Harvard Pilgrim Prescription Drug List

PREMIUM FORMULARY
FOUR-TIER DRUG LIST
BY CATEGORY

LAST UPDATED : 04/26/2015

This list is subject to change at any time.

Harvard Pilgrim Health Care

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

About Harvard Pilgrim's formulary

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

Harvard Pilgrim's 4-Tier Prescription Drug Program

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

How to use this four-tier prescription drug list

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

1. Under "Drug," look up the name of your medication.
2. Once you find the medication, check the tier number to the right of the drug name.
   - Tier 1 ($), our lowest copayment tier, consists of low-cost generics. You pay just $5 for any prescription drug in Tier 1. Tier 1 drugs contain the same active ingredients as their brand-name counterparts.
   - Tier 2 ($$) consists primarily of higher-cost generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Tier 2 may also include brand-name drugs that Harvard Pilgrim has determined to be more effective, less costly or to have fewer side effects than similar medications.
   - Tier 3 ($$$) consists mostly of brand-name drugs without generic equivalents. These drugs have been selected by the plan based on review of the relative safety, effectiveness and cost of the many brand-name drugs on the market. In some cases, Tier 3 may include generic drugs determined to be more costly than their brand-name alternatives.
   - Tier 4 ($$$$) consists of drugs that the plan has not included in Tier 1, Tier 2 or Tier 3.

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
hydrocodone/acetaminophen	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydrocodone/acetaminophen 5mg-500mg	1		
hydrocodone/acetaminophen 7.5mg-650mg	2		
hydrocodone/acetaminophen 7.5mg-750mg	1		
hydrocodone/acetaminophen oral solution	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydromorphone	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydromorphone (liquid)	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydromorphone tab ER 24H	2	Effective 5/15/15: Max. 60 tabs/30- day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Hysingla ER 20mg, 30mg	4	Max: 60 tabs/30 day-supply.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Effective 4/13/15: Prior authorization required
Hysingla ER 40mg, 60mg, 80mg, 100mg, 120mg	4	Max: 30 tabs/30 day-supply.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Effective 4/13/15: Prior authorization required
Kadian 10mg, 20mg, 30mg, 50mg, 60mg, 80mg, 100mg	4	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Kadian 40mg, 70mg, 130mg, 150mg, 200mg	3	Max. 2 caps/daily	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Norco	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Nucynta	3		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Nucynta ER	3	Effective 5/15/15: Max. 60 tabs/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Opana	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Opana ER	4	Effective 5/15/15: Max. 90 tabs/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
opium tincture	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Oxecta	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone hcl er	2	Max. 4 tabs/day (inclusive of all strengths)	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone/acetaminophen	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone/acetaminophen 5mg-325mg	1		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxycodone/aspirin	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Subsys	4	Max. 120 sprays/30-day supply Effective 1/1/15, Prior authorization required.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Synalgos-DC	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
tramadol	2		
tramadol ER	2		
Trezix	4		
Tylenol with Codeine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Ultracet	4		
Ultram	4		
Ultram ER	4		
Vicodin	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vicodin ES	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vicodin HP	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vicoprofen	NC		* This drug is not covered. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Xartemis XR	4	Effective 4/15/15: Max. 4 tabs/day	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Xodol	4		
Zamicet	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zohydro ER	4	Max. 60 tabs/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.. Prior authorization required.
ANTI-EMETICS			
5HT-3 Antagonists			
Anzemet	4	50mg: Max. 6 tabs/copay; 100mg: Max. 3 tabs/copay	* Not available through Mail Service.
granisetron	2	Max. 6 tabs/copay	* Not available through Mail Service.
Granisol	2	Max. 30mL/copay	* Not available through Mail Service.
ondansetron	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay; 4mg/5mL: Max. 100mL (2 bottles)/copay	* Not available through Mail Service.
ondansetron ODT	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Not available through Mail Service.
Sancuso	4	4 patches/copay	* Not available through Mail Service.
Zofran	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay, 4mg/5mL: Max. 100mL (2 bottles)/copay	* Not available through Mail Service.
Zofran ODT	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Not available through Mail Service.
Zuplenz	4	4mg: Max. 18 films/copay; 8mg: Max. 9 films/copay	* Not available through Mail Service.
Anti-Emetics, Fixed-Dose Combination			
Akynzeo	4	Max. 1 cap/copay, Max. 3 caps/28 day-supply	* Not available through Mail Service.
Anti-Emetics, Other			

DRUG NAME	TIER	LIMITATIONS	NOTES
Cesamet	4	Max. 18 tabs/copay	* Not available through Mail Service. * Max. 30-day supply as required by state & federal law or benefit plan design.
Compazine	4		
Diclegis	4	Max. 2800ml/28-day supply	* Not available through Mail Service.
dronabinol	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Marinol	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
prochlorperazine	1		
prochlorperazine (suppository)	2		
promethazine	2		
Transderm-Scop	3	Max. 1 box (4 patches)/ copay	* Not available through Mail Service.
NK1 Receptor Antagonists			
Emend	4	40mg: Max. 4 caps/copay, 80mg: Max. 2 caps/copay, 125mg: Max. 1 cap/copay, Tri-Pack: Max. 1 pack/copay	* Not available through Mail Service.
ANTI-INFLAMMATORY AGENTS			
Antirheumatic Agents			
Arava	4		
hydroxychloroquine	2		
Kineret	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service. Prior authorization required.
leflunomide	2		
Plaquenil	4		
Ridaura	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Non-Steroidal Anti-Inflammatory Drugs (NSAID)			
Anaprox	4		
Anaprox DS	4		
Arthrotec	4		
Cambia	4		
Cataflam	4		
Celebrex	4		
celecoxib	2		
Clinoril	4		
Daypro	4		
diclofenac	2		
diclofenac sodium drops	2		
diflunisal	2		
Duexis	4		
EC-Naprosyn	4		
etodolac	2		
Feldene	4		
Flector	3		
flurbiprofen	2		
ibuprofen	2		
ibuprofen 100mg/5mL (suspension)	2		
Indocin	4		
Indocin Rectal Suppository	3		
indomethacin	2		
ketoprofen	2		
ketorolac, oral	2	Max. 5-days supply / 20 tabs per fill	* Not available through Mail Service.
meclofenamate	2		
mefenamic acid	2		
meloxicam	1		
misoprostol/diclofenac	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Mobic	4		
Motrin	4		
nabumetone	2		
Nalfon	4		
Naprelan	4		
Naprosyn	4		
naproxen	2		
naproxen sodium	2		
naproxen sodium cr	2		
oxaprozin	2		
Pennsaid	4		
piroxicam	2		
Ponstel	4		
salsalate	2		
Sprix	4	Max. 5 bottles/fill	* Not available through Mail Service.
Sulfamylon	4		
sulindac	2		
tolmetin	2		
Vimovo	4		
Voltaren	4		
Voltaren Gel	4		
Voltaren XR	4		
Zipsor	4		
Zorvolex	3		
ANTIBACTERIALS			
Antibacterials, Other			
Cayston	4		* Not available through Mail Service.
Cleocin	4		
clindamycin	2		
Dapsone	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Flagyl	4		
Flagyl ER	4		
Furadantin	4		
Hiprex	4		
Lithostat	4		
Macrobid	4		
Macrodantin	4		
Macrodantin 25mg	3		
methenamine hippurate	2		
metronidazole	2		
metronidazole 250mg & 500mg (tablet)	1		
Monurol	4		
Nebupent	4		
neomycin sulfate	2		
nitrofurantoin	2		
nitrofurantoin, macro	2		
Primsol	4		
Sivextro	4	Max. 6 tabs/copay	* Not available through Mail Service. *
trimethoprim	2		
Vancocin	4		
vancomycin	2		
Vandazole	4		
Xifaxan 200mg	4	Max. 9 tabs/copay	* Not available through Mail Service.
Xifaxan 550mg	3		
Zyvox	4		* Prior authorization required

Cephalosporins

Cedax (capsule)	4		
Cedax (suspension)	4		
cefaclor	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
cefadroxil	2		
cefdinir	2		
cefditoren pivoxil	2		
cefpodoxime	2		
cefprozil	2		
ceftibuten	2		
Ceftin (suspension)	4		
Ceftin (tablet)	4		
cefuroxime axetil	2		
cephalexin	2		
Keflex	4		
Spectracef	4		
Suprax	4		
Macrolides			
azithromycin	2		
Biaxin	4		
Biaxin XL	4		
clarithromycin	2		
Dificid	4	Max. 20 tabs/copay	* Not available through Mail Service.
Ery-Tab	2		
Ery-Tab 333mg	3		
Eryped	3		
erythromycin base, filmtab	2		
erythromycin ethylsuccinate	2		
erythromycin ethylsuccinate 200mg suspension	2		
erythromycin ethylsuccinate/ sulfisoxazole	2		
Ketek	4		
PCE	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Zithromax Tabs/Susp/Tri-Pack/Z-Pack	4		

