide oil	2		
fluticasone topical	2		
hydrocortisone valerate	2		
Kenalog	4		
mometasone furoate (topical)	2		
Momexin	4		
prednicarbate	2		
Synalar	4		
Synalar TS	4		
triamcinolone acetonide	2		
triamcinolone acetonide (lotion)	2		
triamcinolone acetonide (paste)	2		

Corticosteroids - Ultra High Potency

betamethasone dipropionate, augmented	2		
clobetasol propionate	2		
clobetasol propionate/emollient	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Clobex	4		
Cordran	4		
Cormax	2		
Diprolene	4		
Diprolene AF	4		
fluocinonide (micronized)	2		
halobetasol propionate	2		
Olux	4		
Olux-E	4		
Temovate	4		
Ultravate	4		
Ultravate X	4		
Vanos	4		

Corticosteroids, Other

betamethasone dipropionate/ calcipotriene	2		
betamethasone/clotrimazole	2		
Lotrisone	4		
Novacort	4		
nystatin/triamcinolone acetonide	2		
Taclonex	4		

Dermatological Anti-Infectives

Alcortin A	NC		* This drug is not covered.
Altabax	4		
Bactroban Cream	4		
Bactroban Nasal	4		
Bactroban Ointment	4		
mafenide acetate	2		
MetroCream	4		
MetroGel	4		
MetroGel 1% Kit	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
MetroLotion	4		
metronidazole (gel)	2		
metronidazole (lotion)	2		
mupirocin cream	2		
mupirocin ointment	2		
Noritate	3		
Rosadan	4		
sulfacetamide topical lotion	2		

Dermatological Anti-Inflammatory Agents

diclofenac gel	2		
Solaraze	4		
Soolantra	4		

Dermatological Antipruritics

Atopiclair	4		
pruclair	2		
Prudoxin	4		
Zonalon	4		

Dermatological Caustic Agents

Condylox	3		
Condylox Solution	4		
Keralyt gel	4		
podofilox solution	2		
Salex	4		

Dermatological Immunomodulators

Aldara	4		
Elidel	3		* Prior authorization required
imiquimod	2		
Protopic	4		* Prior authorization required
tacrolimus topical	2		* Prior authorization required.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zyclara	4		* Not available through Mail Service.
Dermatological, Antifungals			
Ciclodan	4		* Not available through Mail Service. * Prior authorization required
ciclopirox	2		
ciclopirox (gel)	2		
ciclopirox (shampoo)	2		
ciclopirox 8.0% (solution)	2		* Not available through Mail Service. * Prior authorization required
econazole nitrate	2		
Ecoza	4		
Ertaczo	4		
Exelderm	4		
Extina	4		
Jublia	4		* Not available through Mail Service. * Prior authorization required.
Kerydin	4		* Not available through Mail Service. * Prior authorization required.
ketoconazole cream	2		
ketoconazole shampoo	2		
Ketodan	4		
Loprox Shampoo	4		
Luzu	4		
Mentax	3		
naftifine	2		
Naftin	4		
Nizoral Shampoo 2%	4		
Oxistat	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Penlac	4		* Not available through Mail Service. * Prior authorization required
Vusion	4		
Xolegel	4		
Dermatological, Misc.			
bexarotene	2		* Not available through Mail Service. * This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Bionect	4		
Carac	4		
Drysol	NC		* This drug is not covered.
Efudex	4		
Fluoroplex	4		
fluorouracil cream	2		
Mirvaso	4		
Picato	3		* Not available through Mail Service.
Valchlor	4	Max 1 tube (60 gram)/30 days	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Vectical	4		
Veregen	3		
Emollients			
ammonium lactate	2		
Epiceram	4		
Hylatopic	4		
Hylatopic Plus	4		
Lac-Hydrin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Presera	4		
Promiseb Complete	NC		* This drug is not covered.
Local Anesthetics			
EMLA	4	Prior authorization required for members 17 and older	
lidocaine	2		
lidocaine patch	2		
lidocaine/prilocaine	2	Prior authorization required for members 17 years and older	
Lidoderm	4		
Regenecare	4		
Xylocaine Jelly	4		
Mitotic Inhibitors			
calcipotriene	2		
calcipotriene solution	2		
Dovonex	4		
Dovonex Solution	4		
selenium sulfide	2		
Selseb	4		
Sorilux	4		
Photochemotherapy Agents			
8-MOP	4		
methoxsalen	2		
Oxsoralen-Ultra	4		
Retinoids			
acitretin	2		
Atralin	3	Prior authorization required for members 30 and older	
Avita	2	Prior authorization required for members 30 and older	

DRUG NAME	TIER	LIMITATIONS	NOTES
Panretin	4		* Not available through Mail Service.
Retin-A	4	Prior authorization required for members 30 and older	
Retin-A Micro	1	Prior authorization required for members 30 and older	
Soriatane	4		
Tretin-X	4	Prior authorization required for members 30 and older	
tretinoin, microspheres topical	2	Prior authorization required for members 30 and older	
tretinoin, topical	2	Prior authorization required for members 30 and older	

Topical, Anorectal Agents

Anusol HC Cream	4		
Anusol HC Suppositories	3		
Cortifoam	4		
Epifoam	4		
hydrocortisone 1% (cream/ ointment)	1		
hydrocortisone 2.5% (cream/ ointment)	1		
Pramosone	3		
Procto-Pak 1% (cream)	1		
Proctofoam HC	3		
Proctosol-HC	2		
Proctosol-HC 2.5% (cream)	1		
Rectiv	4		

Topical, Vaginal Agents

Cleocin Cream	4		
Cleocin Vaginal Suppository	4		
Clindesse	4		
Gynazole-1	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Metrogel Vaginal	4		
metronidazole (vaginal gel)	2		
Nuvessa	4		
Terazol	4		
terconazole	2		
Wound Care Agents			
Aurstat	4		
Biafine	4		
Hylase	4		
MB Hydrogel	2		
Neosalus Cream	4		
Neosalus Foam	4		
Nuvail	4		
Prutect	2		
Regranex	4	Annual limit 90 days; Max. 1 tube/30-day supply	* Not available through Mail Service.
Santyl	3		
Silvadene	4		
silver sulfadiazine AF cream	2		
Silvrstat	4		
Sonafine	4		
SSD Cream	4		* Not available through Mail Service.
Thermazine	4		* Not available through Mail Service.
Tropazone	4		
ENZYME REPLACEMENTS/MODIFIERS			
Enzymes, Other			
Aldurazyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known

