Harvard Pilgrim Prescription Drug List

PREMIUM FORMULARY
FOUR-TIER DRUG LIST
IN ALPHABETICAL ORDER

LAST UPDATED : 02/05/2016

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
8			
8-MOP	4		
A			
abacavir	2		
abacavir/lamivudine/zidovudine	2		
Abilify	4		
Abilify Discmelt	4		
Absorica	4		
Abstral	4	Max.120 tabs/30-day supply	* Prior authorization required.
acamprosate calcium	2		
Acanya	3		
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		
Accu-Chek Active Strips	4	204 test 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. HSA Preventive 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 Aviva Plus	4	204 test 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. 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.
Accu-Chek Aviva Strips	4	204 test strips/30-day supply	* Prior authorization requiredFreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products. HSA Preventive 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 Comfort Curve Strips	4	204 test 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. HSA Preventive 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 Compact Strips	4	204 test 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. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
acetaminophen/codeine 300mg-60mg	2		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Actemra (SubQ)	4	Max. 4 syringes/28-day supply	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Acthar HP	Medical		* Prior authorization required. Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
Acticlate	4		
Actigall	4		
Actimmune	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Actiq	4	Max. 120 lozenges/30 days.	* Prior authorization required.
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		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Adderall	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Adderall XR	4		* Fillable at retail pharmacies only. Max. 60-day supply.
adefovir	2		
Adempas	3		* Covered through Specialty Pharmacy Program.Must use Accredo.
Adipex-P	NC		* This drug is not covered.
Adoxa	4		
Adrenaclick	4	Max. 2 units/copay	
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 through Specialty Pharmacy Program.Must use Accredo or Caremark.

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		
Aerochamber (including mask)	Medical		
Aerospan	4		
Afinitor	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Afinitor Disperz	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
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.	* Prior authorization 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.
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		
Akynzeo	4	Max. 1 cap/copay, Max. 3 caps/28 day-supply	
Alagesic LQ	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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 through Specialty Pharmacy Program.Must use Accredo.
Alecensa	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
alendronate sodium 35mg & 70mg tab	1		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
allopurinol	1		
almotriptan malate	2	6.25mg: Max. 12 tabs/ copay; 12.5mg: Max. 6 tabs/copay	* HSA Preventive 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 through Specialty Pharmacy Program.Must use Accredo or Caremark.
Alphanine SD	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
alprazolam	1		
alprazolam (rapid dissolve tablet)	2		
alprazolam ER	2		
alprazolam Intensol	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Alprolix	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
Alrex	4		
Alsuma	4	Max. 6 injections/copay	
Altabax	4		
Altace (Capsules)	4		
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.
Alyacen	$0		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Amerge	4	1mg: Max. 15 tabs/copay; 2.5mg: Max. 6 tabs/copay	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Amethia	$0		* 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.
Amethyst	4		
Amicar	4		
amiloride	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amiloride/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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 NAME	TIER	LIMITATIONS	NOTES
			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		
Amnesteem	2		
amoxicillin	1		
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		* Fillable at retail pharmacies only. Max. 60-day supply.
amphetamine/ dextroamphetamine SR	2		* Fillable at retail pharmacies only. Max. 60-day supply.
ampicillin	2		
ampicillin 250mg cap	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
Ampyra	4	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program.Must use Accredo.
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 plan deductible. Applicable copayment will apply.
Anadrol-50	4		
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. This medication may be eligible for a $0 co-pay under certain benefit plans.
Ancobon	4		
Androderm	3	2mg: Max. 60 patches/30-day supply 4mg: Max. 30 patches/30-day supply	* Prior authorization required for members 18 and older.
Androgel	4	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	* Prior authorization required for members 18 and older.
Androgel 1.62%	3	1.25 gram: Max. 30 packets/30-day supply 2.5 gram: Max. 60 packets/30-day supply 75 gram pump:	* Prior authorization required for members 18 and older.

DRUG NAME	TIER	LIMITATIONS	NOTES
		Max. 2 pumps/30-day supply	
Android	4		
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	* Quantity Limitations.
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		
apraclonidine	2		
Apri	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Apriso	3		
Aptensio XR	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Aptiom	4		
Aptivus	4		
Aqua Glycolic HC	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Aralast NP	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
Aralen	4		
Aranelle	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Aranesp	4	Max. 4 vials or syringes/fill	* Prior authorization required. Covered through Specialty Pharmacy Program.Use Magellan Health (formerly known as ICORE).
Arava	4		
Arcalyst	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
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. This medication may be eligible for a $0 co-pay under certain benefit plans.
aripiprazole	2		
aripiprazole ODT	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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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. This medication may be eligible for a $0 co-pay under certain benefit plans.
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		
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 NAME	TIER	LIMITATIONS	NOTES
			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	4	Prior authorization required for members 30 and older	* Prior authorization required.
Atripla	3		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Aubagio	4	Max. 28 tabs/28 day-supply	* Covered through Specialty Pharmacy Program.Must use Accredo.
Augmentin (suspension)	4		
Augmentin (tablets)	4		
Augmentin 125-31.25mg (suspension)	3		
Augmentin ES 600mg (suspension)	4		
Augmentin XR	4		
Aurstat	4		
Auryxia	4		
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 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
Avar-E	4		
Avar-E LS	4		
Avelox	4		
Aviane	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Avinza	4	Max. 2 caps/daily	* Quantity Limitations.
Avita	2	Prior authorization required for members 30 and older	* Prior authorization required.
Avodart	4		
Avonex	3		* Covered through Specialty Pharmacy Program.Use Accredo.
Axert	4	6.25mg: Max. 12 tabs/ copay; 12.5mg: Max. 6 tabs/copay	* 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	* Prior authorization required for members 18 and older.
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 NAME	TIER	LIMITATIONS	NOTES
			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.
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		
Balziva	$0		* 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
Belbuca	4	Max 60 films per 30 days	
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.
Benefix	Medical		* Covered through Specialty Pharmacy Program.Must use Caremark or Accredo.
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 through Specialty Pharmacy Program.Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Magellan Health (formerly known as ICORE).
Benoxyldoxy	4		
Bentyl	4		
Benzaclin	4		
Benzamycin	4		
benzonatate	2		
benzonatate 100mg	1		
benzonatate 200mg	2		
benztropine 0.5mg, 1mg tab	1		
benztropine 2mg tab	2		
benztropine mesylate	2		
Bepreve	4		
Berinert	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo or Magellan Health (formerly known as ICORE).
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.
betaxolol, ophthalmic	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Betimol	3		
Betoptic S	3		
bexarotene	2		* 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.
Biafine	4		
Biaxin	4		
Biaxin XL	4		
bicalutamide	2		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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 0.03%	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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	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.
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).
Bosulif	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Botox	Medical	Prior authorization required for members 17 and older	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo or Magellan Health (formerly known as ICORE).
Bravelle	3		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.
Breeze 2 Test Strips	4	204 test strips/30-day supply	* Prior authorization required.FreeStyle and Precision test strips; and FreeStyle