Penicillins

amoxicillin	2		
amoxicillin (chewable)	2		
amoxicillin 200mg/5mL (suspension)	2		
amoxicillin 500mg (tablet)	2		
amoxicillin trihydrate ER	2		
amoxicillin trihydrate/clavulanic acid ES 600mg (suspension)	2		
amoxicillin trihydrate/clavulanic acid suspension	2		
amoxicillin trihydrate/clavulanic acid tabs	2		
amoxicillin trihydrate/clavulanic acid tabs XR	2		
ampicillin	2		
Augmentin (suspension)	4		
Augmentin (tablets)	4		
Augmentin 125-31.25mg (suspension)	3		
Augmentin ES 600mg (suspension)	4		
Augmentin XR	4		
dicloxacillin sodium	2		
Moxatag	4		
penicillin v potassium	1		
Trimox 250mg (capsule)	1		
Trimox 250mg/mL (suspension)	1		

Quinolones

Avelox	4		
Cipro	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cipro XR	4		
ciprofloxacin 100mg (tablet)	2		
ciprofloxacin 250mg, 500mg, 750mg (tablets)	1		
ciprofloxacin ER	2		
Factive	4		
Levaquin	4		
levofloxacin	2		
moxifloxacin	2		
Noroxin	4		

Sulfonamides

Bactrim	4		
Bactrim DS	4		
Septra	4		
Septra DS	4		
trimethoprim/sulfamethoxazole	2		
trimethoprim/sulfamethoxazole DS	2		

Tetracyclines

Acticlate	4		
Adoxa	4		
Benoxyldoxy	4		
demeclocycline	2		
Doryx	4		
doxycycline hyclate	2		
doxycycline hyclate 20mg & 75mg	2		
doxycycline hyclate 50mg & 100mg	2		
doxycycline monohydrate	2		
doxycycline monohydrate 40mg	2		
Dynacin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Minocin	4		
minocycline	2		
Monodox	4		
Ocudox	4		
Oracea	4		
Periostat	4		
Solodyn	4		* Prior authorization required
tetracycline	1		
Vibramycin (tablet)	4		
Vibramycin Oral Suspension	4		
Vibramycin Syrup	4		
ANTICONVULSANTS			
Anticonvulsants, Other			
Fycompa	4		
Keppra	4		
Keppra XR	4		
levetiracetam	2		
levetiracetam XR	2		
Onfi	3	Prior authorization required for members 18 and older	
Potiga	4		
Sabril	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Vimpat	3		
Calcium Channel Modifying Agents			
Celontin	3		
ethosuximide	2		
Lyrica	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			is required. * Step Therapy: For members 18 and over.
Zarontin	4		
Zonegran	4		
zonisamide	2		
GABA Augmenting Agents			
Depakene	4		
Depakote	4		
Depakote ER	4		
Depakote Sprinkle	4		
divalproex sodium	2		
divalproex sodium 125mg (sprinkle)	2		
divalproex sodium ER	2		
gabapentin	2		
Gabitril	4		
Gralise	4		
Neurontin	4		
Stavzor	4		
tiagabine	2		
valproic acid	2		
Glutamate Reducing Agents			
felbamate	2		
Felbatol	4		
Lamictal	4		
Lamictal ODT	4		
Lamictal Starter Kit	3		
Lamictal Starter Kit 25mg	4		
Lamictal XR	4		
lamotrigine	2		
lamotrigine ODT	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
lamotrigine starter kit 25mg	2		
lamotrigine tab er 24	2		
Qudexy XR	4		
Topamax	4		
topiramate	2		
topiramate ER	2		
Trokendi XR	4		
Sodium Channel Inhibitors			
Aptiom	4		
Banzel	3		
carbamazepine	2		
carbamazepine ER	2		
Carbatrol	4		
Dilantin	4		
Dilantin Infatab	4		
Equetro	4		
oxcarbazepine	2		
oxcarbazepine suspension	2		
Oxtellar XR	4		
Peganone	4		
Phenytek	4		
phenytoin	2		
phenytoin sodium ER	2		
phenytoin tab chew	2		
Tegretol	4		
Tegretol XR	4		
Trileptal	4		
Trileptal Suspension	4		
ANTIDEMENTIA			
Antidementia Agents, Other			
Ergoloid	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cholinesterase Inhibitors			
Aricept	4		
Aricept ODT	4		
donepezil	2		
donepezil ODT	2		
Exelon	4		
Exelon Patch	3		
galantamine	2		
galantamine ER	2		
Razadyne	4		
Razadyne ER	4		
rivastigmine	2		
Glutamate Pathway Modifiers			
Namenda XR	4		
ANTIDEPRESSANTS			
Antidepressants, Other			
Aplenzin	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
budeprion SR	2		
budeprion XL	2		
bupropion	2		
bupropion SR	2		
bupropion XL	2		
Forfivo XL	3		
maprotiline	2		
mirtazapine	2		
nefazodone	2		
olanzapine/fluoxetine	2		
Oleptro ER	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Remeron	4		
Symbyax	4		
trazodone	1		
trazodone 150mg & 300mg	2		
Viibryd	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Wellbutrin	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Wellbutrin SR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Wellbutrin XL	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over

Monoamine Oxidase Inhibitors

EMSAM	4		
Marplan	4		
Nardil	4		
Parnate	4		
phenelzine	2		
tranylcypromine	2		

Serotonin/Norepinephrine Reuptake Inhibitors

DRUG NAME	TIER	LIMITATIONS	NOTES
Brintellix	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Celexa	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
citalopram hydrobromide tabs	2		
Cymbalta	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
desvenlafaxine ER	2		
desvenlafaxine ER	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
desvenlafaxine fumarate ER	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy for members 18 years and over.
duloxetine	2		
Effexor XR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.

DRUG NAME	TIER	LIMITATIONS	NOTES
escitalopram	2		
Fetzima	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
fluoxetine	1		
fluoxetine (oral solution)	2		
fluoxetine 20mg (tablet)	2		
fluoxetine 40mg (capsule)	2		
Fluoxetine 60mg tabs	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
fluoxetine 90mg (weekly)	2		
fluvoxamine	2		
fluvoxamine er 24h	2		
Khedezla	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Lexapro	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Luvox CR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
paroxetine	2		

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

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

Tricyclics

DRUG NAME	TIER	LIMITATIONS	NOTES
amitriptyline	1		
Anafranil	4		
clomipramine	2		
desipramine	2		
doxepin	2		
doxepin 10mg/mL (oral concentrate)	2		
doxepin 150mg (capsule)	2		
imipramine	2		
imipramine pamoate	2		
Norpramin	4		
nortriptyline	2		
Pamelor	4		
protriptyline	2		
Surmontil	4		
Tofranil	4		
Tofranil PM	4		
Vivactil	4		
ANTIDOTES, DETERRENTS AND TOXICOLOGIC AGENTS			
Antidotes			
Adrenaclick	4	Max. 2 units/copay	* Not available through Mail Service.
Auvi-Q	4	Max. 2 units/copay	* Not available through Mail Service.
Chemet	3		
Epipen	3	Max. 2 units/copay	* Not available through Mail Service.
Epipen Jr.	3	Max. 2 units/copay	* Not available through Mail Service.
Evzio	4	Max. 2 units/copay; Max.4 units/30-day supply	* Not available through Mail Service.
Exjade	4		* Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Ferriprox	4		* Not available through Mail Service. * Sole source through Centric Health.
Jadenu	4		* Not available through Mail Service.
Kayexalate	4		
leucovorin	2		
Mesnex	4		
sodium polystyrene sulfonate	2		
sodium polystyrene sulfonate enema	2		
SPS Rectal Enema	4		
Deterrents			
acamprosate calcium	2		
Antabuse	4		
Bunavail	4	2.1mg/0.3mg, 4.2mg/0.7mg: Max. 90 doses/30-day supply; 6.3mg/1mg: Max: 60 doses/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
buprenorphine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
buprenorphine/naloxone	2		* Max. 30-day supply as required by state & federal law or benefit plan design
Campral calcium	4		
disulfiram	2		
naltrexone	2		
Revia	4		
Suboxone Film	3		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
Subutex	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vivitrol	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Zubsolv	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Smoking Cessation			
Buproban	2	Annual Limit: Max. 360 tabs/180 days.	* Not available through Mail Service.
bupropion, smoking cessation	2	Annual Limit: Max. 180 tabs/90 days.	* Not available through Mail Service.
Chantix	3	Annual limit of 26 weeks	* Not available through Mail Service.
Nicotrol Inhaler	4	Max. 168 units/fill; Limit 180-day supply per year	* Not available through Mail Service.
Nicotrol NS	4	Max. 4 units/fill; Limit 180 day-supply per year	* Not available through Mail Service.
Zyban	4	Max. 60 tabs/fill; Max 360 tabs/year	* Not available through Mail Service.
ANTIFUNGALS			
Antifungals - Oral			
Ancobon	4		
clotrimazole (troche)	2		
Cresemba	4		* Not available through Mail Service.
Diflucan	4		
fluconazole	2		
fluconazole 150mg (tablet)	1		
flucytosine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Grifulvin V	4		
Gris-Peg	4		
griseofulvin	2		
griseofulvin ultramicro	2		
itraconazole	2	Max. 168 caps/year	* Not available through Mail Service. * Prior authorization required
ketoconazole	2		
Lamisil	4	Max. 28 tabs/fill; Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required
Lamisil Granules	4	Max. 28 packets/fill; Max. 84 packets/year	* Not available through Mail Service. * Prior authorization required.
Noxafil (suspension)	4		
Noxafil (tablets)	4		
nystatin	2		
nystatin (cream)	1		
nystatin (ointment)	1		
Onmel	4	Max. 28 tabs/28-day supply; Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required.
Oravig	4		
Sporanox	4	Max. 168 caps/year	* Not available through Mail Service. * Prior authorization required.
Sporanox (solution)	4		
terbinafine	2	Max. 28 tabs/fill, Max. 84 tabs/year	* Not available through Mail Service. * Prior authorization required
Vfend	4		
voriconazole	2		

