Harvard Pilgrim Prescription Drug List

PREMIUM FORMULARY
FOUR-TIER DRUG LIST
IN ALPHABETICAL ORDER

LAST UPDATED : 09/04/2015

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

1. Under "Drug," look up the name of your medication.
2. Once you find the medication, check the tier number to the right of the drug name.
   - 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
norethindrone/ethinyl estradiol/ iron (ferrous fumarate)	2		
8			
8-MOP	4		
A			
abacavir	2		
abacavir/lamivudine/zidovudine	2		
Abilify	4		
Abilify Discmelt	4		
Absorica	4		* Not available through Mail Service.
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.
acamprosate calcium	2		
Acanya	3		* Not available through Mail Service.
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.
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.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
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.
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.
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.
Aceon	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.
acetaminophen/butalbital	2		
acetaminophen/caffeine/ butalbital	2		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
acetaminophen/tramadol	2		
Acetasol HC	2		
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.
Aciphex	4		
AcipHex Sprinkle/capsule	4		
acitretin	2		
Aclaro	NC		* This drug is not covered.
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.
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.
Acticlate	4		
Actigall	4		
Actimmune	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Activella	4		
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.
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.
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.
Acular/LS	4		
Acuvail	4	Max. 30 units/30-day supply	
acyclovir	2		
acyclovir (ointment)	2		
acyclovir (suspension)	2		
Aczone	4		
Adalat CC	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.
adapalene	2	Prior authorization required for members 30 and older	
Adcirca	3	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			required.Not available through Mail Service.
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.
adefovir	2		
Adempas	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Adipex-P	NC		* This drug is not covered.
Adoxa	4		
Adrenaclick	4	Max. 2 units/copay	* Not available through Mail Service.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Aerochamber	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Aerochamber (including mask)	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Aerospan	4		
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.
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.
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.
AK-Pentolate 1%	1		
Akne-Mycin	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Akynzeo	4	Max. 1 cap/copay, Max. 3 caps/28 day-supply	* Not available through Mail Service.
Alagesic LQ	2		
Albenza	3		
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.
Alcaine	2		
alclometasone dipropionate	2		
Alcortin A	NC		* This drug is not covered.
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 deductible. Applicable copayment will apply.
Aldara	4		
Aldurazyme	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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Alevicyn	4		
alfuzosin	2	Max. 30 tabs/30-day supply	
Alinia	4		
Alkeran	4		
allopurinol	1		
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.
Alocril	4		
Alomide	4		
Alora	4		
alosetron	2	Covered for females only	
Alphagan P 0.1%	3		
Alphagan P 0.15%	4		
Alphanate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark.

DRUG NAME	TIER	LIMITATIONS	NOTES
			* 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.
alprazolam	1		
alprazolam (rapid dissolve tablet)	2		
alprazolam ER	2		
alprazolam Intensol	4		
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.
Alrex	4		
Alsuma	4	Max. 6 injections/copay	* Not available through Mail Service.
Altabax	4		
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.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Alyacen	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
amantadine	2		
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.
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 is not tried, prior authorization is required.
amcinonide	2		
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.
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		
amiloride	2		* 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.
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.
aminocaproic acid	2		
amiodarone	2		
Amitiza	3		
amitriptyline	1		
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.
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 will not be subject to your plan deductible. Applicable copayment will apply.
ammonium lactate	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Amnesteem	2		* Not available through Mail Service.
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		
amphetamine/ 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.
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.
ampicillin	2		
Ampyra	4	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Amrix	4		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
Anadrol-50	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Anafranil	4		
anagrelide	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.
Anaprox	4		
Anaprox DS	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.
Ancobon	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Android	4		* Max. 30-day supply as required by state & federal law or benefit plan design
Angeliq	4		
Anoro Ellipta	4	Max. 1 unit/30-day supply	
Antabuse	4		
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.
Anusol HC Cream	4		
Anusol HC Suppositories	3		
Anzemet	4	50mg: Max. 6 tabs/copay; 100mg: Max. 3 tabs/copay	* Not available through Mail Service.
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.
Aplenzin	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Apokyn	4		* Not available through Mail Service.
apraclonidine	2		
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.
Apriso	3		
Aptensio 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.
Aptiom	4		
Aptivus	4		
Aqua Glycolic HC	4		
Aralast NP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Aralen	4		
Aranelle	$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.
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.
Arava	4		
Arcalyst	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
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.
Aricept	4		
Aricept ODT	4		
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
aripiprazole	2		
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.
Armour Thyroid	4		
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.
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.
Arthrotec	4		
Asacol	3		
Asacol HD	3		
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 deductible. Applicable copayment will apply.
aspirin/butalbital/caffeine	2		
Astagraf XL	4		
Astelin	4		
Astepro	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
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.
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.
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.
Ativan	4		
Atopiclair	4		
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.
atovaquone	2		
atovaquone/proguanil	2		
Atralin	3	Prior authorization required for members 30 and older	
Atripla	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
atropine	1		
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.
Atrovent Nasal	4		
Aubagio	4	Max. 28 tabs/28 day-supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Augmentin (suspension)	4		
Augmentin (tablets)	4		
Augmentin 125-31.25mg (suspension)	3		
Augmentin ES 600mg (suspension)	4		
Augmentin XR	4		
Aurstat	4		
Auryxia	4		
Auvi-Q	4	Max. 2 units/copay	* Not available through Mail Service.
Avage	NC		* This drug is not covered.
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.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
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.
Avelox	4		
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.
Avinza	4	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Avita	2	Prior authorization required for members 30 and older	
Avodart	3		
Avonex	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
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.
Axid	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Aygestin	4		
Azasan	3		
Azasite	4		
azathioprine	2		
azelastine	2		
azelastine, nasal	2		
azelastine, ophthalmic	2		
Azelex	3		
Azilect	3		
azithromycin	2		
Azopt	3		
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.
Azulfidine	4		
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.

B

baclofen	2		
Bactrim	4		
Bactrim DS	4		
Bactroban Cream	4		
Bactroban Nasal	4		
Bactroban Ointment	4		
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.
balsalazide disodium	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Banzel	3		
Baraclude (tablet)	4		
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.
Beconase AQ	4		
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.
Belviq	NC		* This drug is not covered.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Benefix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
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.
Benicar 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.
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
Benoxyldoxy	4		
Bentyl	4		
Benzaclin	4		* Not available through Mail Service.
Benzamycin	4		* Not available through Mail Service.
benzonatate	2		
benzonatate 100mg	1		
benzonatate 200mg	2		
benztropine 0.5mg, 1mg tab	1		
benztropine 2mg tab	2		
benztropine mesylate	2		
Bepreve	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Besivance	4		
Betagan	4		
betamethasone dipropionate	2		
betamethasone dipropionate, augmented	2		
betamethasone dipropionate/ calcipotriene	2		
betamethasone valerate	2		
betamethasone valerate 0.1% (lotion)	2		
betamethasone valerate foam	2		
betamethasone/clotrimazole	2		
Betapace	4		
Betapace AF	4		
Betaseron	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
betaxolol, ophthalmic	2		
betaxolol, oral	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.
bethanechol	2		
Bethkis	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Betimol	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Betoptic S	3		
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.
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.
Biafine	4		
Biaxin	4		
Biaxin XL	4		
bicalutamide	2		
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.
Biltricide	4		
bimatoprost	2		
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 deductible. Applicable copayment will apply.
Bionect	4		
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.
bisoprolol/hydrochlorothiazide	2		* 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.
Bleph-10	1		
Blephamide	3		
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.
Bosulif	4		* Covered through Specialty Pharmacy Program. 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. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Bravelle	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
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 required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle

DRUG NAME	TIER	LIMITATIONS	NOTES
			Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Breo Ellipta	3	Max. 1 unit/30-day supply	
Brevicon	2		
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.
brimonidine 0.15%	2		
brimonidine 0.2%	2		
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.
Brisdelle	4		
bromfenac	2		
bromocriptine mesylate	2		
Brovana	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.
budeprion SR	2		
budeprion XL	2		
budesonide	2		
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.
budesonide aqueous, nasal	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
Buphenyl	4		
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
Buproban	2	Annual Limit: Max. 360 tabs/180 days.	* Not available through Mail Service.
bupropion	2		
bupropion SR	2		
bupropion XL	2		
bupropion, smoking cessation	2	Annual Limit: Max. 360 tabs/180-day supply	* Not available through Mail Service.
buspirone	2		
buspirone 5mg tab	1		
Butalbital Compound w/codeine	2		* Mail Service: Max. 30-day supply as required by State 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.
butorphanol	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
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.
C			
cabergoline	2		
Cadeau 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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Cafergot	4		
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.
calcipotriene	2		
calcipotriene solution	2		
calcitonin-salmon nasal spray	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.
calcitriol	2		
calcium acetate	2		
Cambia	4		
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.
Campral calcium	4		
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.
Canasa Rectal Suppository	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
candesartan	2		
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.
Cantil	4		
capecitabine	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Caphosol	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Caprelsa	4		* Not available through Mail Service.
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		
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.
Carac	4		
Carafate (suspension)	3		
Carafate (tablet)	4		
Carbaglu	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
carbamazepine	2		
carbamazepine ER	2		
Carbatrol	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
carbidopa	2		
carbidopa/levodopa	2		
carbidopa/levodopa (rapid dissolve tab)	2		
carbidopa/levodopa SR	2		
carbidopa/levodopa/entacapone	2		
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 will not be subject to your plan deductible. Applicable copayment will apply.
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.
carisoprodol	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
carisoprodol with aspirin	2		
Carnitor	4		
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.
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.
Casodex	4		
Cataflam	4		
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.
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.
Caverject	3	Max. 6 injections/30-day supply; Covered for males over 18 years of age only	
Cayston	4		* Not available through Mail Service.
Cedax (capsule)	4		
Cedax (suspension)	4		
CEENU	4		
cefaclor	2		
cefadroxil	2		
cefdinir	2		
cefditoren pivoxil	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
cefixime	2		
cefpodoxime	2		
cefprozil	2		
ceftibuten	2		
Ceftin (suspension)	4		
Ceftin (tablet)	4		
cefuroxime axetil	2		
Celebrex	4		
celecoxib	2		
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.
CellCept	4		
Celontin	3		
Cenestin	3		
cephalexin	2		
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.
Cesamet	4	Max. 18 tabs/copay	* Not available through Mail Service. * Max. 30-day supply as required by state & federal law or benefit plan design.
cetirizine oral solution	2		
Cetraxal	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cetrotide	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
cevimeline	2		
Chantix	3	Annual limit of 26 weeks	* Not available through Mail Service.
Chemet	3		
Chenodal	4		* Not available through Mail Service. * Sole source through Centric Health.
Cheratussin AC 100-10mg/5	1		
Children's QNASL	4		
chloral hydrate	1		
chlordiazepoxide	1		
chlordiazepoxide/amitriptyline	2		
chlordiazepoxide/clidinium	2		
chlorhexidine gluconate	2		
chloroquine phosphate	2		
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.
chlorpromazine	2		
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
chlorzoxazone	1		
Cholbam	4		
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.
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.
Cialis	3	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only	* Prior authorization required when quantity exceeds limitation.
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
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.
Ciloxan (drops)	4		
Ciloxan (ointment)	4		
cimetidine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cimzia (prefilled syringe)	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service. Prior authorization required.
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.
Cipro	4		
Cipro HC	4		
Cipro XR	4		
Ciprodex	3		
ciprofloxacin (ophthalmic drops)	2		
ciprofloxacin 100mg (tablet)	2		
ciprofloxacin 250mg, 500mg, 750mg (tablets)	1		
ciprofloxacin ER	2		
citalopram hydrobromide tabs	1		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Claravis	2		* Not available through Mail Service.
Clarinex	4		
Clarinex D 24hr	4		
Clarinex Reditab	4		
clarithromycin	2		
clemastine	2		
Cleocin	4		
Cleocin Cream	4		
Cleocin T	4		
Cleocin Vaginal Suppository	4		
Climara	4		
Climara Pro	3		
Clindacin Pac	4		
clindamycin	2		
clindamycin phosphate	2		
clindamycin phosphate 1% foam	2		
clindamycin/benzoyl peroxide	2		* Not available through Mail Service.
Clindesse	4		
Clinoril	4		
clobetasol propionate	2		
clobetasol propionate/emollient	2		
Clobex	4		
clocortolone pivalate	2		
Cloderm	4		
clomiphene citrate	2		
clomipramine	2		
clonazepam	1		
clonazepam (rapid dissolve)	2		
clonidine	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs will not be subject to your plan deductible. Applicable copayment will apply.
clonidine ER	2		
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.
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.
clorazepate	2		
clotrimazole (troche)	2		
clozapine	2		* Not available through Mail Service.
clozapine ODT	2		
Clozaril	4		* Not available through Mail Service.
Coartem	4	Max. 24 tabs/copay	* Not available through Mail Service.
codeine sulfate	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Colazal	4		
colchicine (capsule)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
colchicine (tablet)	2		
Colcrys	4		
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		
Coly-Mycin S	4		
CoLyte	4		
CoLyte with Flavor Packs	4		
Combigan	3		
Combipatch	3		
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.
Combivir	4		
Cometriq	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
Compazine	4		
Complera	4		
Comtan	4		
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 NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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.
Condylox	3		
Condylox Solution	4		
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.
Contrave ER	NC		* This drug is not covered.
Conzip	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Copegus	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Cordarone	4		
Cordran	4		
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.
Corifact	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Caremark.
Corlanor	4	Max. 60 tabs/30-day supply	* Prior authorization required.
Cormax	2		
Cortef	4		
Cortenema	4		
Cortifoam	4		
cortisone acetate	2		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Cosentyx	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Cosopt	4		
Cosopt PF	4		
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.
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.
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.
Creon	3		
Cresemba	4		* Not available through Mail Service.
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.
Crinone	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Crixivan	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
cromolyn	2		
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.
Cuprimine	3		
Cutivate	4		
Cuvposa	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
cyanocobalamin (injection)	1		
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.
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		
CYCLOBENZAPRINE 5mg, 10mg	1		
cyclobenzaprine 7.5mg	2		
Cyclogyl 0.5%	3		
Cyclogyl 1%	4		
Cyclogyl 2%	4		
cyclopentolate 1%	1		
cyclopentolate 2%	2		
cyclophosphamide	2		
cyclophosphamide capsules (Roxane)	3		
Cycloset	3		* 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.
cyclosporine	2		
cyclosporine micro-emulsion	2		
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.
cyproheptadine	2		
Cystadane	4		
Cystagon	4		
Cystaran	4		* Sole source pharmacy. Members must use Walgreens Specialty Pharmacy. CYSTARAN Hotline: 1-877-534-9627
Cytomel	4		
Cytotec	4		
Cytra-2	4		
Cytra-3	2		
D			
D.H.E. 45	3		
Daklinza	4	Max. 28 tabs/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Daliresp	3		
danazol	2		
Dantrium	4		
dantrolene	2		
Dapsone	2		
Daraprim	3		
Daypro	4		

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.
DDAVP	4		
Decadron (ophthalmic)	4		
Delzicol	3		
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.
demeclocycline	2		
Demerol	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Denavir	4		
Depakene	4		
Depakote	4		
Depakote ER	4		
Depakote Sprinkle	4		
Depen	4		
Depo-Testosterone	4	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.
Derma-Smoothe FS	4		
Dermasorb HC	4		
Dermasorb TA	4		
Dermatop	4		
Dermotic (drops)	4		
desipramine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
desloratadine	2		
desloratadine; oral-disintegrating tablet	2		
desmopressin	2		
Desogen	4		
desonide	2		
DesOwen	4		
Desowen Kit	4		
desoximetasone	2		
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.
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.
Detrol	4		
Detrol LA	4		
dexamethasone	2		
dexamethasone (ophthalmic)	2		
dexamethasone (oral solution)	2		
dexamethasone (tablet)	1		
dexamethasone 0.5mg/5mL (elixir)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
dexamethasone 2mg (tablet)	2		
dexamethasone 6mg (tablet)	2		
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.
Dexilant	4		
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.
DexPak	4		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			through mail service and Maine pharmacies.
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.
Diamox Sequels	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.
Diastat Acudial 5-7, 5-10mg	3		
Diastat Acudial, 12.5mg, 15mg, 20mg	4		
Diastix	3		
diazepam	1		
diazepam (solution) (concentrate)	2		
diazepam rectal gel 12.5mg, 15mg, 20mg	2		
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.
Diclegis	4		
diclofenac	2		
diclofenac (ophthalmic)	2		
diclofenac gel	2		
diclofenac sodium drops	2		
dicloxacillin sodium	2		
dicyclomine	2		
didanosine	2		
Didrex	NC		* This drug is not covered.