DRUG NAME	TIER	LIMITATIONS	NOTES
			Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Breo Ellipta	3	Max. 1 unit/30-day supply	
Brevicon	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
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: 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
budesonide aqueous, nasal	2		
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	
Buphenyl	4		
buprenorphine	2		
buprenorphine/naloxone	2		
Buproban	$0	Annual Limit: Max. 360 tabs/180 days.	* This medication is eligible for a $0 co-pay under certain benefit plans.
bupropion	2		
bupropion SR	2		
bupropion XL	2		
bupropion, smoking cessation	$0	Annual Limit: Max. 360 tabs/180-day supply	* This medication is eligible for a $0 co-pay under certain benefit plans.
buspirone	1		
buspirone 5mg tab	1		
Butalbital Compound w/codeine	2		
butalbital, aspirin, caffeine	2		
butalbital/acetaminophen/ caffeine/codeine	2		
butorphanol	2		
Butrans	3	Max. 4 patches/28-day supply	* Quantity Limitations.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
Campral calcium	4		
Camrese	$0		* 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.
Canasa Rectal Suppository	3		
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		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Must use Accredo.
Caphosol	4		* Covered through Specialty Pharmacy Program.Use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
Caprelsa	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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	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.
Carac	4		
Carafate (suspension)	3		
Carafate (tablet)	4		
Carbaglu	4		* Covered through Specialty Pharmacy Program.Use Accredo.
carbamazepine	2		
carbamazepine ER	2		
Carbatrol	4		
carbidopa	2		
carbidopa/levodopa	2		
carbidopa/levodopa (rapid dissolve tab)	2		
carbidopa/levodopa SR	2		
carbidopa/levodopa/entacapone	2		
Cardene SR	4		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Cataflam	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		* Sole source through: IV Solutions 1-800-658-6046
Cedax (capsule)	4		
Cedax (suspension)	4		
CEENU	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
cefaclor	2		
cefadroxil	2		
cefdinir	2		
cefditoren pivoxil	2		
cefixime	2		
cefpodoxime	2		
cefprozil	2		
ceftibuten	2		
Ceftin (suspension)	4		
Ceftin (tablet)	4		
cefuroxime axetil	2		
Celebrex	4		
celecoxib	2		
Celexa	4		* Step Therapy: For members 18 and over.

DRUG NAME	TIER	LIMITATIONS	NOTES
CellCept	4		
Celontin	3		
Cenestin	3		
cephalexin	1		
Cerdelga	3		* Covered through Specialty Pharmacy Program.Must use Accredo.
Cerezyme	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
Cesamet	4	Max. 18 tabs/copay	
cetirizine oral solution	2		
Cetraxal	4		
Cetrotide	3		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.
cevimeline	2		
Chantix	$0	Annual limit of 26 weeks	* This medication is eligible for a $0 co-pay under certain benefit plans.
Chemet	3		
Chenodal	4		* 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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.
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		* Prior authorization required
ciclopirox	2		
ciclopirox (gel)	2		
ciclopirox (shampoo)	2		
ciclopirox 8.0% (solution)	2		* Prior authorization required

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
cimetidine 200mg, 400mg tabs	1		
Cimzia (prefilled syringe)	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Cinryze	Medical	Max. 20 vials/30-day supply	* Covered under medical benefit. No pharmacy copayment applies. Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
Claravis	2		
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		
Clindesse	4		
Clinoril	4		
clobetasol propionate	2		
clobetasol propionate/emollient	2		
Clobex	4		
clocortolone pivalate	2		
Cloderm	4		
clomiphene citrate	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
clomipramine	2		
clonazepam	1		
clonazepam (rapid dissolve)	2		
clonidine	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
clonidine 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.
clorazepate	2		
clotrimazole (troche)	2		
clozapine	2		
clozapine ODT	2		
Clozaril	4		
Coartem	4	Max. 24 tabs/copay	
codeine sulfate	2		
Colazal	4		
colchicine (capsule)	2		
colchicine (tablet)	2		
Colcrys	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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 Benefit, covered preventive drugs will not be subject to your

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
Concerta	4		* Fillable at retail pharmacies only. Max. 60-day supply.
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	* 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. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Contrave ER	NC		* This drug is not covered.
Conzip	4		
Copaxone 20mg	3		* Covered through Specialty Pharmacy Program.Use Accredo.
Copaxone 40mg	3		* Covered through Specialty Pharmacy Program.Use Accredo.
Copegus	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Cordarone	4		
Cordran	4		
Coreg	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.
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 through Specialty Pharmacy Program.Must use Caremark.
Corlanor	3	Max 60 tablets in 30 days	* Prior authorization 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.
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.
Cosentyx	4	Max. 2800ml/28-day supply	* Prior authorization required. Quantity Limitations. Covered through Specialty Pharmacy Program.Must use Accredo.
Cosopt	4		
Cosopt PF	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cotellic	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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		
Covaryx H.S.	4		
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		
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.
Crixivan	3		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
cyanocobalamin (injection)	1		
Cyclafem 1/35	$0		* 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.
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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
cyclophosphamide capsules (Roxane)	3		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Cycloset	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
cyclosporine	2		
cyclosporine micro-emulsion	2		
Cymbalta	4		* 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