DRUG NAME	TIER	LIMITATIONS	NOTES
			as ICORE). * Not available through Mail Service.
Aralast NP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Berinert	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Buphenyl	4		
Carbaglu	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Cerdelga	3		* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Cerezyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Cinryze	Medical	Max. 20 vials/30-day supply	* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service. Prior authorization required.
Cystadane	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cystagon	4		
Elaprase	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Elelyso	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through Centric Health Resources only. 800-305-7881
Fabrazyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Firazyr	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service
Kalbitor	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Krystexxa	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE).
Kuvan	3		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through mail service.
Lumizyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Myozyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Naglazyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Procysbi	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Use Accredo. * Limited pharmacy distribution. Patients must enroll in REMS program, RaptorCares 855-888-4004
Prolastin	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through Centric Health Resources only.. 800-305-7881
Prolastin C	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through

DRUG NAME	TIER	LIMITATIONS	NOTES
			Centric Health Resources only. 800-305-7881
Ravicti	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
sodium phenylbutyrate	2		
Vpriv	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Zavesca	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Zemaira	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through Accredo Nova Factor only.
Enzymes, Pancreatic			
Creon	3		
Pancreaze	3		
Pancrelipase 5,000	2		
Pertzye	4		
Sucraid	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Ultresa	4		
Viokace	4		
Zenpep	3		
Zenpep 5K-17K-27K	4		
GASTROINTESTINAL DRUGS			

DRUG NAME	TIER	LIMITATIONS	NOTES
Antispasmodics			
Bentyl	4		
Cantil	4		
chlordiazepoxide/clidinium	2		
dicyclomine	2		
Librax	4		
methscopolamine bromide	2		
Pamine	4		
Gastrointestinal Agents, Other			
Actigall	4		
Chenodal	4		* Not available through Mail Service. * Sole source through Centric Health.
Cholbam	4		
CoLyte	4		
CoLyte with Flavor Packs	4		
cromolyn	2		
Cuvposa	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
diphenoxylate/atropine	2		
Enulose	2		
Fulyzaq	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Gastrocrom	4		
Gavilyte-G	2		
Gavilyte-H and Bisacodyl	2		
Generlac	2		
Glycate	4		
glycopyrrolate	2		
Go-Lytely	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Kristalose	3		
lactulose	2		
lansoprazole/clarithromycin/ amoxicillin kit	2		
Lomotil	4		
METOCLOPRAMIDE 10mg	1		
metoclopramide 5mg	2		
metoclopramide ODT	2		
Metozolv ODT	4		
Motofen	4		
Movantik	4		
Moviprep	3		
NuLytely	4		
Omeclamox-Pak	4		
Osmoprep	4		
PEG 3350/Electrolyte	2		
Prepopik	3		* Not available through Mail Service.
PrevPac	4		
Pylera	3		
Reglan	4		
Relistor	3		* Not available through Mail Service.
Robinul	4		
Robinul Forte	4		
Suclear	4		
Suprep	4		
Trilyte	2		
Urso	4		
ursodiol	2		

H2 Antagonists

Axid	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
cimetidine	2		
famotidine	1		
nizatidine	2		
Pepcid	4		
ranitidine	2		
Tagamet	4		
Zantac	4		

Inflammatory Bowel Disease Agents

Apriso	3		
Asacol	3		
Asacol HD	3		
Azulfidine	4		
balsalazide disodium	2		
budesonide	2		
Canasa Rectal Suppository	3		
Colazal	4		
Cortenema	4		
Delzicol	3		
Dipentum	4		
Entocort EC	4		
Giazo	4		
hydrocortisone (enema)	2		
Lialda	3		
mesalamine (enema)	2		
Pentasa	3		
Rowasa Enema	4		
sulfasalazine	2		
Uceris	4		

Irritable Bowel Syndrome Agents

alosetron	2	Covered for females only	
Amitiza	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Linzess	3		
Lotronex	4	Covered for females only	
Protectants			
Carafate (suspension)	3		
Carafate (tablet)	4		
Cytotec	4		
misoprostol	2		
sucralfate	2		
Proton Pump Inhibitors			
Aciphex	4		
AcipHex Sprinkle/capsule	4		
Dexilant	4		
esomeprazole magnesium	3		
Esomeprazole strontium	4		
lansoprazole	3		
Nexium	4		
omeprazole 20mg capsule	1		
omeprazole capsule	2		
omeprazole/sodium bicarbonate (capsule)	4		
pantoprazole	2		
Prevacid	4		
Prevacid Solutab	4		
Prilosec	4		
Protonix	4		
Protonix (suspension)	4		
rabeprazole/tablet DR	4		
Zegerid (capsules)	4		
Zegerid Powder Packet	4		
GENITOURINARY AGENTS			
Antispasmotics, Urinary			

DRUG NAME	TIER	LIMITATIONS	NOTES
Detrol	4		
Detrol LA	4		
Ditropan XL	4		
Enablex	4		
flavoxate	2		
Gelnique	4	Max. 30 packets/30-day supply	
Gelnique Pump	4	Max. 1 pump bottle/30-day supply	
Myrbetriq	4		
oxybutynin	2		
Oxytrol	4		
Sanctura	4		
tolterodine	2		
tolterodine LA	2		
Toviaz	3		
trospium chloride	2		
trospium chloride ER cap	2		
Vesicare	3		

BPH Agents

alfuzosin	2	Max. 30 tabs/30-day supply	
Avodart	3		
finasteride 1mg	NC		* This drug is not covered.
finasteride 5mg	2		
Flomax	4		
Jalyn	3		
Proscar	4		
Rapaflo	4		
tamsulosin	2		
Uroxatral	4	Max. 30 tabs/30-day supply	

Erectile Dysfunction

DRUG NAME	TIER	LIMITATIONS	NOTES
Caverject	3	Max. 6 injections/30-day supply; Covered for males over 18 years of age only	
Cialis	3	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only	* Prior authorization required when quantity exceeds limitation.
Edex	3	Max. 6 injections/30-day supply; Covered for males over 18 years of age only	
Levitra	4	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only	* Prior authorization required when quantity exceeds limitation.
Muse	3	Max. 6 suppositories/30-day supply; Covered for males over 18 years of age only	
Staxyn	4	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only.	* Prior Authorization required when quantity exceeds limitation.
Stendra	4	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only.	* Prior authorization required when quantity exceeds limitation.
Viagra	3	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only.	* Prior authorization required when quantity exceeds limitation.