ANTIGOUT

Antigout Agents

DRUG NAME	TIER	LIMITATIONS	NOTES
allopurinol	1		
colchicine (capsule)	2		
colchicine (tablet)	2		
Colcrys	4		
Mitigare	4		
probenecid	2		
probenecid/colchicine	2		
Uloric	3		
Zyloprim	4		
ANTIMIGRAINE AGENTS			
Abortive			
Alsuma	4	Max. 6 injections/copay	* Not available through Mail Service.
Amerge	4	1mg: Max. 15 tabs/copay; 2.5mg: Max. 6 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Axert	4	6.25mg: Max. 12 tabs/copay; 12.5mg: Max. 6 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
D.H.E. 45	3		
dihydroergotamine mesylate nasal spray	2		
Ergomar	3		
Frova	4	Max. 9 tabs/copay	* Not available through Mail Service. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.

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

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

Antimigraine, Other

acetaminophen/butalbital	2		
acetaminophen/caffeine/butalbital	2		
Alagesic LQ	2		
aspirin/butalbital/caffeine	2		
Butalbital Compound w/codeine	2		* Mail Service: Max. 30-day supply as required by State or Federal law, or benefit plan design.
butalbital, aspirin, caffeine	2		* Mail Service: Max. 30-day supply as required by State

DRUG NAME	TIER	LIMITATIONS	NOTES
			or Federal law, or benefit plan design.
butalbital/acetaminophen/ caffeine/codeine	2		* Mail Service: Max. 30-day supply as required by State or Federal law, or benefit plan design.
Cafergot	4		
Esgic	4		
Esgic Plus	4		
Fioricet	4		
Fioricet w/Codeine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Fiorinal	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Fiorinal with Codeine	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
ANTIMYASTHENIC AGENTS			
Parasympathomimetics			
Mestinon tabs	4		
Mestinon Timespan	3		
pyridostigmine	2		
ANTIMYCOBACTERIALS			
Antimycobacterials, Other			
Mycobutin	4		
rifabutin	2		
Antituberculars			
ethambutol	2		
isoniazid	1		
isoniazid (syrup)	2		
Myambutol	4		

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Farydak	4		* Not available through Mail Service.
Femara	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
flutamide	2		
Gilotrif	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Gleevec	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Gleostine	4		
Hexalen	3		
Hycamtin	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Hydrea	4		
hydroxyurea	2		
Ibrance	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Imbruvica	4		* Covered through Specialty Pharmacy Program. Must use Diplomat Pharmacy. * Not available through Mail Service.
Inlyta	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Nilandron	3		
Purinethol	4		
Purixan	4		
Sprycel	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Stivarga	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Sutent	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Tafinlar	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
tamoxifen	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tarceva	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Targretin	4		
Tasigna	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Temodar	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
temozolomide	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Thioguanine	3		
Tykerb	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Votrient	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Xalkori	4	Max. 60 caps/30-day supply	* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service
Xeloda	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Xtandi	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Zelboraf	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service
Zolinza	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Zydelig	4		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zykadia	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Zytiga	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service
ANTIPARASITICS			
Anthelmintics			
Albenza	3		
Biltricide	4		
ivermectin	2		
mebendazole	2		
Stromectol	4		
Antiprotozoals			
Alinia	4		
Aralen	4		
atovaquone	2		
atovaquone/proguanil	2		
chloroquine phosphate	2		
Coartem	4	Max. 24 tabs/copay	* Not available through Mail Service.
Daraprim	3		
Malarone	4		
mefloquine	2		
Mepron	4		
paromomycin	2		
Primaquine	4		
Qualaquin	4		
quinine sulfate	2		
Tindamax	4		
tinidazole	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Yodoxin	3		
Scabicides and Pediculicides			
Eurax	3		
lindane	2		
Lycelle	4		
malathion	2		
Natroba	4		* Not available through Mail Service.
Ovide	4		
permethrin	2		
Sklice	4		
spinosad	2		* Not available through Mail Service.
Ulesfia	4		
ANTIPARKINSONS			
Antiparkinson Agents			
Apokyn	4		* Not available through Mail Service.
Azilect	3		
benztropine mesylate	2		
bromocriptine mesylate	2		
carbidopa	2		
carbidopa/levodopa	2		
carbidopa/levodopa (rapid dissolve tab)	2		
carbidopa/levodopa SR	2		
carbidopa/levodopa/entacapone	2		
Comtan	4		
Eldepryl	4		
entacopone	2		
Lodosyn	4		
Mirapex	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Mirapex ER	4		
Neupro	4		
Parlodel	4		
pramipexole	2		
pramipexole er	2		
Requip	4		
Requip XL	4		
ropinirole	2		
ropinirole hcl tab er 24hr	2		
ropinirole XL	2		
Rytary	4		
selegiline	2		
Sinemet	4		
Sinemet CR	4		
Stalevo	4		
Tasmar	4		
trihexyphenidyl	2		
Zelapar ODT	4		
ANTIPSYCHOTICS			
Atypical Antipsychotics			
Abilify	3		
Abilify Discmelt	4		
clozapine	2		* Not available through Mail Service.
Clozaril	4		* Not available through Mail Service.
Fanapt	4		
Fazaclo	4		* Not available through Mail Service.
Geodon	4		
Invega	4		
Invega Sustenna	Medical		* Covered under medical benefit. No pharmacy copayment applies.

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

Conventional Antipsychotics

DRUG NAME	TIER	LIMITATIONS	NOTES
chlorpromazine	2		
fluphenazine	2		
haloperidol	2		
loxapine	2		
Loxitane	4		
Navane	4		
Orap	3		
perphenazine	2		
thioridazine	2		
thiothixene	2		
trifluoperazine	2		
ANTIVIRALS			
Anti-HIV, Misc.			
Atripla	3		
Complera	4		
Epzicom	3		
Evotaz	4		
Fuzeon	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Isentress	3		
Prezcobix	4		
Selzentry	3		
Stribild	4		
Tivicay	4		
Truvada	3		
Tybost	4		
Viread	3		
Vitekta	4		
Anti-HIV, NNRTI			
Edurant	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Intelence	4		
nevirapine	2		
nevirapine ER 400mg	2		
Rescriptor	3		
Sustiva	3		
Viramune	4		
Viramune XR 100mg	3		
Viramune XR 400mg	4		

Anti-HIV, NRTI

abacavir	2		
abacavir/lamivudine/zidovudine	2		
Combivir	4		
didanosine	2		
Emtriva	4		
Epivir (solution)	4		
Epivir (tablet)	4		
Epivir HBV (solution)	4		
Epivir HBV (tablet)	4		
lamivudine (solution)	2		
lamivudine (tabs)	2		
lamivudine/zidovudine	2		
stavudine	2		
Triumeq	4		
Trizivir	4		
Videx EC	4		
Zerit	4		
Ziagen (tablet)	4		
zidovudine	2		