DRUG NAME	TIER	LIMITATIONS	NOTES
Cytomel	4		
Cytotec	4		
Cytra-2	4		
Cytra-3	2		
D			
D.H.E. 45	3		
Daklinza	3	Max. 28 tabs/28-day supply	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Daliresp	3		
danazol	2		
Dantrium	4		
dantrolene	2		
Dapsone	2		
Daraprim	3		
Daypro	4		
Daytrana	4		* Fillable at retail pharmacies only. Max. 60-day supply.
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		
Denavir	4		
Depakene	4		
Depakote	4		
Depakote ER	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Depakote Sprinkle	4		
Depen	4		
Depo-Testosterone	4	1mL vial: Max. 4 vials/30 day-supply 10mL vial: Max. 1 vial/30 day-supply	* Prior authorization required for members 18 and older.
Derma-Smoothe FS	4		
Dermapak Plus	4		* Prior authorization required.
Dermasorb HC	4		
Dermasorb TA	4		
Dermatop	4		
Dermotic (drops)	4		
desipramine	2		
desloratadine	2		
desloratadine; oral-disintegrating tablet	2		
desmopressin	2		
Desogen	4		
desonide	2		
DesOwen	4		
Desowen Kit	4		
desoximetasone	2		
Desoxyn	4		* Fillable at retail pharmacies only. Max. 60-day supply.
desvenlafaxine ER	2		
desvenlafaxine ER	4		* Step Therapy: For members 18 and over.
desvenlafaxine fumarate ER	4		* Step Therapy for members 18 years and over.
Detrol	4		
Detrol LA	4		
dexamethasone	2		
dexamethasone (ophthalmic)	2		
dexamethasone (oral solution)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
dexamethasone (tablet)	1		
dexamethasone 0.5mg/5mL (elixir)	2		
dexamethasone 2mg (tablet)	2		
dexamethasone 6mg (tablet)	1		
Dexedrine Spansule	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Dexilant	4		
dexmethylphenidate	2		* Fillable at retail pharmacies only. Max. 60-day supply.
dexmethylphenidate XR	2		* Fillable at retail pharmacies only. Max. 60-day supply.
DexPak	4		
dextroamphetamine	2		* Fillable at retail pharmacies only. Max. 60-day supply.
dextroamphetamine sulfate solution	2		* Fillable at retail pharmacies only. Max. 60-day supply.
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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 1.5% drops	2		
diclofenac gel	2		
dicloxacillin sodium	2		
dicyclomine	2		
didanosine	2		
Didrex	NC		* This drug is not covered.
Differin	4		* Prior authorization required for members 30 and older
Dificid	3	Max. 20 tabs/10-day supply, one fill per 30 days	
diflorasone diacetate	2		
Diflucan	4		
diflunisal	2		
digoxin	2		* HSA Preventive 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		
dihydrocodeine/aspirin/caffeine	2		
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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
Dipentum	4		
diphenhydramine	2		
diphenoxylate/atropine	2		
Diprolene	4		
Diprolene AF	4		
Diprosone	4		
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		
donepezil	1		
donepezil ODT	2		
Doral	4		
Doryx	4		
dorzolamide (ophthalmic)	2		
dorzolamide/timolol (ophthalmic)	2		
Dovonex	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
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		
Drysol	NC		* This drug is not covered.
Duac	4		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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 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		* 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	* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
Duragesic	4	Max 15 patches/30-day supply	* Quantity Limitations.
Durezol	4		
Durlaza	4		* Prior authorization 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
dutasteride	2		
dutasteride/tamsulosin	2		
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.
Dyanavel XR	4	Fillable at retail pharmacies only. Max 60-day supply	
Dyazide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
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: 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		
Elaprase	Medical		* Covered through Specialty Pharmacy Program.Use Accredo.
Eldepryl	4		
Elelyso	Medical		* Available through 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Magellan Health (formerly known as ICORE).
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	* This medication is eligible for a $0 co-pay under certain benefit plans.
Elmiron	4		
Elocon	4		
Eloctate	Medical		* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Emadine	4		
Embeda	4	Max. 3 caps/daily	
Emcyt	3		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Emend	4	40mg: Max. 4 caps/copay, 80mg: Max. 2 caps/copay, 125mg: Max. 1 cap/copay, Tri-Pack: Max. 1 pack/ copay	
EMLA	4		
Emoquette	$0		* 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
Enbrel	3		* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
Endocet	2		
Endocet 5mg-325mg	2		
Endocet 7.5mg-325mg	1		
Endometrin	3		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.
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.
Enpresse	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Enstilar	4	Max. 60gms/30 day-supply	
entacopone	2		
entecavir	2		
Entocort EC	4		
Entresto	3	Max. 60 tabs/30-day supply	* Prior authorization required. 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.
Enulose	2		
Envarsus XR	4		
Epaned	4		
Epiceram	4		
Epiduo	4	Prior authorization required for members 30 and older	* Prior authorization required.
Epiduo Forte	4	Prior authorization required for members 30 and over.	* Prior authorization required.
Epifoam	4		
epinastine	2		
Epipen	3	Max. 2 units/copay	
Epipen Jr.	3	Max. 2 units/copay	
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	* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Equetro	4		
ergocalciferol (capsules)	2		
Ergoloid	2		
Ergomar	3		
Erivedge	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Errin	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
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		
Esbriet	3	Max.270 caps/30 day-supply	* 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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Estrace	4		
Estrace (vaginal cream)	3		
estradiol (patch)	2		
estradiol tabs	1		
Estring	3		* Packaged as a 90-day supply. Member pays 3 copayments at retail pharmacy.
Estrogel	4		
estrogen, ester/me-testosterone 0.625mg/1.25mg	2		
estrogen, ester/me-testosterone 1.25mg/2.5mg	2		
estropipate	2		
Estrostep FE	4		
eszopiclone	2		
ethambutol	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.
ethinyl estradiol 30 - desogestrel 0.15	$0		* 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.
ethinyl estradiol 35 - norethindrone 1	$0		* 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.
ethinyl estradiol 35 – norgestimate 0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol/norethindrone acetate	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
ethosuximide	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Eurax	3		
Evamist	4	Max. 1 bottle/copay	
Evekeo	4		* Fillable at retail pharmacies only. Max. 60-day supply.
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	
Exalgo	4	Max. 60 tabs/30 day-supply	* Quantity Limitations.
Exelderm	4		
Exelon	4		
Exelon Patch	4		
exemestane	2		* This medication may be eligible for a $0 co-pay under certain benefit plans. HSA Preventive 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 NAME	TIER	LIMITATIONS	NOTES
			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.
Extavia	4		* Not available through Mail Service. Covered through Specialty Pharmacy Program.Must use Accredo.
Extina	4		
Eylea	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
F			
Fabior	4	Prior authorization required for members 30 and older	* Prior authorization required.
Fabrazyme	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
Factive	4		
famciclovir	2		
famotidine	1		
Famvir	4		
Fanapt	4		
Fareston	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. 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.
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	5		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Fazaclo	4		
Feiba VH Immuno	Unspecified		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
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		* This medication may be eligible for a $0 co-pay under certain benefit plans. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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, 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.
fenofibric acid	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fenoglide	4		* HSA Preventive 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	* Quantity Limitations.
fentanyl citrate (lozenge)	2	Max. 120 lozenges/30-day supply.	* Prior authorization required. Quantity Limitations.
Fentora	4	Max. 120 lozenges/30-day supply	* Quantity Limitations. Prior authorization required.
Ferriprox	4		* Sole source through Centric Health. 866-758-7071
Fetzima	4		* 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 (foam)	3		
Finacea Plus	3		
finasteride 1mg	NC		* This drug is not covered.
finasteride 5mg	2		
Fioricet	4		
Fioricet w/Codeine	4		
Fiorinal	4		
Fiorinal with Codeine	4		
Firazyr	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Flagyl	4		
Flagyl ER	4		
Flarex	4		
flavoxate	2		
flecainide acetate	2		
Flector	3		
Flomax	4		
Flonase	4		
Floriva	4		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Flumadine	4		
flunisolide nasal spray	2		
fluocinolone acetonide	2		
fluocinolone acetonide oil	2		
fluocinonide	2		
fluocinonide (micronized)	2		
fluorometholone, ophthalmic	2		
Fluoroplex	4		
fluorouracil	2		
fluorouracil 0.5% 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		
flurazepam	1		
flurbiprofen	2		
flurbiprofen, ophthalmic	2		
flutamide	2		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
fluvastatin ER	2		
fluvoxamine	2		
fluvoxamine er 24h	2		
FML	4		
Focalin	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Focalin XR	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Focalin XR 25mg, 35mg	3		* Fillable at retail pharmacies only. Max. 60-day supply.
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 Village Pharmacy or Walgreens Specialty Pharmacy or Freedom Drug for coverage.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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		* Prior authorization required.
Fortamet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Forteo	3	Max. 1 syringe/28-day supply	* Prior authorization 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. Covered through Specialty Pharmacy Program.Use Magellan Health (formerly known as ICORE).
Fortesta	4	Prior authorization required for members 18 and older. Max. 2 pumps/30-day supply	* Prior authorization required.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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 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.
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	* 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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 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.
Fycompa	4		
G			
gabapentin	2		
Gabitril	4		
galantamine	2		
galantamine ER	2		
ganciclovir	2		
Gani-Tuss NR 100-10mg/5	2		
Ganirelix	4		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.
Gastrocrom	4		
gatifloxacin	2		
Gattex	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Gavilyte-G	2		
Gavilyte-H and Bisacodyl	2		
Gel-Kam	4		
Gelclair	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Gelnique	4	Max. 30 packets/30-day supply	
Gelnique Pump	4	Max. 1 pump bottle/30-day supply	
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		* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
Genotropin MiniQuick	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
Gentak (ointment)	2		
gentamicin	2		
gentamicin 0.3% (ointment)	2		
Genvoya	4		
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.
Giazo	4		
Gilenya	3	Max. 28 caps/28 day supply	* Covered through Specialty Pharmacy Program.Use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
Gilotrif	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Must use Accredo.
Glatopa 20mg	3		* Covered through Specialty Pharmacy Program.Use Accredo.
Gleevec	3		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Gleostine	3		* This medication is eligible for a $0 co-pay under certain benefit plans.
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		* HSA Preventive 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
Glucocard Test 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.
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		* Prior Authorization required effective 4/1/2016
glyburide	2		
glyburide 1.25mg	1		* 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.
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.
Gralise	4		
granisetron	2	Max. 6 tabs/copay	
Granisol	2	Max. 30mL/copay	

DRUG NAME	TIER	LIMITATIONS	NOTES
Granix	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Grastek	4	Max. 30 tabs/30-day supply	
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	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Hecoria	3		
Hectorol	4		
Helixate FS	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
Hemangeol	4		
Hemenatal 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.
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.
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	* Prior authorization required. Quantity Limitations. Covered through Specialty Pharmacy Program.Must use Accredo.
Hexalen	3		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Hiprex	4		
homatropaire	2		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
Humatrope	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
Humira	3		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Humira Crohns Starter Kit	3	1 kit per year	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Humira Psoriasis Starter Kit	3	Max. 1 kit/year	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Humulin 70/30	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humulin N	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humulin N Kwikpen	3		
Humulin R	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Hycamtin	4		* This medication may be eligible for a $0 co-pay under