Genitourinary Agents, Other

bethanechol	2		
Elmiron	4		
phenazopyridine	1		
Pyridium	3		
Thiola	4		* Sole Source Pharmacy: Dohmen Life Sciences 1-800-305-7881
Urecholine	4		

Phosphate Binders

Auryxia	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Fosrenol	4		
Renagel	3		
Renvela	3		
Velphoro	4		
HORMONAL (ADRENAL)			
Corticosteroids			
Acthar HP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service Prior authorization required.
Cortef	4		
cortisone acetate	2		
dexamethasone	2		
dexamethasone (oral solution)	2		
dexamethasone (tablet)	1		
dexamethasone 0.5mg/5mL (elixir)	2		
dexamethasone 2mg (tablet)	2		
dexamethasone 6mg (tablet)	2		
DexPak	4		
fludrocortisone acetate	2		
hydrocortisone	2		
Medrol	4		
methylprednisolone	2		
Millipred	3		
Orapred	4		
Orapred ODT	4		
PediaPred	4		
prednisolone	2		
prednisolone 5mg (tablet)	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
prednisolone sodium phosphate tab rapdis	2		
prednisone	1		
prednisone 5mg/5mL (oral solution)	2		
Rayos	4		
Veripred 20	4		
HORMONAL (CONTRACEPTIVES)			
Biphasic			
Azurette	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Kariva	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Mircette	4		
Contraceptives, Other			
Implanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Natazia	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Nexplanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through mail service.
Emergency Contraceptive Agents			
Ella	$0	Max. 1 tab/copay	* Not available through Mail Service. * This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
My Way	2	Max. 1 unit/copay	* Not available through Mail Service. * Covered for members less than 17 years of age. For members 17 and above, Next Choice One Step is available without a prescription and is not covered.
Next Choice One Dose	2	Max. 1 unit/copay	* Not available through Mail Service. * Next Choice One Step is covered for members less than 17 years of age. For members 17 and above, Next Choice One Step is available without a prescription and is not covered.
Plan B	4	Max. 1 pack (2 tablets)/ copay	* Not available through Mail Service. * Plan B is covered for members less than 18 years of age. For members age 18 and above, Plan B is available without a prescription and is not covered.
Plan B One-Step	4	Max. 1 unit/copay	* Not available through Mail Service. * Plan B One Step is covered for members less than 17 years of age. For members 17 and above, Plan B One Step is available without a prescription and is not covered.
Monophasic			
norethindrone/ethinyl estradiol/ iron (ferrous fumarate)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Alyacen	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Amethia	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
Amethia lo	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
Amethyst	4		
Angeliq	4		
Apri	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Aviane	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Balziva	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Beyaz	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Brevicon	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Camrese	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Camrese lo	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
Cyclafem 1/35	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Desogen	4		
Emoquette	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 30 - desogestrel 0.15	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 35 - norethindrone 1	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 35 – norgestimate 0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Femcon FE	4		
Generess FE	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Gianvi	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Jolessa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
Junel 1/20	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Junel Fe	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Lessina	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Levlen	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
levonorgestrel/ethinyl estradiol	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Levora	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Lo Loestrin FE	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Lo Minastrin Fe	4		
Lo-Ovral	4		
Loestrin	4		
Loestrin 24 FE	4		
Loestrin Fe	4		
Lomedia 24 FE	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Loseasonique	4		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Low-Ogestrel	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Lutera	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Microgestin	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Minastrin 24 FE	4		
Modicon	4		
Mononessa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Nordette	4		
Norinyl 1/35	$0		* This medication is eligible for a $0 co-pay under certain benefit

DRUG NAME	TIER	LIMITATIONS	NOTES
			plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Norinyl 1/50	4		
Nortrel 0.5/35, 1/35, 7-7-7	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
NuvaRing	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ocella	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ogestrel	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ortho Cyclen	4		
Ortho Evra	4		
Ortho-Cept	4		
Ortho-Novum	4		
Ovcon -35	4		
Previfem	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Quartette	4		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Quasense	$0		* This medication is eligible for a $0 co-pay under certain benefit

DRUG NAME	TIER	LIMITATIONS	NOTES
			plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
Reclipsen	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Safyral	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Seasonale	4		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Seasonique	4		* Packaged as a 3 month supply. Member pays 3 copays at retail pharmacy.
Sprintec	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Sronyx	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Xulane	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Yasmin	4		
Yaz	4		
Zarah	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible

DRUG NAME	TIER	LIMITATIONS	NOTES
			for a $0 co-pay under certain benefit plans.
Zeosa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Zovia	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Progestin Only			
Camila	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Errin	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Nor-QD	4		
Nora-Be	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
norethindrone 0.35 mg	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Triphasic			
Aranelle	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible

DRUG NAME	TIER	LIMITATIONS	NOTES
			for a $0 co-pay under certain benefit plans.
Cyclafem 7-7-7	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Cyclessa	4		
Enpresse	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Estrostep FE	4		
ethinyl estradiol 25 - norgestimate 0.18/0.215/0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 35 - norethindrone 0.5/0.75/1	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 35 – norgestimate 0.18 / 0.215 / 0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Necon	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ortho Tri Cyclen	4		
Ortho Tri-Cyclen LO	4		
Ortho-Novum 7-7-7	4		
Tilia FE	$0		* This medication is eligible for a $0 co-pay under certain benefit