Anti-HIV, Protease Inhibitors

Aptivus	4		
Crixivan	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Invirase	3		
Kaletra	3		
Lexiva	3		
Norvir	3		
Prezista	3		
Reyataz	3		
Viracept	3		
Anti-Influenza Agents			
amantadine	2		
Flumadine	4		
Relenza	4	Max. 1 package per fill	
rimantadine	2		
Tamiflu	3	30mg: Max. 20 caps/180-day supply; 45mg: Max. 20 caps/180-day supply; 75mg: Max 10 caps/180-day supply; 6mg/mL susp: Max. 240ml/180-day supply	* Not available through Mail Service.
Antiherpetic			
acyclovir	2		
acyclovir (ointment)	2		
acyclovir (suspension)	2		
Denavir	4		
famciclovir	2		
Famvir	4		
Sitavig	4	Max. 1 tab/per copay. Max 2 tabs/30 days.	* Not available through Mail Service.
valacyclovir	2		
Valtrex	4		
Xerese	4		
Zovirax	4		
Zovirax (Cream)	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Zovirax (ointment)	4		
Zovirax (Suspension)	4		
Antivirals, Other			
adefovir	2		
Baraclude (tablet)	4		
Copegus	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
entecavir	2		
Harvoni	3	Max. 28 tabs/28 day-supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through mail service.
Hepsera	4		
Olysio	4	Max. 28 tabs/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Rebetol (capsule)	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Rebetol (Solution)	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Ribapak	2		
Ribasphere	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Ribatab	4		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
ribavirin	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Sovaldi	3	Max. 28 tabs/28-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Tyzeka	4		
Viekira Pak	4	Maximum 1 pak per 28-days.	* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
CMV Agents			
ganciclovir	2		
Valcyte	4		
valganciclovir	2		
ANXIOLYTICS			
Anxiolytics, Other			
buspirone	2		
meprobamate	2		
Benzodiazepines			
alprazolam	1		
alprazolam (rapid dissolve tablet)	2		
alprazolam ER	2		
alprazolam Intensol	4		
Ativan	4		
chlordiazepoxide	1		
chlordiazepoxide/amitriptyline	2		
clonazepam	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
clonazepam (rapid dissolve)	2		
clorazepate	2		
Diastat Acudial 5-7, 5-10mg	3		
Diastat Acudial, 12.5mg, 15mg, 20mg	4		
diazepam	1		
diazepam (solution) (concentrate)	2		
diazepam rectal gel 12.5mg, 15mg, 20mg	2		
Doral	4		
estazolam	2		
flurazepam	1		
Halcion	4		
Klonopin	4		
lorazepam	2		
oxazepam	2		
quazepam	2		
Restoril	4		
temazepam	2		
temazepam 15mg & 30mg	1		
Tranxene T-Tabs	4		
triazolam	2		
Valium	4		
Xanax	4		
Xanax XR	4		
BIPOLAR AGENTS			
Bipolar Agents			
Eskalith	4		
lithium carbonate	2		
lithium carbonate SR	2		
lithium citrate	2		
Lithobid	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
BLOOD GLUCOSE REGULATORS			
Alpha Glucosidase Inhibitors			
acarbose	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glyset	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Precose	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Amylinomimetics			
SymlinPen	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Antiglycemic agent, Misc			
Cycloset	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Korlym	4		* Covered through Specialty Pharmacy Program. Must use Centric Health Resource.

DRUG NAME	TIER	LIMITATIONS	NOTES
Biguanides			
Fortamet	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glucophage	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glucophage XR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glumetza	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
metformin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
metformin ER	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Riomet	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
DPP-4 inhibitor			
Januvia	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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Onglyza	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tradjenta	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Fixed-Dose Combination Agents			
Actoplus Met	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Actoplus Met XR	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Avandamet	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Avandaryl	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Duetact	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
glipizide/metformin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glucovance	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
glyburide/metformin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glyxambi	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Invokamet	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Janumet	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Janumet XR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Jentadueto	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Kazano	4		* HSA Preventive drug. The Preventive Drug Benefit enables

DRUG NAME	TIER	LIMITATIONS	NOTES
			access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Kombiglyze XR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Oseni	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone/glimepiride	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone/metformin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Prandimet	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Xigduo XR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glycemic Agents			
Glucagon Emergency Kit	3		* Not available through Mail Service. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Proglycem (suspension)	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Incretin Mimetics			
Bydureon	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that 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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be

DRUG NAME	TIER	LIMITATIONS	NOTES
			subject to your plan deductible. Applicable copayment will apply.
Saxenda	NC		* This drug is not covered.
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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Trulicity	4	Max. 4 pens/28 day-supply	* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Victoza	3		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

Insulins

Afrezza	4	4 & 8 unit single strength kits, Max. 180 cartridges/30-day supply. 4 & 8 unit combo product, Max. 450 cartridges/30-day supply.	* Not available through Mail Service. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible.

DRUG NAME	TIER	LIMITATIONS	NOTES
			Applicable copayment will apply. * Prior authorization required.
Apidra	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Humalog	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Humalog Mix	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Humulin 70/30	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Humulin N	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Humulin N Kwikpen	3		
Humulin R	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Lantus	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Levemir	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Novolin 70/30	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Novolin N	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Novolin R	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Novolog	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Novolog Mix	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Toujeo Solostar	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Meglitinides			
nateglinide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Prandin	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
repaglinide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Starlix	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
SGLT2 Inhibitors			
Farxiga	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Invokana	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Jardiance	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Sulfonylureas			
Amaryl	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
chlorpropamide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Diabeta	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
glimepiride	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
glipizide	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
glipizide extended-release	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glucotrol	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glucotrol XL	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
glyburide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
glyburide 1.25mg	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
glyburide, micronized	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Glynase	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
tolazamide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Thiazolidinediones			
Actos	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Avandia	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS			
Anticoagulants			
Arixtra	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
heparin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Iprivask	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Must use Accredo.
Jantoven	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lovenox	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Pradaxa	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Savaysa	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
warfarin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Xarelto	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Antihemophilia			
Advate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alphanate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alphanine SD	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alprolix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.

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

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

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

Blood Formation Products

DRUG NAME	TIER	LIMITATIONS	NOTES
Aranesp	4	Max. 4 vials or syringes/fill	* Covered through Specialty Pharmacy Program. Use ICORE Healthcare or Accredo. * Not available through Mail Service. Prior authorization required.
Epogen	3	2,000U/3,000U/4,000U/10,000U: Max. 12 vials/fill; 20,000U/40,000U: Max. 4 vials/fill	* Covered through Specialty Pharmacy Program. Use Accredo or ICORE Healthcare. * Not available through Mail Service.Prior authorization required.
Granix	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Mircera	4		* Not available through Mail Service.
Mozobil	3	Max. 4 vials/copay	* Covered through Specialty Pharmacy Program. Must use Accredo or ICORE Healthcare. * Not available through Mail Service.
Neulasta	3		* Covered through Specialty Pharmacy Program. Use Accredo or ICORE Healthcare. * Not available through Mail Service.
Neumega	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Neupogen	3		* Covered through Specialty Pharmacy Program. Use Accredo or ICORE Healthcare. * Not available through Mail Service.
Neupogen (syringe)	4		* Covered through Specialty Pharmacy Program. Use Accredo or ICORE Healthcare. * Not available through Mail Service.
Nplate	Medical		* Covered under medical benefit. No pharmacy copayment applies.

DRUG NAME	TIER	LIMITATIONS	NOTES
			* Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Procrit	3	2,000U/3,000U/4,000U/10,000U: Max. 12 vials/fill; 20,000U/40,000U: Max. 4 vials/fill	* Covered through Specialty Pharmacy Program. Use Accredo or ICORE Healthcare. * Not available through mail servicePrior authorization required
Promacta	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Coagulants			
aminocaproic acid	2		
Lysteda	4	Max. 30 tabs/30-day supply	
tranexamic acid	2	Max. 30 tabs/30-day supply	
Platelet Aggregation Inhibitors			
Aggrenox	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Agrylin	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
anagrelide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Brilinta	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
cilostazol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
clopidogrel	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
dipyridamole	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Effient	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Plavix	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Pletal	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
ticlopidine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Zontivity	4		
CARDIOVASCULAR			
ACE Inhibitors			
Accupril	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Aceon	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Altace (Capsules)	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
benazepril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
captopril	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
captopril 100mg	2		
enalapril	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Epaned	4		
fosinopril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
lisinopril	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lotensin	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Mavik	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
moexipril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Monopril	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
perindopril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Prinivil	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
quinapril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
ramipril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
trandolapril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Univasc	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vasotec	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Zestril	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Alpha Adrenergic Agonists			
Catapres	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Catapres TTS	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
clonidine	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
clonidine transdermal	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
guanfacine HCl	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
methyldopa	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
midodrine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tenex	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Alpha Adrenergic Blocking Agents			
Cardura	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Cardura XL	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dibenzyline	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
doxazosin mesylate	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
doxazosin mesylate 1mg	2		
doxazosin mesylate 2mg	2		
Minipress	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
prazosin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
terazosin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Angiotensin II Receptor Antagonists			
Atacand	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Avapro	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Benicar	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
candesartan	2		
Cozaar	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Diovan	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Edarbi	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
eprosartan	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
irbesartan	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
losartan	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Micardis	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
telmisartan	2		
Teveten	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
valsartan	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

Anti-Arrhythmics

amiodarone	2		
Betapace	4		
Betapace AF	4		
Cordarone	4		
disopyramide	2		
flecainide acetate	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
mexiletine	2		
Multaq	3		
Norpace	4		
Norpace CR	4		
Pacerone	2		
propafenone	2		
quinidine gluconate SR	2		
quinidine sulfate	2		
Rythmol	4		
Rythmol SR	4		
Sorine	2		
sotalol	2		
sotalol AF	2		
Sotylize	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tikosyn	4		* Manufacturer sponsored Tikosyn Program. Members or physicians should call 1-877-TIKOSYN (845-6796) for dispensing information.