DRUG NAME	TIER	LIMITATIONS	NOTES
			certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Hycet	4		
Hycofenix	4		
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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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		
hydrocodone/acetaminophen 5mg-500mg	1		
hydrocodone/acetaminophen 7.5mg-650mg	2		
hydrocodone/acetaminophen 7.5mg-750mg	1		
hydrocodone/acetaminophen oral solution	2		
hydrocodone/chlorpheniramine (suspension)	2		
hydrocodone/homatropine	2		
hydrocortisone	2		
hydrocortisone (enema)	2		
hydrocortisone 1% (cream/ ointment)	1		
hydrocortisone 2.5% (cream/ ointment)	1		
hydrocortisone butyrate	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
hydrocortisone valerate	2		
Hydromet	2		
hydromorphone	2		
hydromorphone (liquid)	2		
hydromorphone tab ER 24H	2	Max. 60 tabs/30- day supply	
hydroxychloroquine	2		
hydroxycobalamin 1,000 mcg (injection)	2		
hydroxyurea	2		* This medication may be eligible for a $0 co-pay under certain benefit plans.
hydroxyzine	2		
hydroxyzine pamoate	2		
Hylase	4		
Hylatopic	4		
Hylatopic Plus	4		
Hyper-Sal	4		
Hysingla ER	4	20mg & 30mg- Max: 60 tabs/30 day-supply. 40mg,60mg,80mg,100mg,120mg- Max: 30 tabs/30 day-supply	* 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		* This medication may be eligible for a $0 co-pay under

DRUG NAME	TIER	LIMITATIONS	NOTES
			certain benefit plans. Covered through Specialty Pharmacy Program.Must use Accredo.
ibuprofen	1		
ibuprofen 100mg/5mL (suspension)	2		
Icar-C Plus	2		
Ilaris	Medical		* Prior authorization required. Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
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	
Imitrex (nasal spray)	4	Max. 6 sprays/copay	
Imitrex (tablets)	4	25mg: Max. 24 tabs/copay; 50mg: Max. 12 tabs/copay, 100mg: Max. 6 tabs/copay	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Implanon	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo or Hemophilia Health Services.
Imuran	4		
Increlex	3		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
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		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Innopran XL	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Inspirease Delivery System	Medical		
Inspirease Replacement Bags	Medical		
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.
Intuniv	4		
Invega	4		
Invega Sustenna	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
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 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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Iressa	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Isentress	3		
isoetharine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
isometheptene, dichloralphenazone, acetaminophen	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	* Prior authorization required.
ivermectin	2		
Ixinity	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
J			
Jadenu	4		* Covered through Specialty Pharmacy Program.Must use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
Jakafi	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Must use Accredo.
Jalyn	4		
Jantoven	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.
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 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	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
Jolessa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Jublia	4		* Prior authorization required.
Junel 1/20	$0		* 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.
Juxtapid	4		* Sole source through Centric Health. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
K			
K-Lor	3		
K-Phos Neutral	4		
K-Phos Original	4		
K-Tab	3		
Kadian 10mg, 20mg, 30mg, 50mg, 60mg, 80mg, 100mg	4	Max. 2 caps/daily	
Kadian 40mg, 70mg, 130mg, 150mg, 200mg	3	Max. 2 caps/daily	
Kalbitor	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
Kaletra	3		
Kalydeco	3		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Kaochlor	4		
Kapvay	4		
Karbinal ER	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Kariva	$0		* 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		
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		* 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	
Ketostix	3		
Keveyis	4		* Covered through Specialty Pharmacy Program.Must use Diplomat Pharmacy.

DRUG NAME	TIER	LIMITATIONS	NOTES
Khedezla	4		* Step Therapy: For members 18 and over.
Kineret	4		* Sole Source Pharmacy: Omnicare/RX Crossroads, 866-547-0644 Prior authorization required.
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.
Kogenate FS	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
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 through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Kuvan	3		* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Kynamro	4		* This drug is not covered.

L

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
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	
Lamisil Granules	4	Max. 28 packets/fill; Max. 84 packets/year	
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
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 supplyEffective 1/1/15, Prior authorization required.	
leflunomide	2		
Lenvima	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo. medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo. Covered through Specialty Pharmacy Program.Use Accredo.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
Letairis	3		* Covered through Specialty Pharmacy Program.Use Accredo.
letrozole	2		* This medication may be eligible for a $0 co-pay under certain benefit plans. HSA Preventive 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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
leuprolide acetate	2		* Covered through IVF Program.Must use Village Pharmacy or Walgreens Specialty Pharmacy or Freedom Drug for coverage.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
levetiracetam	2		
levetiracetam XR	2		
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.
levobunolol	2		
levocetirizine	2		
levofloxacin	1		
levofloxacin, ophthalmic	2		
levonorgestrel/ethinyl estradiol	$0		
Levora	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
levorphanol	2		
Levothroid	2		
levothyroxine	1		
Levoxyl	2		
Lexapro	4		* Step Therapy: For members 18 and over.
Lexiva	3		
Lialda	3		
Librax	4		
lidocaine	2		
lidocaine patch	2		
lidocaine viscous	2		
lidocaine/prilocaine	2		
Lidoderm	4		
lindane	2		
linezolid	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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 300mg cap	1		
lithium carbonate SR	2		
lithium citrate	2		
Lithobid	4		
Lithostat	4		
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	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
Lo Minastrin Fe	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
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.
Lomotil	4		
Lonsurf	4		* This drug may be eligible for $0 copay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
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 Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Loprox Shampoo	4		
lorazepam	1		
Lortab	4		
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 plan deductible. Applicable copayment will apply.
Lotrisone	4		
Lotronex	4	Covered for females only	
lovastatin	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	$0		* HSA Preventive 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.
Low-Ogestrel	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
loxapine	2		
Loxitane	4		
Lumigan 0.01%	3		
Lumizyme	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
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		
Lupron Depot/Lupron-Pedi	Medical		* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Lustra	NC		* This drug is not covered.
Lutera	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Luvox CR	4		* Step Therapy: For members 18 and over.
Luxiq	4		
Luzu	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Lycelle	4		
Lynparza	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Lyrica	4		* Step Therapy: For members 18 and over.
Lysodren	3		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Lysteda	4	Max. 30 tabs/30-day supply	
M			
Macrobid	4		
Macrodantin	4		
mafenide acetate	2		
Makena	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo, Freedom Drug or Village Pharmacy for coverage.
Malarone	4		
malathion	2		
maprotiline	2		
Marinol	4		
Marplan	4		
Matulane	3		* Sole source through Walgreens Specialty Pharmacy.This medication may be eligible for a $0 co-pay under certain benefit plans.
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 NAME	TIER	LIMITATIONS	NOTES
			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.
Maxalt	4	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	* 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	* 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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Megace ES	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
megestrol acetate	2		* This medication may be eligible for a $0 co-pay under certain benefit plans.
megestrol acetate ES	2		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Mekinist	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
meloxicam	1		
memantine	2		
Menest	4		
Menopur	3		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.
Menostar	4		
Mentax	3		
meperidine	2		
Mephyton	3		
meprobamate	2		
Mepron	4		
mercaptopurine	2		* This medication may be eligible for a $0 co-pay under certain benefit plans.
mesalamine (enema)	2		
Mesnex	4		
Mestinon tabs	4		
Mestinon Timespan	4		
Metadate CD	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Metadate ER	2		* Fillable at retail pharmacies only. Max. 60-day supply.
metaproterenol	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.
metaxalone	2		
metformin	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.
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		
methamphetamine	3		* Fillable at retail pharmacies only. Max. 60-day supply.
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		
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 plan deductible. Applicable copayment will apply.
Methylin	2		* Fillable at retail pharmacies only. Max. 60-day supply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Methylin (chew tab)	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Methylin ER	2		
Methylin Solution	4		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate	2		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate (chew tab)	2		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate 24-hr ER tab	2		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate CD	2		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate er	2		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate long-acting	2		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate solution	1		* Fillable at retail pharmacies only. Max. 60-day supply.
methylphenidate SR	2		* Fillable at retail pharmacies only. Max. 60-day supply.
methylprednisolone	2		
methyltestosterone	2		
metipranolol	2		
metoclopramide	1		
metoclopramide ODT	2		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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 (gel)	2		
metronidazole (lotion)	2		
metronidazole (vaginal gel)	2		
metronidazole tabs	2		
Mevacor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Micro-K	4		
Microcyn Hydrogel	4		
Microgestin	$0		* 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 plan deductible. Applicable copayment will apply.
Migranal Nasal Spray	3		
Millipred	3		
Mimvey	2		
Minastrin 24 FE	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
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 NAME	TIER	LIMITATIONS	NOTES
			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		
Mircette	4		
mirtazapine	2		
mirtazapine 15mg	1		
Mirvaso	4		
misoprostol	2		
misoprostol/diclofenac	2		
Mitigare	4		
Moban	4		
Mobic	4		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
molindone	2		
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.
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.
Mononine	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
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	
morphine sulfate	2	Max. 3 tabs/daily	