DRUG NAME	TIER	LIMITATIONS	NOTES
			plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Estarylla	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Legest FE	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Linyah	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Norinyl	4		
Tri-Previfem	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Sprintec	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Trinessa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Trivora	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
Velivet	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
HORMONAL (FERTILITY AGENTS)			
Fertility Agents			
Bravelle	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Cetrotide	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
chorionic gonadotropin	4		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
clomiphene citrate	2		
Follistim AQ	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Ganirelix	4		* Covered through IVF Program. Must use Village Pharmacy or Walgreens Specialty Pharmacy or

DRUG NAME	TIER	LIMITATIONS	NOTES
			Freedom Drug for coverage. * Not available through mail service.
Gonal F	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
leuprolide acetate	2		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Menopur	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Novarel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Ovidrel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Pregnyl	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Repronex	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens

DRUG NAME	TIER	LIMITATIONS	NOTES
			Specialty Pharmacy for coverage. * Not available through mail service.
Serophene	4		
HORMONAL (PARATHYROID/METABOLIC BONE DISEASE)			
Bisphosphonates			
Actonel	4	5mg, 30mg, 150: Max. 1 tab/28-day supply; 35mg: Max. 4 tabs/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
alendronate solution	2	75ml oral solution bottle: 4 bottles/28 day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
alendronate tabs	1	35mg and 70mg: Max. 4 tabs/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Atelvia	4	4 tabs/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Binosto	4	Max. 4 tabs/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Boniva	4	150mg: Max. 1 tab/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Boniva IV	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
etidronate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fosamax (Tablets)	4	35mg and 70mg: Max. 4 tabs/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fosamax Plus D	4	Max. 4 tabs/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ibandronate sodium	2	150mg: Max. 1 tab/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Reclast	Medical		* Covered under medical benefit. No pharmacy copayment applies.

DRUG NAME	TIER	LIMITATIONS	NOTES
			* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
risedronate	2	Max. 4 tabs/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
zoledronic acid	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
zoledronic acid	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE).
Calcimimetics			
Sensipar	4		* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.
Calcium Regulating Hormones			
calcitonin-salmon nasal spray	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Fortical	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Miacalcin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Parathyroid Hormone Analog			
Forteo	3	Max. 1 syringe/28-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Magellan Health (formerly known as ICORE). * Prior authorization required; Not available through mail service.Prior authorization required.
Natpara	4	Max. 2 cartridges/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Selective Estrogen Receptor Modulators			
Evista	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
raloxifene	2		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
HORMONAL (PITUITARY)			
Gonadotropin-releasing Hormone Analogs			
Eligard	4		* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Lupaneta Pack	4		* Not available through Mail Service.
Supprelin LA	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Synarel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Vantas	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Growth Hormone Analogs			
Egrifta	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail ServicePrior authorization required Sole Source Pharmacy: Walgreens Specialty Pharmacy 1-844-EGRIFTA (1-844-347-4382)
Genotropin	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through mail service
Genotropin MiniQuick	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through mail service
Humatrope	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through mail service
Norditropin Flexpro/Nordiflex	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through Mail Service.
Nutropin	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
Nutropin AQ	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
Nutropin AQ NuSpin	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			requiredNot available through Mail Service
Omnitrope	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through mail service.
Saizen	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through Mail Service
Serostim	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through Mail Service
Zorbtive	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
Pituitary, Other			
cabergoline	2		
DDAVP	4		
desmopressin	2		
Gattex	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Increlex	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.Not available through Mail Service.
Lupron Depot/Lupron-Pedi	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.
octreotide	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service
Samsca	4		* Not available through Mail Service.
Sandostatin/LAR	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.
Signifor	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service
Signifor LAR	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo.
Somatuline Depot	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Somavert	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Stimate	3		
HORMONAL (SEX HORMONES)			

DRUG NAME	TIER	LIMITATIONS	NOTES
Androgens			
Anadrol-50	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Androderm	3	Prior authorization required for members 18 and older. 2mg: Max. 60 patches/30-day supply 4mg: Max. 30 patches/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Androgel	4	Prior authorization required for members 18 and older. 2.5 gram: Max. 30 packets/30-day supply 5 gram: Max. 60 packets/30-day supply 75 gram pump: Max. 4/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Androgel 1.62%	3	Prior authorization required for members 18 and older. 1.25 gram: Max. 30 packets/30-day supply 2.5 gram: Max. 60 packets/30-day supply 75 gram pump: Max. 2 pumps/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Android	4		* Max. 30-day supply as required by state & federal law or benefit plan design
Axiron	3	90mL metered-dose pump: Max. 2/30 day-supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Prior authorization required for members 18 and older.
danazol	2		
Depo-Testosterone	4	Prior authorization required for members 18 and older. 1mL vial: Max.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
		4 vials/30 day-supply 10mL vial: Max. 1 vial/30 day-supply	
Fortesta	4	Prior authorization required for members 18 and older. Max 2 pumps/30-day supply	* Mail Service: Max. 30-day supply as required by State or Federal law, or benefit plan design
Methitest	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Natesto	4	Prior authorization required for members 18 and older. Max. 33 grams/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Not available through Mail Service.
Oxandrin	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxandrolone	2		
Striant	3	Prior authorization required for members 18 and older. Max. 60 tabs/30 day-supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Testim	4	Prior authorization required for members 18 and older. Max. 300 grams/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Testone CIK	4	Prior authorization required for members 18 and older. Max. 4 l ml vials/30-day supply.	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
testosterone 1% gel	2	Prior authorization required for members 18 and older. Max. 300 grams/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
testosterone 2% gel	2	Prior authorization required for members 18 and older. Max. 2 pumps/30 day-supply.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
testosterone cypionate	2	Prior authorization required for members 18 and older. 1mL vial: Max. 4 vials/30 day-supply 10mL vial: Max. 1 vial/30 day-supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
testosterone enanthate	2	Prior authorization required for members 18 and older. 1mL syringe: Max. 4 syringes/30-day supply 5mL vial: Max. 1 vial/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Testred	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vogelxo	4	Prior authorization required for members 18 and older. 5 gram: Max. 60 packets/30-day supply 75 gram: Max. 4 pumps/30 day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