DRUG NAME	TIER	LIMITATIONS	NOTES
Differin	4	Prior authorization required for members 30 and older	
Dificid	4	Max. 20 tabs/copay	* Not available through Mail Service.
diflorasone diacetate	2		
Diflucan	4		
diflunisal	2		
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		
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.
dihydroergotamine mesylate nasal spray	2		
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.
Dilantin	4		
Dilantin Infatab	4		
Dilaudid	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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 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.
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.
Dipentum	4		
diphenhydramine	1		
diphenoxylate/atropine	2		
Diprolene	4		
Diprolene AF	4		
Diprosone	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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 Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
disopyramide	2		
disulfiram	2		
Ditropan XL	4		
divalproex sodium	2		
divalproex sodium 125mg (sprinkle)	2		
divalproex sodium ER	2		
Divigel	3		
Dolophine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
donepezil	2		
donepezil ODT	2		
Doral	4		
Doryx	4		
dorzolamide (ophthalmic)	2		
dorzolamide/timolol (ophthalmic)	2		
Dovonex	4		
Dovonex Solution	4		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
doxazosin mesylate 2mg	2		
doxepin	2		
doxepin 10mg/mL (oral concentrate)	2		
doxepin 150mg (capsule)	2		
doxercalciferol	2		
doxycycline hyclate	2		
doxycycline hyclate 20mg & 75mg	2		
doxycycline hyclate 50mg & 100mg	2		
doxycycline monohydrate	2		
doxycycline monohydrate 40mg	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.
dronabinol	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Drysol	NC		* This drug is not covered.
Duac	4		* Not available through Mail Service.
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.
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 NAME	TIER	LIMITATIONS	NOTES
			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.
Duexis	4		* Effective 10/1/15: Prior authorization required.
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.
duloxetine	2		
duloxetine hcl 40mg	2		
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.
Duopa	4	Max. 2800ml/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo.
Duragesic	4	Max 15 patches/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Durezol	4		
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.
Dyazide	4		* 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.
Dymista	3		
Dynacin	4		
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.
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.
E			
EC-Naprosyn	4		
econazole nitrate	2		
Ecoza	4		
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.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Edex	3	Max. 6 injections/30-day supply; Covered for males over 18 years of age only	
Edluar	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Edurant	4		
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.
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.
Efudex	4		
Egrifta	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail ServicePrior authorization required Sole Source Pharmacy: Walgreens Specialty Pharmacy 1-844-EGRIFTA (1-844-347-4382)
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.
Eldepryl	4		
Elelyso	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
Elestat	4		
Elestrin	4		
Elidel	3		* Prior authorization required
Eligard	4		* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Eliphos	2		
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.
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.
Elmiron	4		
Elocon	4		
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.
Emadine	4		
Embeda	4	Max. 3 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Emcyt	3		
Emend	4	40mg: Max. 4 caps/copay, 80mg: Max. 2 caps/copay, 125mg: Max. 1 cap/copay,	* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
		Tri-Pack: Max. 1 pack/ copay	
EMLA	4	Prior authorization required for members 17 and older	
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.
EMSAM	4		
Emtriva	4		
Enablex	4		
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.
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.
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.
Enbrel	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service. Prior authorization required.
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		
Endometrin	3		* Covered through IVF Program. Must use Village Pharmacy or

DRUG NAME	TIER	LIMITATIONS	NOTES
			Walgreens Specialty Pharmacy or Freedom Drug for coverage. * Not available through Mail Service.
Enjuvia	3		
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.
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.
entacopone	2		
entecavir	2		
Entocort EC	4		
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.
Enulose	2		
Epaned	4		
Epiceram	4		
Epiduo	4	Prior authorization required for members 30 and older	
Epiduo Forte	4	Prior authorization required for members 30 and over.	
Epifoam	4		
epinastine	2		
Epipen	3	Max. 2 units/copay	* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Epipen Jr.	3	Max. 2 units/copay	* Not available through Mail Service.
Epiquin Micro	NC		* This drug is not covered.
Episil	3		
Epivir (solution)	4		
Epivir (tablet)	4		
Epivir HBV (solution)	4		
Epivir HBV (tablet)	4		
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.
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.
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.
Epzicom	3		
Equetro	4		
ergocalciferol	2		
Ergoloid	2		
Ergomar	3		
Erivedge	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Ertaczo	4		
Ery-Tab	2		
Ery-Tab 333mg	3		
Erygel	4		
Eryped	3		
erythromycin (ophthalmic)	2		
erythromycin base, filmtab	2		
erythromycin ethylsuccinate	2		
erythromycin ethylsuccinate 200mg suspension	2		
erythromycin ethylsuccinate/ sulfisoxazole	2		
erythromycin/benzoyl peroxide	2		* Not available through Mail Service.
Esbriet	4	Max.270 caps/30 day-supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
escitalopram	2		
Esgic	4		
Esgic Plus	4		
Eskalith	4		
esomeprazole magnesium	3		
Esomeprazole strontium	4		
estazolam	2		
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		

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.
estropipate	2		
Estrostep FE	4		
eszopiclone	2		
ethambutol	2		
Ethedent	1		
Ethedent 1.1%	2		
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 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 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 - 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 0.18 / 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 – norgestimate 0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication

DRUG NAME	TIER	LIMITATIONS	NOTES
			is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol/norethindrone acetate	2		
ethosuximide	2		
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.
etodolac	2		
etoposide	2		
Eurax	3		
Evamist	4	Max. 1 bottle/copay	* Not available through Mail Service.
Evekeo	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.
Evista	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.
Evoclin	4		
Evotaz	4		
Evoxac	4		
Evzio	4	Max. 2 units/copay; Max.4 units/30-day supply	* Not available through Mail Service.
Exalgo	4	Max. 60 tabs/30 day-supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Exelderm	4		
Exelon	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Exelon Patch	3		
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.
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.
Exjade	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Extavia	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Extina	4		
Eylea	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
F			
Fabior	4	Prior authorization required for members 30 and older	
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Factive	4		
famciclovir	2		
famotidine	1		
Famvir	4		
Fanapt	4		
Fareston	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.
Farxiga	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.
Farydak	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Fazaclo	4		* 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.
felbamate	2		
Felbatol	4		
Feldene	4		
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.
Femara	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs will not be subject to your plan deductible. Applicable copayment will apply.
Femcon FE	4		
FemHRT	4		
Femring	4		* Packaged as a 68-day supply. Member pays 3 copayments at retail pharmacy.
Femtrace	4		
fenofibrate	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.
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.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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 design.. Prior authorization required.
Ferriprox	4		* Not available through Mail Service. * Sole source through Centric Health.
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.
Fexmid	4		
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.
Finacea	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Finacea Plus	3		
finasteride 1mg	NC		* This drug is not covered.
finasteride 5mg	2		
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.
Firazyr	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service
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		
Flarex	4		
flavoxate	2		
flecainide acetate	2		
Flector	3		
Flomax	4		
Flonase	4		
Floriva	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Floxin Otic	4		
fluconazole	1		
flucytosine	2		
fludrocortisone acetate	2		
Flumadine	4		
flunisolide nasal spray	2		
fluocinolone acetonide	2		
fluocinolone acetonide oil	2		
fluocinonide	2		
fluocinonide (micronized)	2		
fluorometholone, ophthalmic	2		
Fluoroplex	4		
fluorouracil cream	2		
fluoxetine	1		
fluoxetine (oral solution)	2		
fluoxetine 20mg (tablet)	2		
fluoxetine 40mg (capsule)	2		
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		
fluphenazine	2		
FLUPHENAZINE 1mg tab	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
flurazepam	1		
flurbiprofen	2		
flurbiprofen, ophthalmic	2		
flutamide	2		
fluticasone nasal spray	2		
fluticasone topical	2		
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.
fluvoxamine	2		
fluvoxamine er 24h	2		
FML	4		
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 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			through mail service and Maine pharmacies.
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.
Folgard OS	4		
folic acid	1		* $0 cost share for females 12-50 years of age. Cost share/ copay applies for members not within this age bracket.
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.
Foltrate	4		
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
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.
Forfivo XL	3		
Fortamet	4		* 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.
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.
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
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.
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.
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.
fosinopril/hydrochlorothiazide	2		* 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.
Fosrenol	4		
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.
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.
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.
Frova	4	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.
Fulyzaq	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Furadantin	4		
furosemide	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs will not be subject to your plan deductible. Applicable copayment will apply.
furosemide (oral solution)	2		
Fuzeon	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Fycompa	4		
G			
gabapentin	2		
Gabitril	4		
galantamine	2		
galantamine ER	2		
ganciclovir	2		
Gani-Tuss NR 100-10mg/5	1		
Ganirelix	4		* Covered through IVF Program. Must use Village Pharmacy or Walgreens Specialty Pharmacy or Freedom Drug for coverage. * Not available through mail service.
Gastrocrom	4		
gatifloxacin	2		
Gattex	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Gavilyte-G	2		
Gavilyte-H and Bisacodyl	2		
Gel-Kam	4		
Gelclair	3		
Gelnique	4	Max. 30 packets/30-day supply	
Gelnique Pump	4	Max. 1 pump bottle/30-day supply	