DRUG NAME	TIER	LIMITATIONS	NOTES
morphine sulfate (Roxane) 15mg, 30mg	3	Max. 2 caps/daily	
morphine sulfate cap ER 10mg, 20mg, 30mg, 50mg, 60mg, 80mg, 100mg	2	Max. 2 caps/daily	
morphine sulfate ER	2	Max. 2 caps/daily	
Motofen	4		
Motrin	4		
Movantik	3		
Moviprep	3		
Moxatag	4		
Moxeza	4		
moxifloxacin	2		
Mozobil	3	Max. 4 vials/copay	* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
MS Contin	4	Max. 3 tabs/daily	* Quantity Limitations.
MSIR	4		
Mugard	3		* Not available through Mail Service. Covered through Specialty Pharmacy Program.Must use Accredo.
Multaq	3		
multivitamins with fluoride	1		* Packaged as a 50 day supply. Member pays 2 copays. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
mupirocin cream	2		
mupirocin ointment	2		
Muse	3	Max. 6 suppositories/30-day supply; Covered for males over 18 years of age only	

DRUG NAME	TIER	LIMITATIONS	NOTES
My Way	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Myalept	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Myambutol	4		
Mycobutin	4		
mycophenolate	2		
mycophenolate mofetil suspension	2		
mycophenolic acid	2		
Myfortic	4		
Myleran	3		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Myobloc	Medical	Prior authorization required for members 17 and older	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Myorisan	2		
Myozyme	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
Myrbetriq	3		
Mysoline	4		
Mytussin AC 100-10mg/5	2		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
naftifine	2		
Naftin	4		
Naglazyme	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
Nalfon	4		
Naloxone HCl syringe	Medical		* Available at a retail pharmacy.
naltrexone	2		
Namenda	4		
Namenda XR	4		
Namzaric	4		
Naprelan	4		
Naprosyn	4		
naproxen	1		
naproxen 220mg, 550mg	2		
NAPROXEN SODIUM	1		
naproxen sodium cr	2		
naratriptan	2	1mg: Max. 15 tabs/copay; 2.5mg: Max. 6 tabs/copay	
Narcan (nasal spray)	4	Max. 2 inhalers (1 package)/copay, Max. 4 inhalers (2 packages)/30-day supply	
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Natatab FA 29mg-1mg	1		
Natazia	$0		* 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	* Prior authorization required.
Natpara	4	Max. 2 cartridges/28-day supply	* This drug is not covered.
Natroba	4		
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		
Necon	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
nefazodone	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	4		
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		
Neulasta	3		* Covered through Specialty Pharmacy Program.Use Accredo or Magellan Health (formerly known as ICORE).
Neumega	3		* Covered through Specialty Pharmacy Program.Must use Accredo.
Neupogen	3		* Covered through Specialty Pharmacy Program.Use Accredo

DRUG NAME	TIER	LIMITATIONS	NOTES
			or Magellan Health (formerly known as ICORE).
Neupogen (syringe)	4		* Covered through Specialty Pharmacy Program.Use Accredo or Magellan Health (formerly known as ICORE).
Neupro	4		
Neurontin	4		
Neutrasal	4		
nevirapine	2		
nevirapine ER	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		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Must use Accredo.
Nexium	4		
Nexplanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
Next Choice One Dose	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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	$0	Max. 168 units/fill; Limit 180-day supply per year	* This medication is eligible for a $0 co-pay under certain benefit plans.
Nicotrol NS	$0	Max. 4 units/fill; Limit 180 day-supply per year	* This medication is eligible for a $0 co-pay under certain benefit plans.
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 drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nilandron	3		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
Ninlaro	4		* This medication may eligible for a $0 co-pay under certain benefit plans.
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 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 NAME	TIER	LIMITATIONS	NOTES
			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.
Norco	4		
Nordette	4		
Norditropin Flexpro/Nordiflex	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
norethindrone 0.35 mg	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
norethindrone acetate	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
norethindrone/ethinyl estradiol/ iron (ferrous fumarate)	$0		* 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 benefit plans.
Norinyl 1/50	4		
Noritate	3		
Noroxin	4		
Norpace	4		
Norpace CR	4		
Norpramin	4		
Northera	3		* Covered through Specialty Pharmacy Program.Must use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
Nortrel 0.5/35, 1/35, 7-7-7	$0		* 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.
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		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Novoseven RT	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
Noxafil (suspension)	4		
Noxafil (tablets)	4		
Nplate	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Nucynta	3		
Nucynta ER	3	Max. 60 tabs/30-day supply	
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).
NuLytely	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Nutropin AQ	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Nutropin AQ NuSpin	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Nuvail	4		
NuvaRing	$0		* 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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 GOLD	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete Premier	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
OBAGI-C	NC		* This drug is not covered.
Obredon	4		
Ocella	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
octreotide	Medical		* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Ocudox	4		
Ocufen	4		
Ocuflox	4		
Odomzo	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Ofev	3	Max. 60 caps/30 day-supply	* Covered through Specialty Pharmacy Program.Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo or Walgreens Specialty Pharmacy.
ofloxacin 0.3%	2		
ofloxacin, otic	2		
Ogestrel	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
olanzapine	2		
olanzapine ODT	2		
olanzapine/fluoxetine	2		
Oleptro ER	4		
olopatadine	2		
olopatadine nasal spray	2		
Olux	4		
Olux-E	4		
Olysio	4	Max. 28 tabs/28-day supply	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Omeclamox-Pak	4		
omega 3 acids ethyl esters	2		
omeprazole caps, 10mg & 40mg	2		
omeprazole caps, 20mg	1		
omeprazole/sodium bicarbonate (capsule)	4		
Omnaris	4		
Omnipred	4		
Omnitrope	2		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
ondansetron	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay; 4mg/5mL: Max. 100mL (2 bottles)/copay	* Quantity Limitations.

DRUG NAME	TIER	LIMITATIONS	NOTES
ondansetron ODT	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Quantity Limitations.
One Touch Ultra Test Strips	4	204 test strips/30-day supply	* FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products. Prior authorization 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.
One Touch Verio Test Strips	4	204 test 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. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Onexton	4		
Onfi	3	Prior authorization required for members 18 and older	* Prior authorization required.
Onglyza	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Onmel	4	Max. 28 tabs/28-day supply; Max. 84 tabs/year	* Prior authorization required.
Opana	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Opana ER	4	Max. 90 tabs/30-day supply	* Quantity Limitations.
opium tincture	2		
Opsumit	3		* Covered through Specialty Pharmacy Program.Must use Accredo.
Optivar	4		
Oracea	4		
Orafate	4		
Oralair	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Orap	4		
Orapred	4		
Orapred ODT	4		
Oravig	4		
Orencia (Prefilled Syringe)	4	Max. 4 syringes/28-day supply	* Prior authorization required. Quantity Limitations. Covered through Specialty Pharmacy Program.Must use Accredo.
Orenitram ER	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Orfadin	4		* Sole Source Pharmacy: Dohmen Life Sciences 1-800-305-7881
Orkambi	4	Max. 112 tabs/28 days	* Prior authorization required.
orphenadrine citrate	2		
orphenadrine citrate/aspirin/ caffeine	2		
Ortho Cyclen	4		
Ortho Evra	4		
Ortho Tri Cyclen	4		
Ortho Tri-Cyclen LO	4		
Ortho-Cept	4		
Ortho-Novum	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Otrexup	3		
Ovcon -35	4		
Ovide	4		
Ovidrel	3		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.
Oxandrin	4		
oxandrolone	2		
oxaprozin	2		
oxazepam	2		
oxcarbazepine	2		
oxcarbazepine suspension	2		
Oxecta	4		
Oxistat	4		
Oxsoralen-Ultra	4		
Oxtellar XR	NC		* This drug is not covered.
oxybutynin	2		
oxycodone	2		
oxycodone hcl er	2	Max. 4 tabs/day (inclusive of all strengths)	
oxycodone/acetaminophen	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
oxycodone/acetaminophen 5mg-325mg	2		
oxycodone/aspirin	2		
oxycodone/ibuprofen	2		
Oxycontin	3	Max. 4 tabs/day (inclusive of all strengths)	* Quantity Limitations.
oxymorphone	2		
oxymorphone tab ER 12h	2	Max. 90 tabs/30 day-supply	
Oxytrol	4		
Ozurdex	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.