Beta Adrenergic Blocking Agents

acebutolol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
atenolol	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
betaxolol, oral	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
bisoprolol fumarate	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Bystolic	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
carvedilol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Coreg	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Coreg CR	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Corgard	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Hemangeol	4		* Not available through Mail Service.
Inderal LA	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Inderal XL	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Innopran XL	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Kerlone	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
labetalol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Levatol	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lopressor	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
metoprolol succinate	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
metoprolol tartrate	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nadolol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
pindolol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
propranolol	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
propranolol (oral solution)	2		
propranolol 24hr SA	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
propranolol 60mg	2		
Sectral	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tenormin	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Toprol XL	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Trandate	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Zebeta	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Calcium Channel Blockers			
Adalat CC	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
amlodipine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Calan	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Calan SR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Cardene SR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Cardizem	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Cardizem CD	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Cardizem LA	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Cartia XT	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dilacor XR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dilt-XR	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem 24hr ER	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
diltiazem CD	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem SR	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
felodipine ER	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
isradipine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Matzim LA	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nicardipine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Nifedical XL	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nifedipine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nifedipine SR	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nimodipine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Nimotop	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nisoldipine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Norvasc	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Nymalize	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Procardia	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Procardia XL	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Sular	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Taztia XT	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tiazac	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
verapamil	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
verapamil ER PM	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
verapamil SR	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Verelan	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Verelan PM	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Cardiovascular, Other			
digoxin	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
digoxin (solution)	3		
eplerenone	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Inspra	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Lanoxin	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Northera	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
pentoxifylline	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
reserpine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vecamyl	4		
Diuretics			
acetazolamide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
acetazolamide capsule ER	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Aldactazide	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Aldactone	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
amiloride	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
amiloride/hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
bumetanide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
chlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
chlorthalidone	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Demadex	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Diamox Sequels	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dyazide	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dyrenium	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Edecrin	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
furosemide	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
furosemide (oral solution)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
hydrochlorothiazide	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
hydrochlorothiazide 12.5mg (tablet)	2		
indapamide	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lasix	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Maxzide	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
methazolamide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
metolazone	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Microzide	4		* HSA Preventive drug. The Preventive Drug Benefit enables

DRUG NAME	TIER	LIMITATIONS	NOTES
			access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Naturetin-5	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
spironolactone	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
spironolactone/ hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
torsemide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
triamterene/hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
triamterene/hydrochlorothiazide 50mg-25mg	2		
Zaroxolyn	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Dyslipidemics, Fibrates			
Antara	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
fenofibrate	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
fenofibric acid	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Fenoglide	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Fibricor	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
gemfibrozil	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Lipofen	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
LoFibra	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lopid	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
TriCor	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Triglide	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Trilipix	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dyslipidemics, Other			
cholestyramine/aspartame	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
cholestyramine/sucrose	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Colestid	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
colestipol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
colestipol granules	2		
fenofibrate, micronized	2		
Juxtapid	4		* Not available through Mail Service. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Sole source through Centric Health.
Kynamro	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Liptruzet 10/10mg	4	Max. 30 tabs/30-day supply	* Step Therapy: First level drug treatment required before coverage begins. If first level drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			is not tried, prior authorization is required.
Liptruzet 10/20mg, 10/40mg, 10/80mg	4	Max. 30 tabs/30-day supply	
Lovaza	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
niacin er	2		
Niacor	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Niaspan	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
omega 3 acids ethyl esters	2		
Prevalite	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Questran	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Questran Light	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Vascepa	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vytorin 10/10mg & 10/20mg	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. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vytorin 10/40mg & 10/80mg	4	Max. 30 tabs/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Welchol (tablets)	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Welchol Powder Pack	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Zetia	3	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. * HSA Preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dyslipidemics, Statins			
Altoprev	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
atorvastatin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Crestor	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
fluvastatin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lescol	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lescol XL	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Lipitor	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Livalo	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
lovastatin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Mevacor	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Pravachol	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
pravastatin	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
simvastatin	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Dutoprol	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Edarbyclor	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
enalapril/hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Exforge	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Exforge HCT	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
fosinopril/hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Hyzaar	4		* HSA Preventive drug. The Preventive Drug Benefit enables

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

DRUG NAME	TIER	LIMITATIONS	NOTES
metoprolol/hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Micardis HCT	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
moexipril/hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nadolol-bendroflumethiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Simcor	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tarka	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tekamlo	3	150mg/5mg & 150mg/10mg: Max. 45 tabs/30 days; 300mg/5mg & 300mg/10mg: Max. 30 tabs/30 days	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
telmisartan/amlodipine	2	Max. 30 tabs/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
telmisartan/hctz	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tenoretic	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Teveten HCT	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tribenzor	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Twynsta	4	Max. 30 tabs/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
valsartan/hydrochlorothiazide	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vaseretic	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
verapamil/trandolapril	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Zestoretic	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Ziac	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

Renin Inhibitor, Direct

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

DRUG NAME	TIER	LIMITATIONS	NOTES
isosorbide mononitrate	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Minitran	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
minoxidil	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Monoket	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Nitro-Dur	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nitroglycerin (patch)	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
nitroglycerin spray	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

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

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
dexmethylphenidate	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
dexmethylphenidate XR 10mg	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
dexmethylphenidate XR 5mg, 15mg, 30mg, 40mg	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Focalin	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Focalin XR 10mg	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Focalin XR 20mg, 25mg, 35mg	3		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed

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

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Prevident 5000	4		
Prevident 5000 Booster Paste	4		
Prevident 5000 Plus Cream	4		
Prevident 5000 Sensitive	4		
Prothelial	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
ReNaf	1		
Salagen	4		
sodium fluoride (drops) (chewable tablets)	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
DERMATOLOGICAL/TOPICAL AGENTS			
Acne Treatments			
Absorica	4		* Not available through Mail Service.
Acanya	3		* Not available through Mail Service.
Aczone	4		
adapalene	2	Prior authorization required for members 30 and older	
Akne-Mycin	3		
Amnesteem	2		* Not available through Mail Service.
Azelex	3		
Benzaclin	4		* Not available through Mail Service.
Benzamycin	4		* Not available through Mail Service.
Claravis	2		* Not available through Mail Service.

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

Antipruritics

DRUG NAME	TIER	LIMITATIONS	NOTES
Alevicyn	4		

Corticosteroids - High Potency

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

Corticosteroids - Low Potency

alclometasone dipropionate	2		
Aqua Glycolic HC	4		
Dermasorb HC	4		
desonide	2		
DesOwen	4		
Desowen Kit	4		
hydrocortisone butyrate	2		
Locoid	4		
Pandel	4		
Texacort	4		
Verdeso	4		

Corticosteroids - Medium Potency

clocortolone pivalate	2		
Cloderm	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cutivate	4		
Derma-Smoothe FS	4		
Dermasorb TA	4		
Dermatop	4		
Elocon	4		
fluocinolone acetonide	2		
fluocinolone acetonide oil	2		
fluticasone topical	2		
hydrocortisone valerate	2		
Kenalog	4		
mometasone furoate (topical)	2		
Momexin	4		
prednicarbate	2		
Synalar	4		
Synalar TS	4		
triamcinolone acetonide	2		
triamcinolone acetonide (lotion)	2		
triamcinolone acetonide (paste)	2		

Corticosteroids - Ultra High Potency

betamethasone dipropionate, augmented	2		
clobetasol propionate	2		
clobetasol propionate/emollient	2		
Clobex	4		
Cordran	4		
Cormax	2		
Diprolene	4		
Diprolene AF	4		
fluocinonide (micronized)	2		
halobetasol propionate	2		
Olux	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Olux-E	4		
Temovate	4		
Ultravate	4		
Ultravate X	4		
Vanos	4		

Corticosteroids, Other

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

Dermatological Anti-Infectives

Alcortin A	NC		* This drug is not covered.
Altabax	4		
Bactroban Cream	4		
Bactroban Nasal	4		
Bactroban Ointment	4		
mafenide acetate	2		
MetroCream	4		
MetroGel	4		
MetroGel 1% Kit	3		
MetroLotion	4		
metronidazole (gel)	2		
metronidazole (lotion)	2		
mupirocin cream	2		
mupirocin ointment	2		
Noritate	3		
Rosadan	4		
sulfacetamide topical lotion	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Dermatological Anti-Inflammatory Agents			
diclofenac gel	2		
Solaraze	4		
Soolantra	4		
Dermatological Antipruritics			
Atopiclair	4		
pruclair	2		
Prudoxin	4		
Zonalon	4		
Dermatological Caustic Agents			
Condylox	3		
Condylox Solution	4		
Keralyt gel	4		
podofilox solution	2		
Salex	4		
Dermatological Immunomodulators			
Aldara	4		
Elidel	3		* Prior authorization required
imiquimod	2		
Protopic	4		* Prior authorization required
tacrolimus topical	2		* Prior authorization required.
Zyclara	4		* Not available through Mail Service.
Dermatological, Antifungals			
Ciclodan	4		* Not available through Mail Service. * Prior authorization required
ciclopirox	2		
ciclopirox (gel)	2		
ciclopirox (shampoo)	2		

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

Dermatological, Misc.