DRUG NAME	TIER	LIMITATIONS	NOTES
gemfibrozil	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.
Genadur	NC		* This drug is not covered.
Generess FE	4		
Generlac	2		
Gengraf	2		
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
Gentak (ointment)	2		
gentamicin	2		
gentamicin 0.3% (ointment)	2		
Geodon	4		
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.
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.
Giazo	4		
Gilenya	3	Max. 28 caps/28 day supply	* Covered through Specialty Pharmacy Program. Must use Accredo.
Gilotrif	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Glatopa 20mg	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Gleevec	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Gleostine	4		
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.
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.
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.
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.
Glucocard	4	Max. 204 strips/30 day-supply	* Prior authorization required. FreeStyle and Precision test strips; and

DRUG NAME	TIER	LIMITATIONS	NOTES
			FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Glucophage	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 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.
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.
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.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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 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.
Glycate	4		
glycopyrrolate	2		
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.
Glyset	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.
Glyxambi	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.
Go-Lytely	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Gralise	4		
granisetron	2	Max. 6 tabs/copay	* Not available through Mail Service.
Granisol	2	Max. 30mL/copay	* Not available through Mail Service.
Granix	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Grastek	4	Max. 30 tabs/30-day supply	* Not available through Mail Service.
Grifulvin V	4		
Gris-Peg	4		
griseofulvin	2		
griseofulvin ultramicro	2		
guaifenesin-codeine 100-10mg/5	1		
GUANFACINE 1mg	1		
guanfacine ER	2		
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.
Guiatuss AC 100-10mg/5	1		
Gynazole-1	4		
H			
Halcion	4		
halobetasol propionate	2		
Halog	4		
haloperidol	2		
Harvoni	3	Max. 28 tabs/28 day-supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through mail service.
Hecoria	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Hectorol	4		
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.
Hemangeol	4		* Not available through Mail Service.
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.
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.
heparin	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.
Hepsera	4		
Hetlioz	4	Max. 30 caps/30-day supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Hexalen	3		
Hiprex	4		
homatropaire	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Horizant	4		
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.
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.
Humatrope	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through mail service
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.
Humulin 70/30	3		* 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.
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.
Hycamtin	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Hycet	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Hycofenix	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
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.
Hydrea	4		
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.
hydrocodone/acetaminophen	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
hydrocortisone	2		
hydrocortisone (enema)	2		
hydrocortisone 1% (cream/ ointment)	1		
hydrocortisone 2.5% (cream/ ointment)	1		
hydrocortisone butyrate	2		
hydrocortisone valerate	2		
Hydromet	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

DRUG NAME	TIER	LIMITATIONS	NOTES
			& federal law or benefit plan design.
hydroxychloroquine	2		
hydroxycobalamin 1,000 mcg (injection)	2		
hydroxyurea	2		
hydroxyzine	2		
hydroxyzine pamoate	2		
Hylase	4		
Hylatopic	4		
Hylatopic Plus	4		
Hyper-Sal	4		
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
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.
I			
I-Lid	4		
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.
Ibrance	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
ibuprofen	2		
ibuprofen 100mg/5mL (suspension)	2		
Icar-C Plus	2		
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.
Ilevro	4		
Imbruvica	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
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.
imipramine	2		
imipramine pamoate	2		
imiquimod	2		
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.
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.
Imuran	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Increlex	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.Not available through Mail Service.
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.
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.
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.
Indocin	4		
Indocin Rectal Suppository	3		
indomethacin	2		
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.
Inlyta	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Innopran XL	3		* HSA Preventive drug. If your plan includes the Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Inspirease Delivery System	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Inspirease Replacement Bags	Medical		* Covered under medical benefit. No pharmacy copayment applies.
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.
Intelence	4		
Intermezzo	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Intron-A	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Intuniv	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.
Invirase	3		
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.
Invokana	3		* HSA Preventive drug. If your plan includes the Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Ionamin	NC		* This drug is not covered.
Iophen-C NR 100-10mg/5	1		
Iopidine	4		
ipratropium solution	2		
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.
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.
Iquix	4		
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.
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.
Irenka	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Isentress	3		
isoetharine	2		* HSA Preventive drug. If your plan includes the Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
isometheptene, dichloralphenazone, acetaminophen	2		
isoniazid	1		
isoniazid (syrup)	2		
Isopto Atropine	3		
Isopto Carbachol	4		
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.
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.
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.
Istalol	4		
itraconazole	2	Max. 168 caps/year	* Not available through Mail Service. * Prior authorization required
ivermectin	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Ixinity	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
J			
Jadenu	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Jakafi	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Jalyn	3		
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.
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.
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.
Jardiance	4		* 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.
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.
Jinteli	2		
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.
Jublia	4		* Not available through Mail Service. * Prior authorization required.
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.
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 plan deductible. Applicable copayment will apply. * Sole source through Centric Health.
K			
K-Lor	3		
K-Phos Neutral	4		
K-Phos Original	4		
K-Tab	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
Kalbitor	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Kaletra	3		
Kalydeco	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail servicePrior authorization required
Kaochlor	4		
Kapvay	4		
Karbinal ER	4		
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.
Kayexalate	4		
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.
Keflex	4		
Kenalog	4		
Keppra	4		
Keppra XR	4		
Keralyt gel	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Kerydin	4		* Not available through Mail Service. * Prior authorization required.
Ketek	4		
ketoconazole	2		
ketoconazole cream	2		
ketoconazole shampoo	2		
Ketodan	4		
KETOPROFEN	2		
ketoprofen 50mg caps	1		
ketorolac tromethamine	2		
ketorolac, oral	2	Max. 5-days supply / 20 tabs per fill	* Not available through Mail Service.
Ketostix	3		
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.
Kineret	4		* Prior authorization required. Sole Source Pharmacy: Omnicare/RX Crossroads, 866-547-0644
Kitabis Pak	4		* Kitabis Pak includes nebulizer.
Klonopin	4		
Klor-Con	4		
Koate-DVI	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark.

DRUG NAME	TIER	LIMITATIONS	NOTES
			* 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.
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.
Korlym	4		* Covered through Specialty Pharmacy Program. Must use Centric Health Resource.
Kristalose	3		
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 Accredo. * Not available through mail service.
Kynamro	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
L			
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.
Lac-Hydrin	4		
Lacrisert	3		
lactulose	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Lamictal	4		
Lamictal ODT	4		
Lamictal Starter Kit	3		
Lamictal Starter Kit 25mg	4		
Lamictal XR	4		
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.
lamivudine (solution)	2		
lamivudine (tabs)	2		
lamivudine/zidovudine	2		
lamotrigine	1		
lamotrigine ODT	2		
lamotrigine starter kit 25mg	2		
lamotrigine tab er 24	2		
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.
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.
lansoprazole	3		
lansoprazole/clarithromycin/ amoxicillin kit	2		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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.
Lastacaft	4		
latanoprost	2		
Latisse	NC		* This drug is not covered.
Latuda	3		
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.
leflunomide	2		
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.
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.
Lessina	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication

DRUG NAME	TIER	LIMITATIONS	NOTES
			is eligible for a $0 co-pay under certain benefit plans.
Letairis	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * 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.
leucovorin	2		
Leukeran	3		
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.
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.
Levaquin	4		
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.
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.
levetiracetam	2		
levetiracetam XR	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Levitra	4	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only	* Prior authorization required when quantity exceeds limitation.
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.
levobunolol	2		
levocetirizine	2		
levofloxacin	2		
LEVOFLOXACIN 250mg, 500mg	1		
levofloxacin, ophthalmic	2		
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.
levorphanol	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Levothroid	2		
levothyroxine	1		
Levoxyl	2		
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.
Lexiva	3		
Lialda	3		
Librax	4		
lidocaine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
lidocaine patch	2		
lidocaine viscous	2		
lidocaine/prilocaine	2	Prior authorization required for members 17 years and older	
Lidoderm	4		
lindane	2		
linezolid	2		* Prior authorization required.
Linzess	3		
liothyronine	2		
Lipitor	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.
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.
lisinopril	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.
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.
lithium carbonate	2		
lithium carbonate SR	2		
lithium citrate	2		
Lithobid	4		
Lithostat	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Lo Loestrin FE	4		
Lo Minastrin Fe	4		
Lo-Ovral	4		
Locoid	4		
Lodosyn	4		
Loestrin	4		
Loestrin 24 FE	4		
Loestrin Fe	4		
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.
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.
Lomotil	4		
lomustine	2		
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.
Lopressor	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 HCT	4		* HSA Preventive drug. If your plan includes the Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Loprox Shampoo	4		
lorazepam	2		
Lortab	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Lorzone	4		
losartan	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.
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.
Loseasonique	4		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Lotemax	3		
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.
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 will not be subject to your

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
Lotrisone	4		
Lotronex	4	Covered for females only	
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.
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.
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.
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.
loxapine	2		
Loxitane	4		
Lumigan	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Lunesta	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Lupaneta Pack	4		* Not available through Mail Service.
Lupron Depot/Lupron-Pedi	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.
Lustra	NC		* This drug is not covered.
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.
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.
Luxiq	4		
Luzu	4		
Lycelle	4		
Lynparza	4		* Not available through Mail Service.
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.
Lysodren	3		
Lysteda	4	Max. 30 tabs/30-day supply	

DRUG NAME	TIER	LIMITATIONS	NOTES
M			
Macrobid	4		
Macrodantin	4		
Macrodantin 25mg	3		
mafenide acetate	2		
Makena	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Covered through IVF Program. Must use Village Pharmacy for coverage. * Not available through mail service.
Malarone	4		
malathion	2		
maprotiline	2		
Marinol	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Marplan	4		
Matulane	3		* Sole source through Walgreens Specialty Pharmacy.
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.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Maxidex	4		
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.
MB Hydrogel	2		
mebendazole	2		
meclofenamate	2		
Medrol	4		
medroxyprogesterone acetate (tablets)	1		
mefenamic acid	2		
mefloquine	2		
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.
meloxicam	1		
memantine	2		
Menest	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Menopur	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Menostar	4		
Mentax	3		
meperidine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Mephyton	3		
meprobamate	2		
Mepron	4		
mercaptopurine	2		
mesalamine (enema)	2		
Mesnex	4		
Mestinon tabs	4		
Mestinon Timespan	4		
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.
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.
metaxalone	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
methadone	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
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.
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.
methenamine hippurate	2		
methimazole	2		
Methitest	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
methocarbamol	2		
methotrexate	2		
methoxsalen	2		
methscopolamine bromide	2		
methyldopa	2		* 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.
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, 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,

DRUG NAME	TIER	LIMITATIONS	NOTES
			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, 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.
methylprednisolone	2		
metipranolol	2		
METOCLOPRAMIDE 10mg	1		
metoclopramide 5mg	2		
metoclopramide ODT	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
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.
Metozolv ODT	4		
MetroCream	4		
MetroGel	4		
MetroGel 1% Kit	3		
Metrogel Vaginal	4		
MetroLotion	4		
metronidazole	2		
metronidazole (gel)	2		
metronidazole (lotion)	2		
metronidazole (vaginal gel)	2		
metronidazole 250mg & 500mg (tablet)	1		
Mevacor	4		* 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.
mexiletine	2		
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.
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.
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.
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.
Micro-K	4		
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.
Micronor	4		
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.
midodrine	2		* 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.
Migranal Nasal Spray	3		
Millipred	3		
Minastrin 24 FE	4		
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.
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.
Minivelle patch	4		
Minocin	4		
minocycline	2		
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.
Mirapex	4		
Mirapex ER	4		
Mircera	4		* Not available through Mail Service.
Mircette	4		
mirtazapine	2		
mirtazapine 15mg	1		
Mirvaso	4		
misoprostol	2		
misoprostol/diclofenac	2		
Mitigare	4		
Mobic	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
modafinil	4	Max. 30 tabs/30-day supply	* Prior authorization required.
Modicon	4		
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.
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.
mometasone furoate (topical)	2		
Momexin	4		
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.
Monodox	4		
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.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
Monurol	4		
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.
Motofen	4		
Motrin	4		
Movantik	4		
Moviprep	3		
Moxatag	4		
Moxeza	4		
moxifloxacin	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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		
Mugard	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Multaq	3		
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.
mupirocin cream	2		
mupirocin ointment	2		
Muse	3	Max. 6 suppositories/30-day supply; Covered for males over 18 years of age only	
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.
Myalept	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Myambutol	4		
Mycobutin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
mycophenolate	2		
mycophenolate mofetil suspension	2		
mycophenolic acid	2		
Myfortic	4		
Myleran	3		
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.
Myorisan	2		* 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.
Myrbetriq	4		
Mysoline	4		
Mytussin AC 100-10mg/5	1		
N			
nabumetone	2		
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
naftifine	2		
Naftin	4		
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.
Nalfon	4		
naltrexone	2		
Namenda	4		
Namenda XR	4		
Namzaric	4		
Naprelan	4		
Naprosyn	4		
naproxen	1		
naproxen 550mg	2		
NAPROXEN SODIUM	2		
NAPROXEN SODIUM 275 MG TAB	1		
naproxen sodium cr	2		
naratriptan	2	1mg: Max. 15 tabs/copay; 2.5mg: Max. 6 tabs/copay	* Not available through Mail Service.
Nardil	4		
Nasacort AQ	4		
Nascobal	4		
Nasonex	3		
Natacyn	3		
Natalcare PIC	1		
Natalcare Plus 27mg-1mg	1		
Natalcare Rx 27-0.5mg	1		
Natalcare Three 28mg-1mg	1		
Natatab FA 29mg-1mg	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
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.
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.
Natpara	4	Max. 2 cartridges/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Natroba	4		* Not available through Mail Service.
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.
Navane	4		
Nebupent	4		
Nebusal	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
nefazodone	2		
neomycin sulfate	2		
neomycin-polymixin-hc	2		
neomycin-polymyxin-dexamethasone	2		
neomycin-polymyxin-hydrocortisone	2		
neomycin/bacitracin/polymyxin 3.5mg-400 (ointment)	2		
Neoral	4		
Neosalus Cream	4		
Neosalus Foam	4		
Nephrocaps	2		
Nephrocaps QT	4		
Nephron FA	2		
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.
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.
Neuac	4		* Not available through Mail Service.
Neulasta	3		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			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 known as ICORE). * Not available through Mail Service.
Neupro	4		
Neurontin	4		
Neutrasal	4		
nevirapine	2		
nevirapine ER 400mg	2		
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.
Nexavar	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Nexium	4		
Nexplanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
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.
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.
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.
nifedipine SR	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nilandron	3		
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.
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.
nitrofurantoin	2		
nitrofurantoin, macro	2		
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 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
nizatidine	2		
Nizoral Shampoo 2%	4		
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.
Norco	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Nordette	4		
Norditropin Flexpro/Nordiflex	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through Mail Service.
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.
norethindrone acetate	2		* This medication is eligible for a $0 co-pay under certain benefit plans.
Norinyl 1/35	$0		* This medication is eligible for a $0 co-pay under certain