Estrogen/Methyltestosterone combos

Covaryx	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Covaryx H.S.	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
estrogen, ester/me-testosterone 0.625mg/1.25mg	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design
estrogen, ester/me-testosterone 1.25mg/2.5mg	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Estrogen/Progestin Combos			
Activella	4		
Climara Pro	3		
Combipatch	3		
ethinyl estradiol/norethindrone acetate	2		
FemHRT	4		
Jinteli	2		
Premphase	3		
Prempro	3		
Estrogens			
Alora	4		
Cenestin	3		
Climara	4		
Divigel	3		
Elestrin	4		
Enjuvia	3		
Estrace	4		
Estrace (vaginal cream)	3		
estradiol	1		
estradiol (patch)	2		
Estring	3		* Packaged as a 90-day supply. Member pays 3 copayments at retail pharmacy.
Estrogel	4		
estropipate	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Evamist	4	Max. 1 bottle/copay	* Not available through Mail Service.
Femring	4		* Packaged as a 68-day supply. Member pays 3 copayments at retail pharmacy.
Femtrace	4		
Menest	4		
Menostar	4		
Minivelle patch	4		
Premarin	3		
Premarin (vaginal cream)	3		
Vagifem	3		
Vivelle-DOT	4		
Estrogens/SERM Combos			
Duavee	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Progestins			
Aygestin	4		
Crinone	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Endometrin	3		* Covered through IVF Program. Must use Village Pharmacy or Walgreens Specialty Pharmacy or Freedom Drug for coverage. * Not available through Mail Service.
Makena	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pharmacy Program. Must use Accredo. * Covered through IVF Program. Must use Village Pharmacy for coverage. * Not available through mail service.
medroxyprogesterone acetate (tablets)	1		
Micronor	4		
norethindrone acetate	2		* This medication is eligible for a $0 co-pay under certain benefit plans.
progesterone	2		
Progesterone In Oil [brand name]	4		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
progesterone in oil [generic]	2		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Prometrium	4		
Provera	4		
HORMONAL (THYROID AGENTS)			
Thyroid Agents			
Armour Thyroid	4		
Cytomel	4		
Levothroid	2		
levothyroxine	1		
Levoxyl	2		
liothyronine	2		
methimazole	2		
propylthiouracil	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Synthroid	3		
Tapazole	4		
Thyrolar	4		
Tirosint	4		
Unithroid	2		
IMMUNOLOGIC AGENTS			
Immunologic Agents, Other			
Arcalyst	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Benlysta	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service
Cosentyx	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Ilaris	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available at mail service. Prior authorization required.
Otezla	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Synagis	Medical	Covered for members under 2 years of age; Maximum of 5 doses per 180 days.	* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.Prior authorization required.
Immunomodulators			
Actimmune	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Aubagio	4	Max. 28 tabs/28 day-supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Avonex	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Betaseron	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Copaxone 20mg	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Copaxone 40mg	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Extavia	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Gilenya	3	Max. 28 caps/28 day supply	* Covered through Specialty Pharmacy Program. Must use Accredo.
Glatopa 20mg	3		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Intron-A	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Peg-Intron	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Pegasys	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Plegridy	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Pomalyst	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Rebif	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Rebif Rebi-Dose	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Revlimid	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Stelara	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available

DRUG NAME	TIER	LIMITATIONS	NOTES
			through Mail Service. Prior authorization required.
Sylatron	4		* Covered through Specialty Pharmacy Program. Must use Accredo.
Tecfidera	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Thalomid	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Immunosuppressants, non-TNF			
Actemra (SubQ)	4	Max. 4 syringes/28-day supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Astagraf XL	4		
Azasan	3		
azathioprine	2		
CellCept	4		
Cuprimine	3		
cyclosporine	2		
cyclosporine micro-emulsion	2		
Depen	4		
Gengraf	2		
Hecoria	3		
Imuran	4		
methotrexate	2		
mycophenolate	2		
mycophenolate mofetil suspension	2		
mycophenolic acid	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Myfortic	4		
Neoral	4		
Nulojix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service
Orencia (Prefilled Syringe)	4	Max. 4 syringes/28-day supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Otrexup	3		* Not available through Mail Service.
Prograf	3		
Rapamune	4		
Rasuvo	3	Max. 4 syringes/28 day-supply	* Not available through Mail Service.
Rheumatrex	3		
Sandimmune	4		
Sandimmune Oral Soln	3		
sirolimus	2		
tacrolimus	2		
Trexall	4		
Xeljanz	4	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service..Prior authorization required.
Zortress	4		

Immunosuppressants, TNF Inhibitors

Cimzia (prefilled syringe)	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available

DRUG NAME	TIER	LIMITATIONS	NOTES
			through mail service. Prior authorization required.
Enbrel	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service. Prior authorization required.
Humira	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service. Prior authorization required.
Humira Crohns Starter Kit	3	1 kit per year	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service. Prior authorization required.
Humira Psoriasis Starter Kit	3	Max. 1 kit/year	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service. Prior authorization required.
Simponi	4	Max. 1 pen injector/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service. Prior authorization required.
Vaccines/Serums			
Micrhogam Ultra-Filtered Plus	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
RhoGam Ultra-Filtered Plus	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Vivotif-Berna	4		
Zostavax	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service
MEDICAL SUPPLIES			
Glucose Test Strips			
Accu-Chek Active Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Accu-Chek Aviva Plus	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Accu-Chek Aviva Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Accu-Chek Comfort Curve Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Accu-Chek Compact Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Breeze 2 Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Contour Next Strips	4	Max. 204 strips/30-day supply.	* Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
ContourTest Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Diastix	3		
Freestyle Insulinx	3	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Freestyle Lite Test Strips	3	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Freestyle Test Strips	3	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glucocard	4	Max. 204 strips/30 day-supply	* Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Ketostix	3		
One Touch Ultra Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
One Touch Verio Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.