Bionect	4		
Carac	4		
Drysol	NC		* This drug is not covered.
Efudex	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Fluoroplex	4		
fluorouracil cream	2		
Mirvaso	4		
Picato	3		* Not available through Mail Service.
Valchlor	4	Max 1 tube (60 gram)/30 days	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Vectical	4		
Veregen	3		
Emollients			
ammonium lactate	2		
Epiceram	4		
Hylatopic	4		
Hylatopic Plus	4		
Lac-Hydrin	4		
Presera	4		
Promiseb Complete	NC		* This drug is not covered.
Local Anesthetics			
EMLA	4	Prior authorization required for members 17 and older	
lidocaine	2		
lidocaine patch	2		
lidocaine/prilocaine	2	Prior authorization required for members 17 years and older	
Lidoderm	4		
Regenecare	4		
Xylocaine Jelly	4		
Mitotic Inhibitors			
calcipotriene	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
calcipotriene solution	2		
Dovonex	4		
Dovonex Solution	4		
selenium sulfide	2		
Selseb	4		
Sorilux	4		
Photochemotherapy Agents			
8-MOP	4		
methoxsalen	2		
Oxsoralen-Ultra	4		
Retinoids			
acitretin	2		
Atralin	3	Prior authorization required for members 30 and older	
Avita	2	Prior authorization required for members 30 and older	
Panretin	4		* Not available through Mail Service.
Retin-A	4	Prior authorization required for members 30 and older	
Retin-A Micro	1	Prior authorization required for members 30 and older	
Soriatane	4		
Tretin-X	4	Prior authorization required for members 30 and older	
tretinoin, microspheres topical	2	Prior authorization required for members 30 and older	
tretinoin, topical	2	Prior authorization required for members 30 and older	
Topical, Anorectal Agents			
Anusol HC Cream	4		
Anusol HC Suppositories	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Cortifoam	4		
Epifoam	4		
hydrocortisone 1% (cream/ ointment)	1		
hydrocortisone 2.5% (cream/ ointment)	1		
Pramosone	3		
Procto-Pak 1% (cream)	1		
Proctofoam HC	3		
Proctosol-HC	2		
Proctosol-HC 2.5% (cream)	1		
Rectiv	4		
Topical, Vaginal Agents			
Cleocin Cream	4		
Cleocin Vaginal Suppository	4		
Clindesse	4		
Gynazole-1	4		
Metrogel Vaginal	4		
metronidazole (vaginal gel)	2		
Nuvessa	4		
Terazol	4		
terconazole	2		
Wound Care Agents			
Aurstat	4		
Biafine	4		
Hylase	4		
Neosalus Cream	4		
Neosalus Foam	4		
Nuvail	4		
Prutect	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Regranex	4	Annual limit 90 days; Max. 1 tube/30-day supply	* Not available through Mail Service.
Santyl	2		
Silvadene	4		
silver sulfadiazine AF cream	2		
Silvrstat	4		
Sonafine	4		
SSD Cream	4		* Not available through Mail Service.
Thermazine	4		* Not available through Mail Service.
Tropazone	4		
ENZYME REPLACEMENTS/MODIFIERS			
Enzymes, Other			
Aldurazyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Aralast NP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Berinert	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or ICORE Healthcare. * Not available through Mail Service.
Buphenyl	4		
Carbaglu	4		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Cerdelga	3		* Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Cerezyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Cinryze	Medical	Max. 20 vials/30-day supply	* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service. Prior authorization required.
Cystadane	4		
Cystagon	4		
Elaprase	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Elelyso	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through Centric Health Resources only. 800-305-7881
Fabrazyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Firazyr	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service
Kalbitor	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Krystexxa	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare.
Kuvan	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Lumizyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Myozyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Naglazyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Procysbi	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program.

DRUG NAME	TIER	LIMITATIONS	NOTES
			Use Accredo. * Limited pharmacy distribution. Patients must enroll in REMS program, RaptorCares 855-888-4004
Prolastin	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through Centric Health Resources only.. 800-305-7881
Prolastin C	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through Centric Health Resources only. 800-305-7881
Ravicti	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
sodium phenylbutyrate	2		
Vpriv	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Zavesca	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Zemaira	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. Available through Accredo Nova Factor only.

Enzymes, Pancreatic

Creon	3		
Pancreaze	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Pancrelipase 5,000	2		
Pertzye	4		
Sucraid	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Ultresa	4		
Viokace	4		
Zenpep	3		
GASTROINTESTINAL DRUGS			
Antispasmodics			
Bentyl	4		
Cantil	4		
chlordiazepoxide/clidinium	2		
dicyclomine	2		
Librax	4		
methscopolamine bromide	2		
Pamine	4		
Gastrointestinal Agents, Other			
Actigall	4		
Chenodal	4		* Not available through Mail Service. * Sole source through Centric Health.
Cholbam	4		
CoLyte	4		
CoLyte with Flavor Packs	4		
cromolyn	2		
Cuvposa	4		* Available from Diplomat Pharmacy only.
diphenoxylate/atropine	2		
Enulose	2		
Fulyzaq	4		* Step Therapy: First level drug treatment required before

DRUG NAME	TIER	LIMITATIONS	NOTES
			coverage begins. If first level drug is not tried, prior authorization is required.
Gastrocrom	4		
Gavilyte-G	2		
Generlac	2		
Glycate	4		
glycopyrrolate	2		
Go-Lytely	4		
Kristalose	3		
lactulose	2		
lansoprazole/clarithromycin/ amoxicillin kit	2		
Lomotil	4		
metoclopramide	2		
metoclopramide ODT	2		
Metozolv ODT	4		
Motofen	4		
Movantik	4		
Moviprep	3		
NuLytely	4		
Omeclamox-Pak	4		
Osmoprep	4		
PEG 3350/Electrolyte	2		
Prepopik	3		* Not available through Mail Service.
PrevPac	4		
Pylera	3		
Reglan	4		
Relistor	3		* Not available through Mail Service.
Robinul	4		
Robinul Forte	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Suclear	4		
Suprep	4		
Trilyte	2		
Urso	4		
ursodiol	2		

H2 Antagonists

Axid	4		
cimetidine	2		
famotidine	2		
famotidine 20mg	1		
nizatidine	2		
Pepcid	4		
ranitidine	2		
Tagamet	4		
Zantac	4		

Inflammatory Bowel Disease Agents

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

DRUG NAME	TIER	LIMITATIONS	NOTES
mesalamine (enema)	2		
Pentasa	3		
Rowasa Enema	4		
sulfasalazine	2		
Uceris	4		
Irritable Bowel Syndrome Agents			
Amitiza	3		
Linzess	3		
Lotronex	3	Covered for females only	
Protectants			
Carafate (suspension)	3		
Carafate (tablet)	4		
Cytotec	4		
misoprostol	2		
sucralfate	2		
Proton Pump Inhibitors			
Aciphex	4		
AcipHex Sprinkle/capsule	4		
Dexilant	4		
esomeprazole magnesium	3		
Esomeprazole strontium	4		
lansoprazole	3		
Nexium	4		
omeprazole	2		
omeprazole/sodium bicarbonate (capsule)	4		
pantoprazole	2		
Prevacid	4		
Prevacid Solutab	4		
Prilosec	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Protonix	4		
Protonix (suspension)	4		
rabeprazole/tablet DR	4		
Zegerid (capsules)	4		
Zegerid Powder Packet	4		
GENITOURINARY AGENTS			
Antispasmotics, Urinary			
Detrol	4		
Detrol LA	4		
Ditropan XL	4		
Enablex	4		
flavoxate	2		
Gelnique	4	Max. 30 packets/30-day supply	
Gelnique Pump	4	Max. 1 pump bottle/30-day supply	
Myrbetriq	4		
oxybutynin	2		
Oxytrol	4		
Sanctura	4		
tolterodine	2		
tolterodine LA	2		
Toviaz	3		
trospium chloride	2		
trospium chloride ER cap	2		
Vesicare	3		
BPH Agents			
alfuzosin	2	Max. 30 tabs/30-day supply	
Avodart	3		
finasteride 1mg	NC		* This drug is not covered.
finasteride 5mg	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Flomax	4		
Jalyn	3		
Proscar	4		
Rapaflo	4		
tamsulosin	2		
Uroxatral	4	Max. 30 tabs/30-day supply	