DRUG NAME	TIER	LIMITATIONS	NOTES
			benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Norinyl 1/50	4		
Noritate	3		
Noroxin	4		
Norpace	4		
Norpace CR	4		
Norpramin	4		
Northera	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
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.
nortriptyline	2		
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.
Norvir	3		
Novacort	4		
Novarel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Novo Twist needles	3		
Novoeight	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark.
NovoFine needles	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
Noxafil (suspension)	4		
Noxafil (tablets)	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
Nuedexta	3		
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
NuLytely	4		
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 deductible. Applicable copayment will apply.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Prior authorization requiredNot available through Mail Service
Nutropin AQ NuSpin	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
Nuvail	4		
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.
Nuvessa	4		
Nuvigil	3	Max. 30 tabs/30-day supply	* Prior authorization required
Nymalize	4		
nystatin	2		
nystatin (cream)	1		
nystatin (ointment)	1		
nystatin/triamcinolone acetonide	2		
O			
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
OBAGI-C	NC		* This drug is not covered.
Obredon	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
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.
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
Ocudox	4		
Ocufen	4		
Ocuflox	4		
Ofev	4	Max. 60 caps/30 day-supply	* Covered through Specialty Pharmacy Program. Must use Walgreens Specialty Pharmacy. * Sole Source Pharmacy: Walgreens Specialty 800-420-3228 Not available through Mail Service
ofloxacin 0.3%	2		
ofloxacin, otic	2		
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.
olanzapine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
olanzapine ODT	2		* Covered through Specialty Pharmacy Program. Use Accredo.
olanzapine/fluoxetine	2		
Oleptro ER	4		
olopatadine nasal spray	2		
Olux	4		
Olux-E	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.
Omeclamox-Pak	4		
omega 3 acids ethyl esters	2		
omeprazole 20mg capsule	1		
omeprazole capsule	2		
omeprazole/sodium bicarbonate (capsule)	4		
Omnaris	4		
Omnipred	4		
Omnitrope	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot 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.
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

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.
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.
Onexton	4		* Not available through Mail Service.
Onfi	3	Prior authorization required for members 18 and older	
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.
Onmel	4	Max. 28 tabs/28-day supply; Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
opium tincture	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Opsumit	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Optivar	4		
Oracea	4		
Orafate	NC		* This drug is not covered.
Oralair	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Orap	3		
Orapred	4		
Orapred ODT	4		
Oravig	4		
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.
Orenitram ER	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
Orkambi	4		* Not available through Mail Service. * Prior authorization required.
orphenadrine citrate	2		
orphenadrine citrate/aspirin/ caffeine	2		
Ortho Cyclen	4		
Ortho Evra	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Ortho Tri Cyclen	4		
Ortho Tri-Cyclen LO	4		
Ortho-Cept	4		
Ortho-Novum	4		
Ortho-Novum 7-7-7	4		
Oseni	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.
Osmoprep	4		
Osphena	4		
Otezla	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Otrexup	3		* Not available through Mail Service.
Ovcon -35	4		
Ovide	4		
Ovidrel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * 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		
oxaprozin	2		
oxazepam	2		
oxcarbazepine	2		
oxcarbazepine suspension	2		
Oxecta	4		* Mail Service: Max. 30-day supply as required by state

DRUG NAME	TIER	LIMITATIONS	NOTES
			& federal law or benefit plan design.
Oxistat	4		
Oxsoralen-Ultra	4		
Oxtellar XR	4		
oxybutynin	2		
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Oxytrol	4		
Ozurdex	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
P			
Pacerone	2		
Palgic Liquid	2		
Pamelor	4		
Pamine	4		
Pancreaze	3		
Pancrelipase 5,000	2		
Pandel	4		
Panretin	4		* Not available through Mail Service.
pantoprazole	2		
paricalcitol	2		
Parlodel	4		
Parnate	4		
paromomycin	2		
paroxetine	2		
Pataday	3		
Patanase Nasal Spray	4		
Patanol	3		
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		
Paxil CR	4		* 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. * 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.
Pazeo	4		
PCE	4		
PediaPred	4		
PEG 3350/Electrolyte	2		
Peg-Intron	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Peganone	4		
Pegasys	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
penicillin v potassium	1		
Penlac	4		* Not available through Mail Service. * Prior authorization required
Pennsaid	4		
Pentasa	3		
pentazocine/acetaminophen	2		
pentazocine/naloxone	2		
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.
Pepcid	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
Peridex	4		
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.
PerioGard Oral Rinse	2		
Periostat	4		
permethrin	2		
perphenazine	2		
Pertzye	4		
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.
phenazopyridine	1		
phenelzine	2		
phenobarbital	1		
phenobarbital 20mg/5mL (elixir)	2		
phenoxybenzamine	2		* 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.
phentermine	NC		* This drug is not covered. *
phenylephrine 2.5% (drops)	2		
Phenytek	4		
phenytoin	2		
phenytoin sodium ER	2		
phenytoin tab chew	2		
Phos-Flur	3		
PhosLo	4		
Phoslyra	3		
Phospholine Iodide	3		
Picato	3		* Not available through Mail Service.
pilocarpine (oral)	2		
pilocarpine 3% (ophthalmic drops)	2		
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.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
piroxicam	2		
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.
Plaquenil	4		
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.
Plegridy	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
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.
Pliaglis	NC		* This drug is not covered.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
podofilox solution	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 deductible. Applicable copayment will apply.
polymyxin-trimethoprim (ophthalmic)	2		
Pomalyst	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Ponstel	4		
Potaba	4		
potassium chloride	2		
potassium citrate	2		
Potiga	4		
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.
Praluent	4	Max. 2 pens/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
pramipexole	2		
pramipexole er	2		
Pramosone	3		
Prandimet	4		* HSA Preventive drug. If your plan includes the Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
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.
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.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Pred Forte	4		
Pred G	4		
Pred Mild	3		
prednicarbate	2		
prednisolone	2		
prednisolone 5mg (tablet)	1		
prednisolone acetate	2		
prednisolone sodium phosphate tab rapdis	2		
prednisone	1		
prednisone 5mg/5mL (oral solution)	2		
Prefera-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.
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.
Pregnyl	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Premarin	3		
Premarin (vaginal cream)	3		
Premesis Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs will not be subject to your plan deductible. Applicable copayment will apply.
Premphase	3		
Prempro	3		
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.
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Prepopik	3		* Not available through Mail Service.
Preque 10	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.
Presera	4		
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.
Prevacid	4		
Prevacid Solutab	4		
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.
Prevident	3		
Prevident 5000	4		
Prevident 5000 Booster Paste	4		
Prevident 5000 Plus Cream	4		
Prevident 5000 Sensitive	4		
Previfem	$0		* This medication is eligible for a $0 co-pay under certain

DRUG NAME	TIER	LIMITATIONS	NOTES
			benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
PrevPac	4		
Prezcobix	4		
Prezista	3		
Prilosec	4		
Primaquine	4		
primidone	2		
Primsol	4		
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.
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.
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.
probenecid	2		
probenecid/colchicine	2		
Procardia	4		* 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.
Procardia 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.
prochlorperazine	1		
prochlorperazine (suppository)	2		
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
Procto-Pak 1% (cream)	1		
Proctofoam HC	3		
Proctosol-HC	2		
Proctosol-HC 2.5% (cream)	1		
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
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.
Profilnine SD	Medical		* Covered under medical benefit. No pharmacy copayment

DRUG NAME	TIER	LIMITATIONS	NOTES
			applies. * Covered through Specialty Pharmacy Program. Must use Caremark or Accredo. * Not available through Mail Service.
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.
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.
Prograf	3		
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 Centric Health Resources only. 800-305-7881
Prolensa	4		
Prolia	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health

DRUG NAME	TIER	LIMITATIONS	NOTES
			(formerly known as ICORE). * Not available through Mail Service.
Promacta	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
promethazine	2		
promethazine DM 15-6.25/5	2		
promethazine/codeine	2		
Prometrium	4		
Promiseb Complete	NC		* This drug is not covered.
propafenone	2		
proparacaine	2		
Propecia	NC		* This drug is not covered.
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 deductible. Applicable copayment will apply.
propranolol 60mg	2		
propylthiouracil	2		
Proscar	4		
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.
Prothelial	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Protonix	4		
Protonix (suspension)	4		
Protopic	4		* Prior authorization required
protriptyline	2		
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.
Provera	4		
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.
Provigil	4	Max. 30 tabs/30-day supply	* Prior authorization required
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.
pruclair	2		
Prudoxin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Prutect	2		
pseudoephedrine/hydrocodone/ chlorpheniramine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
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.
Pulmozyme	3		
Purinethol	4		
Purixan	4		
Pylera	3		
pyrazinamide	2		
Pyridium	3		
pyridostigmine	2		
pyridostigmine SR	2		
Q			
QNASL	4		
Qsymia	NC		* This drug is not covered.
Qualaquin	4		
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 plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
quazepam	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Qudexy XR	4		
Questran	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.
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.
quetiapine	2		
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.
Quillivant 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.
quinapril	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.
quinidine gluconate SR	2		
quinidine sulfate	2		
quinine sulfate	2		
Quixin	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
R			
rabeprazole/tablet DR	4		
Ragwitek	4	Max. 30 tabs/30-day supply	* Not available through Mail Service.
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.
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.
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.
ranitidine	2		
Rapaflo	4		
Rapamune	4		
Rasuvo	3	Max. 4 syringes/28 day-supply	* Not available through Mail Service.
Ravicti	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Rayos	4		
Razadyne	4		
Razadyne ER	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Reclast	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.
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.
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.
Rectiv	4		
Regenecare	4		
Reglan	4		
Regranex	4	Annual limit 90 days; Max. 1 tube/30-day supply	* Not available through Mail Service.
Relenza	4	Max. 1 package per fill	
Relistor	3		* Not available through Mail Service.
Relpax	3	20mg: Max. 12 tabs/copay; 40mg: Max. 6 tabs/copay	* Not available through Mail Service.
Remeron	4		
ReNaf	1		
Renagel	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Renax	2		
Renova	NC		* This drug is not covered.
Renvela	3		
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.
Reprexain	2		* Not available through Mail Service. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Repronex	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Requip	4		
Requip XL	4		
Rescriptor	3		
Rescula	4		
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.
Restasis	3	Max. 60 vials/month	
Restoril	4		
Retin-A	4	Prior authorization required for members 30 and older	
Retin-A Micro	1	Prior authorization required for members 30 and older	
Revatio	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service