P

Pacerone	2		
Palgic Liquid	2		
paliperidone ER	2		
Pamelor	4		
Pamine	4		
Pancreaze	3		
Pancrelipase 5,000	2		
Pandel	4		
Panretin	4		
pantoprazole	2		
paricalcitol	2		
Parlodel	4		
Parnate	4		
paromomycin	2		
paroxetine	2		
paroxetine 10mg, 20mg, 30mg, 40mg	1		
Pataday	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Patanase Nasal Spray	4		
Patanol	4		
Paxil	4		* Step Therapy: For members 18 and over.
Paxil (liquid)	3		
Paxil CR	4		* Step Therapy: For members 18 and over.
Paxil CR 37.5mg	3		* 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.
Peganone	4		
Pegasys	3		* Covered through Specialty Pharmacy Program.Use Accredo.
penicillin v potassium	1		
Penlac	4		* Prior authorization required
Pennsaid 2% solution	4		* Prior Authorization required effected 4/1/2016
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		
Percocet	4		
Percodan	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	1		
Periostat	4		
permethrin	2		
perphenazine	2		
Pertzye	4		
Pexeva	3		* Step Therapy: For members 18 and over.
phenazopyridine	1		
phenelzine	2		
phenobarbital	1		
phenobarbital 20mg/5mL (elixir)	2		
phenoxybenzamine	2		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Picato	3		
pilocarpine (oral)	2		
pilocarpine 3% (ophthalmic drops)	2		
pimozide	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 plan deductible. Applicable copayment will apply.
piroxicam	2		
Plan B One-Step	$0		
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		* Covered through Specialty Pharmacy Program.Must use Accredo.
Pletal	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.
Plexion (cleanser)	4		
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 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		* Covered through Specialty Pharmacy Program.Must use Accredo.
Ponstel	4		
Potaba	4		
potassium chloride	2		
potassium citrate	2		
Potiga	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	* Prior authorization required. Covered through Specialty Pharmacy Program.Use Walgreens Specialty Pharmacy.
pramipexole	2		
pramipexole er	2		
Pramosone	3		
Prandimet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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 NAME	TIER	LIMITATIONS	NOTES
			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.
Pred Forte	4		
Pred G	4		
Pred Mild	3		
prednicarbate	2		
prednisolone	2		
prednisolone 15 MG/5 mL syrup	1		
prednisolone 5mg (tablet)	1		
prednisolone acetate	2		
prednisolone sodium phosphate tab rapdis	2		
prednisone	1		
prednisone 5mg/5mL (oral solution)	1		
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Premarin	3		
Premarin (vaginal cream)	3		
Premesis Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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		
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		

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Prenate Pixie	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Restore	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Star	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenexa	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prepopik	3		
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	
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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 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: 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		
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 plan deductible. Applicable copayment will apply.
Procardia XL	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.
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	* Prior authorization required. Quantity Limitations. Covered through Specialty Pharmacy Program.Use Accredo or Magellan Health (formerly known as ICORE).
Procto-Pak 1% (cream)	1		
Proctofoam HC	3		
Proctosol-HC	2		
Proctosol-HC 2.5% (cream)	1		
Procysbi	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Prodigy Test Strips	4	204 test 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. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Profilnine SD	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
progesterone	2		
Progesterone In Oil [brand name]	4		* This drug is not covered.
progesterone in oil [generic]	2		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.

DRUG NAME	TIER	LIMITATIONS	NOTES
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		* Available through Dohmen Life Sciences only..800-305-7881 Covered under medical benefit. No pharmacy copayment applies.
Prolastin C	Medical		* Available through Dohmen Life Sciences only. 800-305-7881 Covered under medical benefit. No pharmacy copayment applies.
Prolensa	4		
Prolia	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Promacta	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
promethazine	1		
promethazine DM 15-6.25/5	2		
promethazine/codeine	2		
Prometrium	4		
Promiseb Complete	4		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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 Accredo.
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		
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

DRUG NAME	TIER	LIMITATIONS	NOTES
Prozac	4		* Step Therapy: For members 18 and over.
Prozac Weekly	4		* Step Therapy: For members 18 and over.
pruclair	2		
Prudoxin	4		
Prutect	2		
pseudoephedrine/hydrocodone/ chlorpheniramine	2		
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		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Purixan	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Pylera	3		
pyrazinamide	2		
Pyridium	3		
pyridostigmine	2		
pyridostigmine SR	2		
Q			
QNASL	4		
Qsymia	NC		* This drug is not covered.
Qualaquin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Quartette	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Quasense	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
quazepam	2		
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		* Fillable at retail pharmacies only. Max. 60-day supply.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs will not be subject to your plan deductible. Applicable copayment will apply.
R			
rabeprazole/tablet DR	4		
Ragwitek	4	Max. 30 tabs/30-day supply	
raloxifene	2		* This medication is eligible for a $0 co-pay under certain benefit plans.
ramipril 5mg, 10mg	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.
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 150mg, 300mg tabs	1		
ranitidine tabs	2		
Rapaflo	4		
Rapamune	4		
Rasuvo	3	Max. 4 syringes/28 day-supply	
Ravicti	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Rayos	4		* Prior authorization required.
Razadyne	4		
Razadyne ER	4		
Rebetol (capsule)	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Rebetol (Solution)	3		* Covered through Specialty Pharmacy Program.Use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
Rebif	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Rebif Rebi-Dose	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Reclast	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Reclipsen	$0		* 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 Accredo or Caremark.
Rectiv	4		
Regenecare	4		
Reglan	4		
Regranex	4	Annual limit 90 days; Max. 1 tube/30-day supply	
Relenza	4	Max. 1 package per fill	
Relistor	3		
Relpax	3	20mg: Max. 12 tabs/copay; 40mg: Max. 6 tabs/copay	
Remeron	4		
ReNaf	2		
Renagel	3		
Renax	2		
Renova	NC		* This drug is not covered.
Renvela	3		
repaglinide	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.
repaglinide/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.
Repatha	3		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Walgreens Specialty Pharmacy.
Reprexain	2		
Repronex	3		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage.
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	* Prior authorization required.
Retin-A Micro	4	Prior authorization required for members 30 and older	* Prior authorization required.
Revatio	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Revia	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Revlimid	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Rexulti	4	Max. 30 tabs/30-day supply	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
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.
RiaSTAP	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Caremark.
Ribapak	2		
Ribasphere	2		* Covered through Specialty Pharmacy Program.Must use Accredo.
Ribatab	4		* Covered through Specialty Pharmacy Program.Use Accredo.
ribavirin	2		* Covered through Specialty Pharmacy Program.Use Accredo.
Ridaura	4		
rifabutin	2		
Rifadin	4		
Rifamate	4		
rifampin	2		
Rifater	4		
Rilutek	4		
riluzole	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Risperdal	4		
Risperdal Consta	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
Risperdal M-TAB	4		
risperidone	2		
risperidone M-Tab ODT	2		
Ritalin	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Ritalin LA	4		* Fillable at retail pharmacies only. Max. 60-day supply.
rivastigmine	2		
rivastigmine patch	2		
Rixubis	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
rizatriptan	2	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	
rizatriptan; oral-disintegrating tablet	2	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	
Robaxin	4		
Robinul	4		
Robinul Forte	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
Roxicet 5mg-325mg	2		
Roxicodone	4		
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.Use Accredo.
Safyral	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Saizen	4		* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
Salagen	4		
Salex	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Salivamax	4		
salsalate	2		
Samsca	4		
Sanctura	4		
Sancuso	4	4 patches/copay	
Sandimmune	4		
Sandimmune Oral Soln	3		
Sandostatin/LAR	Medical		* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Santyl	3		
Saphris	4		
Sarafem	4		* 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: 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		
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.
Seebri Neohaler	4	Max. 1 unit (60 blisters)/30-day supply	* Quantity Limitations.