DRUG NAME	TIER	LIMITATIONS	NOTES
Precision Q-I-D Test Strips	3	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Precision Xtra Test Strips	3	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prodigy Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Sof-Tact Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
SureStep Pro Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Insulin Delivery Systems			
V-Go	4	Max. 30 units/30 day supply	
Needles and Syringes			
BD Micro-Fine Insulin Syringe	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
BD Ultra-Fine Insulin Syringe	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
BD Ultra-Fine Pen Needles	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lancets	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Novo Twist needles	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
NovoFine needles	3		
Spacer Devices			
Aerochamber	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Aerochamber (including mask)	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Inspirease Delivery System	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Inspirease Replacement Bags	Medical		* Covered under medical benefit. No pharmacy copayment applies.
OPHTHALMIC			
Antiglaucoma Agents			
AK-Pentolate 1%	1		
Alphagan P 0.1%	3		
Alphagan P 0.15%	4		
apraclonidine	2		
atropine	1		
Azopt	3		
Betagan	4		
betaxolol, ophthalmic	2		
Betimol	3		
Betoptic S	3		
brimonidine 0.15%	2		
brimonidine 0.2%	2		
Combigan	3		
Cosopt	4		
Cosopt PF	4		
Cyclogyl 0.5%	3		
Cyclogyl 1%	4		
Cyclogyl 2%	4		
cyclopentolate 1%	1		
cyclopentolate 2%	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
dorzolamide (ophthalmic)	2		
dorzolamide/timolol (ophthalmic)	2		
homatropaire	2		
Iopidine	4		
Isopto Atropine	3		
Isopto Carbachol	4		
Istalol	4		
levobunolol	2		
metipranolol	2		
phenylephrine 2.5% (drops)	2		
Phospholine Iodide	3		
pilocarpine 3% (ophthalmic drops)	2		
Simbrinza	3		
timolol	1		
timolol (ophthalmic gel)	2		
Timoptic	4		
Timoptic-XE	4		
Trusopt	4		

Ophthalmic Anti-Allergy

Alocril	4		
Alomide	4		
azelastine, ophthalmic	2		
Bepreve	4		
Elestat	4		
Emadine	4		
epinastine	2		
Lastacaft	4		
Optivar	4		
Pataday	3		
Patanol	3		
Pazeo	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Ophthalmic Anti-Inflammatory			
Acular/LS	4		
Acuvail	4	Max. 30 units/30-day supply	
Alrex	4		
Blephamide	3		
bromfenac	2		
Decadron (ophthalmic)	4		
dexamethasone (ophthalmic)	2		
diclofenac (ophthalmic)	2		
Durezol	4		
Flarex	4		
fluorometholone, ophthalmic	2		
flurbiprofen, ophthalmic	2		
FML	4		
Ilevro	4		
ketorolac tromethamine	2		
Lotemax	3		
Maxidex	4		
neomycin-polymixin-hc	2		
neomycin-polymyxin-dexamethasone	2		
Ocufen	4		
Omnipred	4		
Pred Forte	4		
Pred Mild	3		
prednisolone acetate	2		
Prolensa	4		
Vexol	4		
Ophthalmic Antibiotics			
Azasite	4		
Besivance	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Bleph-10	1		
Ciloxan (drops)	4		
Ciloxan (ointment)	4		
ciprofloxacin (ophthalmic drops)	2		
erythromycin (ophthalmic)	2		
gatifloxacin	2		
Gentak (ointment)	2		
gentamicin	2		
gentamicin 0.3% (ointment)	2		
Iquix	4		
levofloxacin, ophthalmic	2		
Moxeza	4		
neomycin/bacitracin/polymyxin 3.5mg-400 (ointment)	2		
Ocuflox	4		
ofloxacin 0.3%	2		
polymyxin-trimethoprim (ophthalmic)	2		
Pred G	4		
Quixin	4		
sulfacetamide sodium 10% (drops)	2		
Sulfamide (drops)	1		
Tobradex	4		
Tobradex ST	4		
tobramycin (drops)	2		
tobramycin/dexamethasone (ophthalmic)	2		
Tobrex (drops)	4		
Tobrex (ointment)	3		
Vigamox	4		
Zylet	3		
Zymaxid	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Ophthalmic Antivirals			
trifluridine	2		
Viroptic	4		
Zirgan	4		
Ophthalmic Lubricating Agents			
Lacrisert	3		
Ophthalmic Prostaglandins			
bimatoprost	2		
latanoprost	2		
Lumigan	4		
Rescula	4		
Travatan Z	3		
travoprost	2		
Xalatan	4		
Zioptan	4		
Ophthalmic, Other			
Alcaine	2		
Cystaran	4		* Sole source pharmacy. Members must use Walgreens Specialty Pharmacy. CYSTARAN Hotline: 1-877-534-9627
Eylea	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
I-Lid	4		
Natacyn	3		
Ozurdex	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
proparacaine	2		
Restasis	3	Max. 60 vials/month	
tetracaine	2		
OTIC			
Otic Agents			
Acetasol HC	2		
Cetraxal	4		
Cipro HC	4		
Ciprodex	3		
Coly-Mycin S	4		
Dermotic (drops)	4		
Floxin Otic	4		
neomycin-polymyxin-hydrocortisone	2		
ofloxacin, otic	2		
Vosol HC	4		
RESPIRATORY AGENTS			
Antihistamines			
Astelin	4		
Astepro	4		
azelastine	2		
azelastine, nasal	2		
cetirizine oral solution	2		
Clarinex	4		
Clarinex D 24hr	4		
Clarinex Reditab	4		
clemastine	2		
cyproheptadine	2		
desloratadine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
desloratadine; oral-disintegrating tablet	2		
diphenhydramine	1		
hydroxyzine	2		
hydroxyzine pamoate	2		
Karbinal ER	4		
levocetirizine	2		
Palgic Liquid	2		
Semprex-D	4		
Vistaril	4		
Xyzal	4		