DRUG NAME	TIER	LIMITATIONS	NOTES
Revia	4		
Revlimid	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Rexulti	4	Max. 30 tabs/30-day supply	
Reyataz	3		
Rheumatrex	3		
Rhinocort AQUA	4		
RhoGam 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.
RiaSTAP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Caremark. * 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.
Ridaura	4		
rifabutin	2		
Rifadin	4		
Rifamate	4		
rifampin	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Rifater	4		
Rilutek	4		
riluzole	2		
rimantadine	2		
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.
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.
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		
risperidone	2		
risperidone M-Tab ODT	2		
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,

DRUG NAME	TIER	LIMITATIONS	NOTES
			max 60-day supply allowed through mail service and Maine Pharmacies.
rivastigmine	2		
Rixubis	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * 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.
Robaxin	4		
Robinul	4		
Robinul Forte	4		
Rocaltrol	4		
Rocaltrol Solution	3		
ropinirole	2		
ropinirole hcl tab er 24hr	2		
ropinirole XL	2		
Rosadan	4		
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.
Rowasa Enema	4		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			& federal law or benefit plan design.
Rozerem	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Rytary	4		
Rythmol	4		
Rythmol SR	4		
S			
Sabril	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
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.
Saizen	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through Mail Service
Salagen	4		
Salex	4		
salsalate	2		
Samsca	4		* Not available through Mail Service.
Sanctura	4		
Sancuso	4	4 patches/copay	* Not available through Mail Service.
Sandimmune	4		
Sandimmune Oral Soln	3		
Sandostatin/LAR	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health

DRUG NAME	TIER	LIMITATIONS	NOTES
			(formerly known as ICORE). * Not available through mail service.
Santyl	3		
Saphris	4		
Sarafem	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.
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.
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.
Saxenda	NC		* This drug is not covered.
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.
Seconal	1		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
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.
Select-OB	2		* HSA Preventive drug. If your plan includes the Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
selegiline	2		
selenium sulfide	2		
Selseb	4		
Selzentry	3		
Semprex-D	4		
Sensipar	4		* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.
Septra	4		
Septra DS	4		
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 deductible. Applicable copayment will apply.
Serophene	4		
Seroquel	4		
Seroquel XR	3		
Serostim	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through Mail Service
sertraline	1		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
sildenafil (PAH)	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through mail service..
Silenor	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Silvadene	4		
silver sulfadiazine AF cream	2		
Silvrstat	4		
Simbrinza	3		
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.
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.
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.
Sinemet	4		
Sinemet CR	4		
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.
sirolimus	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Sirturo	4		* Packaged as a 6-month (180 day) supply. Member pays 6 copays at retail pharmacy.
Sitavig	4	Max. 1 tab/per copay. Max 2 tabs/30 days.	* Not available through Mail Service.
Sivextro	4	Max. 6 tabs/copay	* Not available through Mail Service. *
Skelaxin	4		
Sklice	4		
Sodium Chloride	2		
sodium chloride vial-neb	2		
sodium citrate/citric acid	2		
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.
sodium phenylbutyrate	2		
sodium polystyrene sulfonate	2		
sodium polystyrene sulfonate enema	2		
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.
Solaraze	4		
Soliris	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health

DRUG NAME	TIER	LIMITATIONS	NOTES
			(formerly known as ICORE). * Not available through Mail Service.
Solodyn	4		* Prior authorization required
Soma	4		
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.
Sonafine	4		
Sonata	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Soolantra	4		
Soriatane	4		
Sorilux	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.
Sovaldi	3	Max. 28 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
Spectracef	4		
spinosad	2		* Not available through Mail Service.
Spiriva	3	Max. 1 unit (30 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.
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.
spironolactone	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.
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.
Sporanox	4	Max. 168 caps/year	* Not available through Mail Service. * Prior authorization required.
Sporanox (solution)	4		
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.
Sprix	4	Max. 5 bottles/fill	* Not available through Mail Service.
Sprycel	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
SPS Rectal Enema	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
SSD Cream	4		* Not available through Mail Service.
Stalevo	4		
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.
stavudine	2		
Stavzor	4		
Staxyn	4	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only.	* Prior Authorization required when quantity exceeds limitation.
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 through Mail Service. Prior authorization required.
Stendra	4	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only.	* Prior authorization required when quantity exceeds limitation.
Stimate	3		
Stiolto Respimat	4	Max. 1 unit/30-day supply	
Stivarga	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Strattera	3		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Stribild	4		
Striverdi Respimat	4	Max. 1 inhaler/30-day supply	
Stromectol	4		
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.
Suboxone Film	3		* 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.
Subutex	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Suclear	4		
Sucraid	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
sucralfate	2		
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.
sulfacetamide sodium 10% (drops)	2		
sulfacetamide topical lotion	2		
Sulfamide (drops)	1		
Sulfamylon	4		
sulfasalazine	2		
sulindac	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
sumatriptan (injection)	2	Max. 3 boxes (6 inj)/copay	* Not available through Mail Service.
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.
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.
Suprax	4		
Suprenza ODT	NC		* This drug is not covered.
Suprep	4		
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 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.
Surmontil	4		
Sustiva	3		
Sutent	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Sylatron	4		* Covered through Specialty Pharmacy Program. Must use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Symbyax	4		
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.
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 Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.Prior authorization required.
Synalar	4		
Synalar TS	4		
Synalgos-DC	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Synarel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Synthroid	3		
T			
Taclonex	4		
tacrolimus	2		
tacrolimus topical	2		* Prior authorization required.
Tafinlar	4		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Tagamet	4		
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.
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.
tamsulosin	2		
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 Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tapazole	4		
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Tasigna	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Tasmar	4		
Tazorac	4	Prior authorization required for members 30 and older	
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.
Tecfidera	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * 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.
Tegretol	4		
Tegretol XR	4		
Tekamlo	3	150mg/5mg & 150mg/10mg: Max. 45 tabs/30 days; 300mg/5mg & 300mg/10mg: Max. 30 tabs/30 days	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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.
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	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
temazepam	2		
temazepam 15mg & 30mg	1		
Temodar	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Temovate	4		
temozolomide	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Tenex	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.
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.
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.
Terazol	4		
terazosin 10mg	2		* HSA Preventive drug. If your plan includes the Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
terbinafine	2	Max. 28 tabs/fill, Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required
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.
terconazole	2		
Tessalon	4		
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 deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
tetracaine	2		
tetracycline	1		
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.
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.
Texacort	4		
Thalomid	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Theo 24	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.
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.
Thermazine	4		* Not available through Mail Service.
Thioguanine	3		
Thiola	4		* Sole Source Pharmacy: Dohmen Life Sciences 1-800-305-7881
thioridazine	2		
thiothixene	2		
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.
Thyrolar	4		
tiagabine	2		
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Tikosyn	4		* Manufacturer sponsored Tikosyn Program. Members or physicians should call 1-877-TIKOSYN (845-6796) for dispensing information.
Tilia 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.
timolol	1		
timolol (ophthalmic gel)	2		
Timoptic	4		
Timoptic-XE	4		
Tindamax	4		
tinidazole	2		
Tirosint	4		
Tivicay	4		
Tivorbex	4		
tizanidine	2		
TL Folate	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.
TL G-Fol OS	2		
Tobi	4		* Covered through Specialty Pharmacy Program. Must use Accredo.
Tobi Podhaler	3		* Covered through Specialty Pharmacy Program. Use Accredo.
Tobradex	4		
Tobradex ST	4		
tobramycin (drops)	2		
tobramycin (inh neb)	2		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
tobramycin/dexamethasone (ophthalmic)	2		
Tobrex (drops)	4		
Tobrex (ointment)	3		
Tofranil	4		
Tofranil PM	4		
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.
tolcapone	2		
tolmetin	2		
tolterodine	2		
tolterodine LA	2		
Topamax	4		
Topicort	4		
topiramate	2		
topiramate ER	2		
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.
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.
Toujeo Solostar	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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Toviaz	3		
Tracleer	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
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.
tramadol	2		
tramadol ER	2		
tramadol hcl er	2		
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.
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.
tranexamic acid	2	Max. 30 tabs/30-day supply	
Transderm-Scop	3	Max. 1 box (4 patches)/ copay	* Not available through Mail Service.
Tranxene T-Tabs	4		
tranylcypromine	2		
Travatan Z	3		
travoprost	2		
trazodone	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
trazodone 150mg & 300mg	2		
Tretin-X	4	Prior authorization required for members 30 and older	
tretinoin 0.05%, emollient	NC		* This drug is not covered.
tretinoin, microspheres topical	2	Prior authorization required for members 30 and older	
tretinoin, topical	2	Prior authorization required for members 30 and older	
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.
Trexall	4		
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.
Trezix	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
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-Luma	NC		* This drug is not covered.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
triamcinolone acetonide	2		
triamcinolone acetonide (lotion)	2		
triamcinolone acetonide (paste)	2		
triamcinolone acetonide aqueous, nasal	2		
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		
triazolam	2		
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
trifluoperazine	2		
trifluridine	2		
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.
trihexyphenidyl	2		
Trileptal	4		
Trileptal Suspension	4		
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.
Trilyte	2		
trimethoprim	2		
trimethoprim/sulfamethoxazole	1		
trimethoprim/sulfamethoxazole DS	1		
Trimox 250mg (capsule)	1		
Trimox 250mg/mL (suspension)	1		
Trinate 28mg-1mg	2		
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.
Triumeq	4		
Triveen-PRX RNF	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs will not be subject to your plan deductible. Applicable copayment will apply.
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.
Trizivir	4		
Trokendi XR	4		
Tropazone	4		
trospium chloride	2		
trospium chloride ER cap	2		
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.
Trusopt	4		
Truvada	3		
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.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			& federal law or benefit plan design.
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.
Tybost	4		
Tykerb	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Tylenol with Codeine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tyvaso	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Tyzeka	4		
Tyzine	4		
U			
Uceris	4		
Ulesfia	4		
Uloric	3		
Ultracet	4		
Ultram	4		
Ultram ER	4		
Ultravate	4		
Ultravate X	4		
Ultresa	4		
Unithroid	2		
Univasc	4		* 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.
Urecholine	4		
Urocit-K	4		
Uroxatral	4	Max. 30 tabs/30-day supply	
Urso	4		
ursodiol	2		
V			
V-Go	4	Max. 30 units/30 day supply	
Vagifem	3		
valacyclovir	2		
Valchlor	4	Max 1 tube (60 gram)/30 days	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Valcyte	4		
valganciclovir	2		
Valium	4		
valproic acid	2		
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.
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.
Valtrex	4		
Vancocin	4		
vancomycin	2		
Vandazole	4		
Vaniqa	NC		* This drug is not covered.