DRUG NAME	TIER	LIMITATIONS	NOTES
Select-OB	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
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).
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		* Prior authorization required. Covered through Specialty Pharmacy Program.Use Accredo.
sertraline	1		
Signifor	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Signifor LAR	Medical		
sildenafil (PAH)	2		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
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	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
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		
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.	
Sivextro	4	Max. 6 tabs/copay	
Skelaxin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Sklice	4		
Sodium Chloride	2		
sodium chloride vial-neb	2		
sodium citrate/citric acid	2		
sodium fluoride (drops) (chewable tablets)	1		* $0 cost share for children through age 5. Children age 6 and over copay 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.
sodium fluoride 0.25mg	2		
sodium phenylbutyrate	2		
sodium polystyrene sulfonate	2		
sodium polystyrene sulfonate enema	2		
Sof-Tact Test Strips	4	204 test 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. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Solaraze	4		
Soliris	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
Solodyn	4		* Prior authorization required
Soma	4		
Somatuline Depot	3		* Covered through Specialty Pharmacy Program.Must use Accredo.

DRUG NAME	TIER	LIMITATIONS	NOTES
Somavert	4		* Covered through Specialty Pharmacy Program.Use Accredo.
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.
Sovaldi	3	Max. 28 tabs/28-day supply	* Prior authorization required. Quantity Limitations. Covered through Specialty Pharmacy Program.Must use Accredo.
Spectracef	4		
spinosad	2		
Spiriva	3	Max. 1 unit (30 blisters)/30-day supply	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs 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 NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
SPIRONOLACTONE 25mg tab	1		
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	* Prior authorization required.
Sporanox (solution)	4		
Sprintec	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Sprix	4	Max. 5 bottles/fill	
Sprycel	3		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
SPS Rectal Enema	4		
Sronyx	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
SSD Cream	4		
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		* Prior authorization required. Covered under medical

DRUG NAME	TIER	LIMITATIONS	NOTES
			benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
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		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Must use Walgreens Specialty Pharmacy or Accredo.
Strattera	3		
Strensiq	4		
Striant	3	Max. 60 tabs/30 day-supply	* Prior authorization required for members 18 and older.
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		
Subsys	4	Max. 120 sprays/30-day supply	* Prior authorization required.
Subutex	4		
Suclear	4		
Sucraid	4		* Covered through Specialty Pharmacy Program.Use Accredo.
sucralfate	2		
Sular	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.
sulfacetamide sodium 10% (drops)	2		
sulfacetamide sodium/sulfur 10%-2% cream	2		
sulfacetamide sodium/sulfur 10%-5% cream	2		
sulfacetamide sodium/sulfur 9.8%-4.8% (cleanser)	2		
sulfacetamide topical lotion	2		
Sulfamide (drops)	1		
Sulfamylon	4		
sulfasalazine	2		
sulindac	2		
sumatriptan (injection)	2	Max. 3 boxes (6 inj)/copay	
sumatriptan (nasal spray)	2	Max. 6 sprays/copay	
sumatriptan (tablets)	2	25mg: Max. 24 tabs/copay; 50mg: Max. 12 tabs/copay; 100mg: Max. 6 tabs/copay	
Sumavel Dosepro	4	Max. 6 pens/copay	
Supprelin LA	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Suprax	4		
Suprenza ODT	NC		* This drug is not covered.
Suprep	4		
SureStep Pro Test Strips	4	204 test 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			care products. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Surmontil	4		
Sustiva	3		
Sutent	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Sylatron	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
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.	* Prior authorization required. Covered under medical benefit. No pharmacy copayment applies. Quantity Limitations. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Synalar	4		
Synalar TS	4		
Synalgos-DC	4		
Synarel	3		* Covered through IVF Program.Must use Freedom Drug or Village Pharmacy or

DRUG NAME	TIER	LIMITATIONS	NOTES
			Walgreens Specialty Pharmacy for coverage.
Synjardy	4		
Synthroid	3		
T			
Taclonex	4		
tacrolimus	2		
tacrolimus topical	2		* Prior authorization required.
Tafinlar	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Tagamet	4		
Tagrisso	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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	
tamoxifen	2		* This medication may be eligible for a $0 co-pay under certain benefit plans. HSA Preventive 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			plan deductible. Applicable copayment will apply.
Tapazole	4		
Tarceva	3		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Targretin	4		* This medication may be 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.
Tasigna	3		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Tasmar	4		
Tazorac	4	Prior authorization required for members 30 and older	* Prior authorization required.
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.
Technivie	4	Max. 56 tabs/28-day supply	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Tegretol	4		
Tegretol XR	4		
Tekamlo	3	150mg/5mg & 150mg/10mg: Max. 45 tabs/30 days; 300mg/5mg	* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
		& 300mg/10mg: Max. 30 tabs/30 days	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		
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 Walgreens Specialty Pharmacy or Accredo.
Temovate	4		
temozolomide	2		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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	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	
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	Max. 300 grams/30-day supply	* Prior authorization required for members 18 and older.
Testone CIK	4	Max. 4 l ml vials/30-day supply.	* Prior authorization required for members 18 and older.
testosterone 1% gel	2	Max. 300 grams/30-day supply	* Prior authorization required for members 18 and older.
testosterone 2% gel	2	Max. 2 pumps/30 day-supply.	* Prior authorization required for members 18 and older.
testosterone cypionate	2	1mL vial: Max. 4 vials/30 day-supply 10mL vial: Max. 1 vial/30 day-supply	* Prior authorization required for members 18 and older.
testosterone enanthate	2	1mL syringe: Max. 4 syringes/30-day supply	* Prior authorization required for members 18 and older.