Erectile Dysfunction

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

Genitourinary Agents, Other

bethanechol	2
Elmiron	4
phenazopyridine	1

DRUG NAME	TIER	LIMITATIONS	NOTES
Pyridium	3		
Thiola	4		* Sole Source Pharmacy: Dohmen Life Sciences 1-800-305-7881
Urecholine	4		
Phosphate Binders			
Auryxia	4		
Fosrenol	4		
Renagel	3		
Renvela	3		
Velphoro	4		
HORMONAL (ADRENAL)			
Corticosteroids			
Acthar HP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service Prior authorization required.
Cortef	4		
cortisone acetate	2		
dexamethasone	2		
dexamethasone (oral solution)	2		
dexamethasone (tablet)	1		
dexamethasone 0.5mg/5mL (elixir)	2		
dexamethasone 2mg (tablet)	2		
dexamethasone 6mg (tablet)	2		
DexPak	4		
fludrocortisone acetate	2		
hydrocortisone	2		
Medrol	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
methylprednisolone	2		
Millipred	3		
Orapred	4		
Orapred ODT	4		
PediaPred	4		
prednisolone	2		
prednisolone 5mg (tablet)	1		
prednisolone sodium phosphate tab rapdis	2		
prednisone	1		
prednisone 5mg/5mL (oral solution)	2		
Rayos	4		
Veripred 20	4		
HORMONAL (CONTRACEPTIVES)			
Biphasic			
Azurette	2		
Kariva	2		
Mircette	4		
Contraceptives, Other			
Implanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or ICORE Healthcare. * Not available through Mail Service.
Natazia	3		
Nexplanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Emergency Contraceptive Agents			
Ella	3	Max. 1 tab/copay	* Not available through Mail Service.
My Way	2	Max. 1 unit/copay	* Not available through Mail Service. * Covered for members less than 17 years of age. For members 17 and above, Next Choice One Step is available without a prescription and is not covered.
Next Choice One Dose	2	Max. 1 unit/copay	* Not available through Mail Service. * Next Choice One Step is covered for members less than 17 years of age. For members 17 and above, Next Choice One Step is available without a prescription and is not covered.
Plan B	4	Max. 1 pack (2 tablets)/ copay	* Not available through Mail Service. * Plan B is covered for members less than 18 years of age. For members age 18 and above, Plan B is available without a prescription and is not covered.
Plan B One-Step	4	Max. 1 unit/copay	* Not available through Mail Service. * Plan B One Step is covered for members less than 17 years of age. For members 17 and above, Plan B One Step is available without a prescription and is not covered.
Monophasic			
norethindrone/ethinyl estradiol/ iron (ferrous fumarate)	2		
Amethia	2		* Packaged as a 3 month supply. Member pays 3 copays at retail pharmacy.

DRUG NAME	TIER	LIMITATIONS	NOTES
Amethia lo	2		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Amethyst	4		
Angeliq	4		
Apri	2		
Aviane	2		
Balziva	2		
Beyaz	3		
Brevicon	2		
Camrese	2		
Camrese lo	2		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Cyclafem 1/35	2		
Desogen	4		
Emoquette	2		
ethinyl estradiol 30 - desogestrel 0.15	2		
ethinyl estradiol 35 - norethindrone 1	2		
ethinyl estradiol 35 – norgestimate 0.25	2		
Femcon FE	4		
Generess FE	4		
Gianvi	2		
Jolessa	2		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Junel 1/20	2		
Junel Fe	2		
Lessina	2		
Levlen	2		
Levora	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Lo Loestrin FE	4		
Lo Minastrin Fe	4		
Lo-Ovral	4		
Loestrin	4		
Loestrin 24 FE	4		
Loestrin Fe	4		
Lomedia 24 FE	2		
Loseasonique	4		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Low-Ogestrel	2		
Lutera	2		
Microgestin	2		
Minastrin 24 FE	4		
Modicon	4		
Mononessa	2		
Nordette	4		
Norinyl 1/35	2		
Norinyl 1/50	4		
Nortrel 0.5/35	2		
Nortrel 1/35	2		
NuvaRing	3		
Ocella	2		
Ogestrel	2		
Ortho Cyclen	4		
Ortho Evra	4		
Ortho-Cept	4		
Ortho-Novum	4		
Ovcon -35	4		
Previfem	2		
Quartette	4		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.

DRUG NAME	TIER	LIMITATIONS	NOTES
Quasense	2		* Packaged as a 3 month supply (91 days). Member pays 3 copayments.
Reclipsen	2		
Safyral	3		
Seasonale	4		* Packaged as a 3 month supply (91 days). Member pays 3 copayments at retail pharmacy.
Seasonique	4		* Packaged as a 3 month supply. Member pays 3 copays at retail pharmacy.
Sprintec	2		
Sronyx	2		
Xulane	2		
Yasmin	4		
Yaz	4		
Zarah	2		
Zeosa	2		
Zovia	2		
Progestin Only			
Camila	2		
Errin	2		
Nor-QD	4		
Nora-Be	2		
norethindrone 0.35 mg	2		
Triphasic			
Aranelle	2		
Cyclafem 7-7-7	2		
Cyclessa	4		
Enpresse	2		
Estrostep FE	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
ethinyl estradiol 25 - norgestimate 0.18/0.215/0.25	2		
ethinyl estradiol 35 - norethindrone 0.5/0.75/1	2		
ethinyl estradiol 35 – norgestimate 0.18 / 0.215 / 0.25	2		
Necon	2		
Nortrel 7-7-7	2		
Ortho Tri Cyclen	4		
Ortho Tri-Cyclen LO	4		
Ortho-Novum 7-7-7	4		
Tilia FE	2		
Tri-Estarylla	2		
Tri-Legest FE	2		
Tri-Linyah	2		
Tri-Norinyl	4		
Tri-Previfem	2		
Tri-Sprintec	2		
Trinessa	2		
Trivora	2		
Velivet	2		
HORMONAL (FERTILITY AGENTS)			
Fertility Agents			
Bravelle	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Cetrotide	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
chorionic gonadotropin	4		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
clomiphene citrate	2		
Follistim AQ	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Ganirelix	4		* Covered through IVF Program. Must use Village Pharmacy or Walgreens Specialty Pharmacy or Freedom Drug for coverage. * Not available through mail service.
Gonal F	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
leuprolide acetate	2		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Menopur	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Novarel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Ovidrel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Pregnyl	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Repronex	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Serophene	4		
HORMONAL (PARATHYROID/METABOLIC BONE DISEASE)			
Bisphosphonates			
Actonel 150mg	4	150mg: Max. 1 tab/28-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Actonel 35mg, 75mg	3	35mg: Max. 4 tabs/28-day supply; 75mg: Max. 2 tabs/28-day supply;	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
alendronate	2	35mg and 70mg: Max. 4 tabs/28-day supply; 75ml oral solution bottle: 4 bottles/28 day supply.	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Atelvia	3	4 tabs/28-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Binosto	4	Max. 4 tabs/28-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Boniva	4	150mg: Max. 1 tab/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that 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 ICORE Healthcare. * Not available through Mail Service.
etidronate	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that 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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Fosamax Plus D	4	Max. 4 tabs/28-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
ibandronate sodium	2	150mg: Max. 1 tab/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Reclast	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
risedronate 150mg	2	150mg: Max. 1 tab/28-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
zoledronic acid	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
zoledronic acid	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare.
Calcimimetics			
Sensipar	4		* Covered through Specialty Pharmacy Program. Must

DRUG NAME	TIER	LIMITATIONS	NOTES
			use ICORE Healthcare. * Not available through mail service.
Calcium Regulating Hormones			
calcitonin-salmon nasal spray	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Fortical	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Miacalcin	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Parathyroid Hormone Analog			
Forteo	3	Max. 1 syringe/28-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use ICORE Healthcare. * Prior authorization required; Not available through mail service.Prior authorization required.
Natpara	4	Max. 2 cartridges/28-day supply	* Not available through Mail Service.
Selective Estrogen Receptor Modulators			

DRUG NAME	TIER	LIMITATIONS	NOTES
Evista	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
raloxifene	2		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
HORMONAL (PITUITARY)			
Gonadotropin-releasing Hormone Analogs			
Eligard	4		* Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Lupaneta Pack	4		* Not available through Mail Service.
Supprelin LA	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Synarel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Vantas	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Growth Hormone Analogs			

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

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

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

Androgens

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

DRUG NAME	TIER	LIMITATIONS	NOTES
		10mL vial: Max. 1 vial/30 day-supply	
Fortesta	4	Prior authorization required for members 18 and older. Max 2 pumps/30-day supply	* Mail Service: Max. 30-day supply as required by State or Federal law, or benefit plan design
Methitest	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Natesto	4	Prior authorization required for members 18 and older. Max. 33 grams/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Not available through Mail Service.
Oxandrin	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
oxandrolone	2		
Striant	3	Prior authorization required for members 18 and older. Max. 60 tabs/30 day-supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Testim	4	Prior authorization required for members 18 and older. Max. 300 grams/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
testosterone 1% gel	2	Prior authorization required for members 18 and older. Max. 300 grams/30-day supply	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
testosterone 2% gel	2	Prior authorization required for members 18 and older. Max. 2 pumps/30 day-supply.	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
testosterone cypionate	2	Prior authorization required for members 18 and older. 1mL vial: Max. 4 vials/30 day-supply 	* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

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

Estrogen/Methyltestosterone combos

Covaryx	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Covaryx H.S.	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
estrogen, ester/me-testosterone 0.625mg/1.25mg	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design
estrogen, ester/me-testosterone 1.25mg/2.5mg	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