DRUG NAME	TIER	LIMITATIONS	NOTES
Vanos	4		
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.
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.
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.
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.
Vecamyl	4		
Vectical	4		
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.
Velphoro	4		
Veltin	4	Prior authorization required for members 30 and older	
venlafaxine (tablet)	2		
venlafaxine ER (capsules)	2		
venlafaxine ER (tablets)	2		
Venlafaxine ER (tablets) (Brand)	4		* Step Therapy: First level drug treatment required

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
Ventavis	4		* Not available through mail service. Available through Accredo Nova Factor only.
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.
Veramyst	3		
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.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Verdeso	4		
Veregen	3		
Verelan	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.
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.
Veripred 20	4		
Versacloz	4		* Not available through Mail Service.
Vesicare	3		
Vexol	4		
Vfend	4		
Vi-Q-Tuss 100-5mg/5	1		
Viagra	3	Max. 4 tabs/30-day supply; Covered for males over 18 years of age only.	* Prior authorization required when quantity exceeds limitation.
Vibramycin (tablet)	4		
Vibramycin Oral Suspension	4		
Vibramycin Syrup	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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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.
Videx EC	4		
Viekira Pak	4	Maximum 1 pak per 28-days.	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Vigamox	4		
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.
Vimovo	4		* Effective 10/1/15: Prior authorization required.
Vimpat	3		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
Viokace	4		
Viracept	3		
Viramune	4		
Viramune XR 100mg	3		
Viramune XR 400mg	4		
Viread	3		
Viroptic	4		
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.
Vistaril	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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 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.
Vitamin D 50,000 Unit (capsule)	1		
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.
Vitekta	4		
Vituz	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vivactil	4		
Vivelle-DOT	4		
Vivitrol	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Vivotif-Berna	4		
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.
Voltaren	4		
Voltaren Gel	4		
Voltaren XR	4		
voriconazole	2		
Vosol HC	4		
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.
Votrient	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
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.
Vusion	4		
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.
Vyvanse	3		* 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.
W			
warfarin	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.
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.
Wellbutrin	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 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
Wilate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program.

DRUG NAME	TIER	LIMITATIONS	NOTES
			Must use Caremark. * Not available through mail service
X			
Xalatan	4		
Xalkori	4	Max. 60 caps/30-day supply	* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service
Xanax	4		
Xanax XR	4		
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.
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.
Xeljanz	4	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service..Prior authorization required.
Xeloda	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Xenazine	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Xenical	NC		* This drug is not covered.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
Xerese	4		
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
Xifaxan 200mg	4	Max. 9 tabs/copay	* Not available through Mail Service.
Xifaxan 550mg	3		
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.
Xodol	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.
Xolegel	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Xtandi	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
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.
Xylocaine Jelly	4		
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.
Xyrem	4		* Not available through Mail Service. * Available through Express Scripts Only, 866-997-3688 x66247
Xyzal	4		
Y			
Yasmin	4		
Yaz	4		
Yodoxin	3		
Z			
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.
zaleplon	2		
Zamicet	4		* Mail Service: Max. 30-day supply as required by state

DRUG NAME	TIER	LIMITATIONS	NOTES
			& federal law or benefit plan design.
Zanaflex	4		
Zantac	4		
Zarah	$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.
Zarontin	4		
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.
Zavesca	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
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.
Zegerid (capsules)	4		
Zegerid Powder Packet	4		
Zelapar ODT	4		
Zelboraf	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.
Zemplar	4		
Zenatane	2		* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zenpep	3		
Zenpep 5K-17K-27K	4		
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.
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.
Zerit	4		
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.
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.
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.
Zetonna	4		
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.
Ziagen (tablet)	4		
Ziana	4	Prior authorization required for members 30 and older	

DRUG NAME	TIER	LIMITATIONS	NOTES
zidovudine	2		
zinc sulfate	2		
Zioptan	4		
ziprasidone	2		
Zipsor	4		
Zirgan	4		
Zithromax Tabs/Susp/Tri-Pack/Z-Pack	4		
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.
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.
Zohydro ER	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.
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).
Zolinza	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
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.
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.
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.
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.
Zonalon	4		
Zonatuss	4		
Zonegran	4		
zonisamide	2		
Zontivity	4		
Zorbtive	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service

DRUG NAME	TIER	LIMITATIONS	NOTES
Zortress	4		
Zorvolex	3		
Zostavax	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service
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.
Zovirax	4		
Zovirax (Cream)	4		
Zovirax (ointment)	4		
Zovirax (Suspension)	4		
Zubsolv	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Zuplenz	4	4mg: Max. 18 films/copay; 8mg: Max. 9 films/copay	* Not available through Mail Service.
Zutripro	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Zyban	4	Max. 60 tabs/fill; Max 360 tabs/year	* Not available through Mail Service.
Zyclara	4		* 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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zykadia	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Zylet	3		
Zyloprim	4		
Zymaxid	4		
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		
Zytiga	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service
Zyvox	4		* Prior authorization required