Antileukotrienes

Accolate	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
montelukast	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Singulair	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
zafirlukast	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zyflo CR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Antitussives and Expectorants			
benzonatate	2		
benzonatate 100mg	1		
benzonatate 200mg	2		
Cheratussin AC 100-10mg/5	1		
Gani-Tuss NR 100-10mg/5	1		
guaifenesin-codeine 100-10mg/5	1		
Guiatuss AC 100-10mg/5	1		
Hycofenix	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydrocodone/chlorpheniramine (suspension)	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydrocodone/homatropine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Hydromet	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Iophen-C NR 100-10mg/5	1		
Mytussin AC 100-10mg/5	1		
Obredon	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
promethazine DM 15-6.25/5	2		
promethazine/codeine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
pseudoephedrine/hydrocodone/ chlorpheniramine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tessalon	4		
Tussicaps	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tussionex	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tuzistra XR	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vi-Q-Tuss 100-5mg/5	1		
Vituz	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Zonatuss	4		
Zutripro	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

Bronchodilators, Anticholinergic

Atrovent HFA	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Incruse Ellipta	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ipratropium solution	2		
Spiriva	3	Max. 1 unit (30 blisters)/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Spiriva Respimat	3	Max. 1 inhaler/30 day-supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Stiolto Respimat	4	Max. 1 unit/30-day supply	
Tudorza Pressair	3	Max. 1 unit/30 day-supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Bronchodilators, Sympathomimetics			
albuterol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
albuterol 2mg & 4mg (tablet)	1		
albuterol 2mg/5mL (syrup)	1		
albuterol sulfate ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Arcapta Neohaler	4	Max 1 unit (30 capsules)/ 30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Brovana	4		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Combivent Respimat	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Duoneb	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Foradil	3	Max. 1 unit (60 caps)/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ipratropium/albuterol (nebulizer solution)	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
isoetharine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
levalbuterol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Maxair Autohaler	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metaproterenol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Perforomist	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ProAir HFA	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ProAir Respiclick	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Proventil HFA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Serevent Diskus	3	Max. 1 unit (60 blisters)/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Striverdi Respimat	4	Max. 1 inhaler/30-day supply	
terbutaline	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Ventolin HFA	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vospire ER	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Xopenex	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Xopenex HFA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Bronchodilators, Xanthines			
Theo 24	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
theophylline	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Inhaled Corticosteroids			
Advair Diskus	3	Max. 1 unit (60 blisters)/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Advair HFA	3	Max. 1 unit/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Aerospan	4		
Alvesco	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Anoro Ellipta	4	Max. 1 unit/30-day supply	
Asmanex	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Asmanex HFA	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Breo Ellipta	3	Max. 1 unit/30-day supply	
budesonide ampule-neb	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dulera	3	Max. 1 inhaler/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Flovent Diskus	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Flovent HFA	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Pulmicort Flexhaler	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Pulmicort Respule	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
QVAR	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Symbicort	3	Max. 1 inhaler(120 doses)/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Mast-Cell Stabilizers			
cromolyn sodium	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nasal Inhalers			
Arnuity Ellipta	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Atrovent Nasal	4		
Beconase AQ	4		
budesonide aqueous, nasal	2		
Children’s QNASL	4		
Dymista	3		
Flonase	4		
flunisolide nasal spray	2		
fluticasone nasal spray	2		
Nasacort AQ	4		
Nasonex	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
olopatadine nasal spray	2		
Omnaris	4		
Patanase Nasal Spray	4		
QNASL	4		
Rhinocort AQUA	4		
triamcinolone acetonide aqueous, nasal	2		
Veramyst	3		
Zetonna	4		

Pulmonary Arterial Hypertension Agents

Adcirca	3	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.Not available through Mail Service.
Adempas	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Letairis	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Opsumit	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Orenitram ER	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Revatio	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service

DRUG NAME	TIER	LIMITATIONS	NOTES
sildenafil (PAH)	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through mail service..
Tracleer	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Tyvaso	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Ventavis	4		* Not available through mail service. Available through Accredo Nova Factor only.
Respiratory, Other			
Bethkis	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Daliresp	3		
Esbriet	4	Max.270 caps/30 day-supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Hyper-Sal	4		
Kalydeco	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail servicePrior authorization required
Kitabis Pak	4		* Kitabis Pak includes nebulizer.
Nebusal	4		
Ofev	4	Max. 60 caps/30 day-supply	* Covered through Specialty Pharmacy Program. Must use Walgreens Specialty Pharmacy. * Sole Source

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pharmacy: Walgreens Specialty 800-420-3228 Not available through Mail Service
Orkambi	4		* Not available through Mail Service. * Prior authorization required.
Pulmozyme	3		
sodium chloride vial-neb	2		
Tobi	4		* Covered through Specialty Pharmacy Program. Must use Accredo.
Tobi Podhaler	3		* Covered through Specialty Pharmacy Program. Use Accredo.
tobramycin (inh neb)	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Tyzine	4		
Xolair	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service. Prior authorization required.
SEDATIVES and HYPNOTICS			
Sedative and Hypnotic Agents			
Ambien	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Ambien CR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			is not tried, prior authorization is required.
Belsomra	4	Max. 1 tab/daily	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
chloral hydrate	1		
Edluar	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
eszopiclone	2		
Hetlioz	4	Max. 30 caps/30-day supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Intermezzo	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Lunesta	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Rozerem	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Silenor	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.