DRUG NAME	TIER	LIMITATIONS	NOTES
		5mL vial: Max. 1 vial/30-day supply	
Testred	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
tetrabenazine	2		* Covered through Specialty Pharmacy Program.Use Accredo.
tetracaine	2		
tetracycline	2		
Tetrix	4		
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.
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Thioguanine	3		* This medication may be eligible for a $0 co-pay under certain benefit plans.
Thiola	4		* Sole Source Pharmacy: Dohmen Life Sciences 1-800-305-7881
thioridazine	2		
thiothixene	2		
Thyrogen	Medical		* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
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.
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.
timolol	1		
timolol XE (ophthalmic gel)	2		
Timoptic	4		
Timoptic-XE	4		
Tindamax	4		
tinidazole	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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 Accredo.
tobramycin/dexamethasone (ophthalmic)	2		
tobramycin/nebulizer	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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	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.
Toviaz	3		
Tracleer	3		* Covered through Specialty Pharmacy Program.Use Accredo.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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	
Tranxene T-Tabs	4		
tranylcypromine	2		
Travatan Z	3		
travoprost	2		
trazodone	1		
Tresiba Flextouch	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tretin-X	4		* Prior authorization required for members 30 and older.
tretinoin 0.05%, emollient	NC		* This drug is not covered.
tretinoin topical gel	2		* Prior authorization required for members 30 and older.
tretinoin, microspheres topical	2		* Prior authorization required for members 30 and older.
tretinoin, topical	2		* Prior authorization required for members 30 and older.
Tretten	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo or Caremark.
Trexall	4		
Treximet	3	Max. 9 tabs/copay	* 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.
Trezix	4		
Tri-Estarylla	$0		* 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.
Tri-Linyah	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Lo-Sprintec	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Luma	NC		* This drug is not covered.
Tri-Norinyl	4		
Tri-Previfem	$0		* 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.
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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
TriCor	4		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Trinate 28mg-1mg	2		
Trinessa	$0		* 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 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.
Trizivir	4		
Trokendi XR	4		
Tropazone	4		
trospium chloride	2		
trospium chloride ER cap	2		
True Metrix BG Test Strips	4	Max. 204 strips/30-day supply	* FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products. Prior authorization required. Quantity Limitations.
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 NAME	TIER	LIMITATIONS	NOTES
			Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tussicaps	4		
Tussionex	4		
Tuzistra XR	4		
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		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Tylenol with Codeine	4		
Tyvaso	3		* Covered through Specialty Pharmacy Program.Must use Accredo.
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
Univasc	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Uptravi	4		* Prior authorization required.
Urecholine	4		
Urocit-K	4		
Uroxatral	4	Max. 30 tabs/30-day supply	
Urso	4		
ursodiol	2		
Utibron Neohaler	4	Max. 1 unit (60 blisters)/30-day supply	* Quantity Limitations.
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.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Valtrex	4		
Vancocin	4		
vancomycin	2		
Vandazole	4		
Vaniqa	NC		* This drug is not covered.
Vanos	4		
Vantas	Medical		* Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Varubi	4	Max. 2 tabs/copay	* Quantity Limitations.
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.
Velphoro	4		
Veltassa	4		
Veltin	4		* Prior authorization required for members 30 and older.
venlafaxine (tablet)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
venlafaxine ER (capsules)	2		
venlafaxine ER (tablets)	2		
Venlafaxine ER (tablets) (Brand)	4		* Step Therapy: For members 18 and over.
Venlafaxine ER (tablets) 225mg	4		* Step Therapy: For members 18 and over.
Ventavis	4		* 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.
Verdeso	4		
Veregen	3		
Verelan	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.
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		
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.
Viberzi	4		
Vibramycin	4		
Vibramycin Syrup	4		
Vicodin	2		
Vicodin ES	2		
Vicodin HP	2		
Vicoprofen	4		
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.	* Prior authorization required. Covered through Specialty

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pharmacy Program.Must use Accredo.
Vigamox	4		
Viibryd	4		* Step Therapy: For members 18 and over.
Vimovo	4		* 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 drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vinate-M 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.
Viokace	4		
Viracept	3		
Viramune	4		
Viramune XR	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 FE +	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.
Vitafol Nano	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol Ultra	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol-One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol-Plus	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitamed MD One Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vitamed MD Plus Rx	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan 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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Vitatrue	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		
Vivactil	4		
Vivelle-DOT	4		
Vivitrol	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
Vivlodex	4	Max. 30 caps/30-day supply	* Prior authorization required.
Vivotif-Berna	4		
Vogelxo	4	5 gram: Max. 60 packets/30-day supply 75 gram: Max. 4 pumps/30 day supply	* Prior authorization required for members 18 and older.
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		* >This medication may be eligible for a $0 co-pay under certain benefit plans. Covered

DRUG NAME	TIER	LIMITATIONS	NOTES
			through Specialty Pharmacy Program.Use Accredo.
Vpriv	Medical		* Covered through Specialty Pharmacy Program.Must use Accredo.
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		* Fillable at retail pharmacies only. Max. 60-day supply.
W			
warfarin	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.
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: For members 18 and over.
Wellbutrin SR	4		* Step Therapy: For members 18 and over.
Wellbutrin XL	4		* Step Therapy: For members 18 and over
Wilate	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered

DRUG NAME	TIER	LIMITATIONS	NOTES
			through Specialty Pharmacy Program.Must use Caremark.
X			
Xalatan	4		
Xalkori	4	Max. 60 caps/30-day supply	* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
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	Max. 4 tabs/daily	* Quantity Limitations.
Xeljanz	4	Max. 60 tabs/30-day supply	* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Xeloda	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Xenazine	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
Xenical	NC		* This drug is not covered.
Xeomin	Medical		* Covered under medical benefit. No pharmacy copayment applies. Prior authorization required. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
Xerese	4		
Xgeva	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy

DRUG NAME	TIER	LIMITATIONS	NOTES
			Program.Must use Magellan Health (formerly known as ICORE).
Xiaflex	Medical		* Managed Distribution Xiaflex Xperience http://www.xiaflex.com/procedure_training.jspFor the treatment of Peyronie's Disease contact US Bioservices at 800-801-1140 Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE) or Accredo.
Xifaxan 200mg	4	Max. 9 tabs/copay	
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. Prior authorization required. Covered through Specialty Pharmacy Program.Must use Magellan Health (formerly known as ICORE).
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.
Xopenex HFA	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.
Xtandi	3		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Xulane	$0		* 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.
Xyrem	4		* 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		
Zanaflex	4		
Zantac	4		
Zarah	$0		* This medication is eligible for a $0 co-pay under certain benefit plans.
Zarontin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Zarxio	4		* Covered through Specialty Pharmacy Program.Use Accredo.
Zavesca	4		* Covered through Specialty Pharmacy Program.Must use Accredo.
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.
Zecuity	4	Max. 4 patches/copay	* Prior authorization required.
Zegerid (capsules)	4		
Zegerid Powder Packet	4		
Zelapar ODT	4		
Zelboraf	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Zemaira	Medical		* Covered under medical benefit. No pharmacy copayment applies. Covered through Specialty Pharmacy Program.Must use Accredo.
Zemplar	4		
Zenatane	2		
Zenpep	3		
Zenzedi	4		* Fillable at retail pharmacies only. Max. 60-day supply.
Zenzedi 5mg 10mg	2		* Fillable at retail pharmacies only. Max. 60-day supply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zeosa	$0		* 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
zidovudine	2		
zinc sulfate	2		
Zioptan	4		
ziprasidone	2		
Zipsor	4		
Zirgan	4		
Zithromax Tabs/Susp/Tri-Pack/Z-Pack	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Zocor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Zofran	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay, 4mg/5mL: Max. 100mL (2 bottles)/copay	* Quantity Limitations.
Zofran ODT	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Quantity Limitations.
Zohydro ER	4	Max. 60 tabs/30-day supply	* Prior authorization required. Quantity Limitations.
zoledronic acid	Medical		* 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		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Must use Accredo.
zolmitriptan	2	5mg: Max. 6 tabs/copay, 2.5mg: Max. 12 tabs/copay	
zolmitriptan ODT	2	5mg: Max. 6 tabs/copay; 2.5mg: Max. 12 tabs/copay	
Zoloft	4		* Step Therapy: For members 18 and over.
zolpidem	1		
zolpidem ER	2		
Zolpimist	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zomig	4	2.5mg: Max. 12 tabs/ copay; 5mg: Max. 6 tabs/ copay; Nasal Spray: Max. 6 sprays/copay	* 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	* 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		* Prior authorization required. Covered through Specialty Pharmacy Program.Must use Accredo.
Zortress	4		
Zorvolex	3		
Zostavax	Medical		* May be dispensed at a retail pharmacy.
Zovia	$0		* 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		
Zuplenz	4	4mg: Max. 18 films/copay; 8mg: Max. 9 films/copay	* Quantity Limitations.
Zutripro	4		
Zyban	$0	Max. 60 tabs/fill; Max 360 tabs/year	* This medication is eligible for a $0 co-pay under certain benefit plans.
Zyclara	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Zydelig	4		* This medication may be 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.
Zykadia	4		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Must use Accredo.
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.
Zyprexa Zydis	4		
Zytiga	3		* This medication may be eligible for a $0 co-pay under certain benefit plans. Covered through Specialty Pharmacy Program.Use Accredo.
Zyvox	4		