DRUG NAME	TIER	LIMITATIONS	NOTES
Sonata	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
zaleplon	2		
zolpidem	1		
zolpidem ER	2		
Zolpimist	4	Max. 1 can/30-day supply	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
SKELETAL MUSCLE RELAXANTS			
Skeletal Muscle Relaxant Agents			
Amrix	4		
baclofen	2		
carisoprodol	2		
carisoprodol with aspirin	2		
chlorzoxazone	1		
CYCLOBENZAPRINE 5mg, 10mg	1		
cyclobenzaprine 7.5mg	2		
Dantrium	4		
dantrolene	2		
Fexmid	4		
Lorzone	4		
metaxalone	2		
methocarbamol	2		
orphenadrine citrate	2		
orphenadrine citrate/aspirin/caffeine	2		
Robaxin	4		
Skelaxin	4		
Soma	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
tizanidine	2		
Zanaflex	4		
THERAPEUTIC NUTRIENTS, MINERALS AND ELECTROLYTES			
Electrolytes/Minerals			
calcium acetate	2		
Carnitor	4		
Cytra-2	4		
Cytra-3	2		
Eliphos	2		
K-Lor	3		
K-Phos Neutral	4		
K-Phos Original	4		
K-Tab	3		
Kaochlor	4		
Klor-Con	4		
Micro-K	4		
PhosLo	4		
Phoslyra	3		
potassium chloride	2		
potassium citrate	2		
sodium citrate/citric acid	2		
Urocit-K	4		
zinc sulfate	2		
Prenatal Vitamins			
Bal-Care DHA Essential	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cadeau DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal DHA 27	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal Harmony	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal Rx	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Concept DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Concept OB	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Duet DHA Balanced	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Duet DHA EC	4		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Enbrace HR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Folet DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Gesticare DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Hemenatal OB	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Hemenatal OB + DHA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Infanate Plus	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Natalcare PIC	1		
Natalcare Plus 27mg-1mg	1		
Natalcare Rx 27-0.5mg	1		
Natalcare Three 28mg-1mg	1		
Natatab FA 29mg-1mg	1		
Natelle EZ	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Natelle One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nestabs ABC	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nexa Plus	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nutri-Tab OB	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nutri-Tab OB + DHA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
OB Complete	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete 400	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete Premier	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
PNV-DHA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
PNV-Select	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prefera-OB	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Prefera-OB One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prefera-OB plus DHA	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Premesis Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenafirst 17mg-1mg	2		
Prenaissance Balance	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenaissance Next	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenaissance Next-B	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Prenaplus 27mg-1mg	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenatabs FA 29mg-1mg	1		
Prenatal 1 Plus 1 27mg-1mg	1		
Prenatal Low Iron 27mg-1mg	1		
Prenatal MTR 27mg-1mg	1		
Prenatal Plus	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenatal Plus 27mg-1mg	1		
Prenatal Rx 1 60mg-1mg	1		
Prenatal Z 65mg-1mg	1		
Prenate Chewable	4		
Prenate DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Elite	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Enhance	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Prenate Essential	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Mini	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Pixie	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Restore	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Star	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenexa	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Preque 10	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Protect Natal	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Provida DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Provida OB	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Rovin-A DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Select-OB	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Strovite One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
TL Folate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
Tricare	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tricare Prenatal DHA One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Trinate 28mg-1mg	2		
Triveen-PRX RNF	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vinate DHA RF	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vinate One 60mg-1mg	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vinate-M 27mg-1mg	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Virt-Bal DHA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol Nano	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol Ultra	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol-One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol-Plus	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitamed MD One Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitamed MD Plus Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Vitamed MD RediChew Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitapearl	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitamins - Multiple Vitamins			
Folgard OS	4		
Icar-C Plus	2		
multivitamins with fluoride	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Packaged as a 50 day supply. Member pays 2 copays.
Nephrocaps	2		
Nephrocaps QT	4		
Nephron FA	2		
POLY-VI-FLOR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
POLY-VI-FLOR with IRON	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Quflora	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Renax	2		
TL G-Fol OS	2		
Vitamins - Vitamin B			
cyanocobalamin (injection)	1		
folic acid	1		* $0 cost share for females 12-50 years of age. Cost share/copay applies for members not within this age bracket.
Foltrate	4		
hydroxycobalamin 1,000 mcg (injection)	2		
Nascobal	4		
Vitamins - Vitamin D			
calcitriol	2		
doxercalciferol	2		
Drisdol	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ergocalciferol	2		
Hectorol	4		
paricalcitol	2		
Rocaltrol	4		
Rocaltrol Solution	3		
Vitamin D 50,000 Unit (capsule)	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
Zemplar	4		
Vitamins - Vitamin K			
Mephyton	3		
UNCLASSIFIED			
Cosmetic			
Aclaro	NC		* This drug is not covered.
Avage	NC		* This drug is not covered.
Epiquin Micro	NC		* This drug is not covered.
Genadur	NC		* This drug is not covered.
Latisse	NC		* This drug is not covered.
Lustra	NC		* This drug is not covered.
OBAGI-C	NC		* This drug is not covered.
Pliaglis	NC		* This drug is not covered.
Propecia	NC		* This drug is not covered.
Renova	NC		* This drug is not covered.
tretinoin 0.05%, emollient	NC		* This drug is not covered.
Tri-Luma	NC		* This drug is not covered.
Vaniqa	NC		* This drug is not covered.
Diagnostics			
Thyrogen	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Unclassified			
Ampyra	4	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Botox	Medical	Prior authorization required for members 17 and older	* Covered under medical benefit. No pharmacy copayment applies.

DRUG NAME	TIER	LIMITATIONS	NOTES
			* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Brisdelle	4		
Dysport	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.Prior authorization required.
Grastek	4	Max. 30 tabs/30-day supply	* Not available through Mail Service.
Myalept	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Myobloc	Medical	Prior authorization required for members 17 and older	* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Oralair	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Orfadin	4		* Sole Source Pharmacy: Dohmen Life Sciences 1-800-305-7881
Osphena	4		
Potaba	4		
Prolia	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Ragwitek	4	Max. 30 tabs/30-day supply	* Not available through Mail Service.
Sodium Chloride	2		
Soliris	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Xeomin	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail ServicePrior authorization required
Xgeva	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE).
Xiaflex	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Managed Distribution Xiaflex Xperience http://www.xiaflex.com/procedure_training.jsp For the treatment of Peyronie's Disease contact US Bioservices at 800-801-1140

Weight Loss Agents

DRUG NAME	TIER	LIMITATIONS	NOTES
Adipex-P	NC		* This drug is not covered.
Belviq	NC		* This drug is not covered.
Contrave ER	NC		* This drug is not covered.
Didrex	NC		* This drug is not covered.
Ionamin	NC		* This drug is not covered.
phentermine	NC		* This drug is not covered. *
Qsymia	NC		* This drug is not covered.
Saxenda	NC		* This drug is not covered.
Suprenza ODT	NC		* This drug is not covered.
Xenical	NC		* This drug is not covered.