Estrogen/Progestin Combos

Activella	4		
Climara Pro	3		
Combipatch	3		
ethinyl estradiol/norethindrone acetate	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
FemHRT	4		
Jinteli	2		
Premphase	3		
Prempro	3		
Estrogens			
Alora	4		
Cenestin	3		
Climara	4		
Divigel	3		
Elestrin	4		
Enjuvia	3		
Estrace	4		
Estrace (vaginal cream)	3		
estradiol	2		
estradiol (patch)	2		
Estring	3		* Packaged as a 90-day supply. Member pays 3 copayments at retail pharmacy.
Estrogel	4		
estropipate	2		
Evamist	4	Max. 1 bottle/copay	* Not available through Mail Service.
Femring	4		* Packaged as a 68-day supply. Member pays 3 copayments at retail pharmacy.
Femtrace	4		
Menest	4		
Menostar	4		
Minivelle patch	4		
Premarin	3		
Premarin (vaginal cream)	3		
Vagifem	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Vivelle-DOT	4		
Estrogens/SERM Combos			
Duavee	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Progestins			
Aygestin	4		
Crinone	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Endometrin	3		* Covered through IVF Program. Must use Village Pharmacy or Walgreens Specialty Pharmacy or Freedom Drug for coverage. * Not available through Mail Service.
Makena	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Covered through IVF Program. Must use Village Pharmacy for coverage. * Not available through mail service.
medroxyprogesterone acetate (tablets)	1		
Micronor	4		
norethindrone acetate	2		
progesterone	2		
Progesterone In Oil [brand name]	4		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens

DRUG NAME	TIER	LIMITATIONS	NOTES
			Specialty Pharmacy for coverage. * Not available through mail service.
progesterone in oil [generic]	2		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Prometrium	4		
Provera	4		
HORMONAL (THYROID AGENTS)			
Thyroid Agents			
Armour Thyroid	4		
Cytomel	4		
Levothroid	2		
levothyroxine	2		
Levoxyl	2		
liothyronine	2		
methimazole	2		
propylthiouracil	2		
Synthroid	3		
Tapazole	4		
Thyrolar	4		
Tirosint	4		
Unithroid	2		
IMMUNOLOGIC AGENTS			
Immunologic Agents, Other			
Arcalyst	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Benlysta	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pharmacy Program. Must use ICORE Healthcare. * Not available through mail service
Cosentyx	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Ilaris	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available at mail service. Prior authorization required.
Otezla	4	Effective 4/1/15: Prior authorization required.	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Synagis	Medical	Covered for members under 2 years of age; Maximum of 5 doses per 180 days.	* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.Prior authorization required.
Immunomodulators			
Actimmune	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Aubagio	4	Max. 28 tabs/28 day-supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Avonex	3		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
Betaseron	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Copaxone	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Extavia	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Gilenya	3	Max. 28 caps/28 day supply	* Covered through Specialty Pharmacy Program. Must use Accredo.
Intron-A	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Peg-Intron	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Pegasys	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Plegridy	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Pomalyst	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Rebif	4		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through mail service.
Revlimid	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Stelara	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service. Prior authorization required.
Sylatron	4		* Covered through Specialty Pharmacy Program. Must use Accredo.
Tecfidera	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Thalomid	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Immunosuppressants, non-TNF			
Actemra (SubQ)	4	Max. 4 syringes/28 day supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Astagraf XL	4		
Azasan	3		
azathioprine	2		
CellCept	4		
Cuprimine	3		
cyclosporine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
cyclosporine micro-emulsion	2		
Depen	4		
Gengraf	2		
Hecoria	3		
Imuran	4		
methotrexate	2		
mycophenolate	2		
mycophenolate mofetil suspension	2		
mycophenolic acid	2		
Myfortic	4		
Neoral	4		
Nulojix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through mail service
Orencia (Prefilled Syringe)	4	Max. 4 syringes/28-day supply	* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Otrexup	3		* Not available through Mail Service.
Prograf	3		
Rapamune	4		
Rasuvo	3	Max. 4 syringes/28 day-supply	* Not available through Mail Service.
Rheumatrex	3		
Sandimmune	4		
Sandimmune Oral Soln	3		
sirolimus	2		
tacrolimus	2		
Trexall	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Xeljanz	4	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service..Prior authorization required.
Zortress	4		

Immunosuppressants, TNF Inhibitors

Cimzia (prefilled syringe)	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service. Prior authorization required.
Enbrel	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service. Prior authorization required.
Humira	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service. Prior authorization required.
Humira Crohns Starter Kit	3	1 kit per year	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service. Prior authorization required.
Humira Psoriasis Starter Kit	3	Max. 1 kit/year	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service. Prior authorization required.
Simponi	4	Max. 1 pen injector/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service. Prior authorization required.

Vaccines/Serums

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Breeze 2 Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Contour Next Strips	4	Max. 204 strips/30-day supply.	* Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
ContourTest Strips	4	204 test strips/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pilgrim's preferred Diabetes care products.
Sof-Tact Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
SureStep Pro Test Strips	4	204 test strips/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Insulin Delivery Systems			
V-Go	4	Max. 30 units/30 day supply	
Needles and Syringes			
BD Micro-Fine Insulin Syringe	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
BD Ultra-Fine Insulin Syringe	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
BD Ultra-Fine Pen Needles	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Lancets	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Novo Twist needles	3		
NovoFine needles	3		
Spacer Devices			
Aerochamber	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Aerochamber (including mask)	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Inspirease Delivery System	Medical		* Covered under medical benefit. No pharmacy copayment applies.
Inspirease Replacement Bags	Medical		* Covered under medical benefit. No pharmacy copayment applies.
OPHTHALMIC			
Antiglaucoma Agents			
AK-Pentolate 1%	1		
Alphagan P 0.1%	3		
Alphagan P 0.15%	4		
apraclonidine	2		
atropine	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
Azopt	3		
Betagan	4		
betaxolol, ophthalmic	2		
Betimol	3		
Betoptic S	3		
brimonidine 0.15%	2		
brimonidine 0.2%	2		
Combigan	3		
Cosopt	4		
Cosopt PF	4		
Cyclogyl 0.5%	3		
Cyclogyl 1%	4		
Cyclogyl 2%	4		
cyclopentolate 1%	1		
cyclopentolate 2%	2		
dorzolamide (ophthalmic)	2		
dorzolamide/timolol (ophthalmic)	2		
homatropaire	2		
Iopidine	4		
Isopto Atropine	3		
Isopto Carbachol	4		
Istalol	4		
levobunolol	2		
metipranolol	2		
phenylephrine 2.5% (drops)	2		
Phospholine Iodide	3		
pilocarpine 3% (ophthalmic drops)	2		
Simbrinza	3		
timolol	2		
timolol (ophthalmic gel)	2		
Timoptic	4		
Timoptic-XE	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Trusopt	4		

Ophthalmic Anti-Allergy

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

Ophthalmic Anti-Inflammatory

Acular/LS	4		
Acuvail	4	Max. 30 units/30-day supply	
Alrex	4		
Blephamide	3		
bromfenac	2		
Decadron (ophthalmic)	4		
dexamethasone (ophthalmic)	2		
diclofenac (ophthalmic)	2		
Durezol	4		
Flarex	4		
fluorometholone, ophthalmic	2		
flurbiprofen, ophthalmic	2		
FML	4		
Ilevro	4		
ketorolac tromethamine	2		
Lotemax	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Maxidex	4		
neomycin-polymixin-hc	2		
neomycin-polymyxin-dexamethasone	2		
Ocufen	4		
Omnipred	4		
Pred Forte	4		
Pred Mild	3		
prednisolone acetate	2		
Prolensa	4		
Vexol	4		

Ophthalmic Antibiotics

Azasite	4		
Besivance	4		
Bleph-10	1		
Ciloxan (drops)	4		
Ciloxan (ointment)	4		
ciprofloxacin (ophthalmic drops)	2		
erythromycin (ophthalmic)	2		
gatifloxacin	2		
Gentak (ointment)	2		
gentamicin	2		
gentamicin 0.3% (ointment)	2		
Iquix	4		
levofloxacin, ophthalmic	2		
Moxeza	4		
neomycin/bacitracin/polymyxin 3.5mg-400 (ointment)	2		
Ocuflox	4		
ofloxacin 0.3%	2		
polymyxin-trimethoprim (ophthalmic)	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Pred G	4		
Quixin	4		
sulfacetamide sodium 10% (drops)	1		
Sulfamide (drops)	1		
Tobradex	4		
Tobradex ST	4		
tobramycin (drops)	2		
tobramycin/dexamethasone (ophthalmic)	2		
Tobrex (drops)	4		
Tobrex (ointment)	3		
Vigamox	4		
Zylet	3		
Zymaxid	4		

Ophthalmic Antivirals

trifluridine	2		
Viroptic	4		
Zirgan	4		

Ophthalmic Lubricating Agents

Lacrisert	3		

Ophthalmic Prostaglandins

latanoprost	2		
Lumigan	3		
Rescula	4		
Travatan Z	3		
travoprost	2		
Xalatan	4		
Zioptan	4		

Ophthalmic, Other

DRUG NAME	TIER	LIMITATIONS	NOTES
Alcaine	2		
Cystaran	4		* Sole source pharmacy. Members must use Walgreens Specialty Pharmacy. CYSTARAN Hotline: 1-877-534-9627
Eylea	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
I-Lid	4		
Natacyn	3		
Ozurdex	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
proparacaine	2		
Restasis	3	Max. 60 vials/month	
tetracaine	2		
OTIC			
Otic Agents			
Acetasol HC	2		
antipyrine/benzocaine/glycerine (ear drops)	2		
Cetraxal	4		
Cipro HC	4		
Ciprodex	3		
Coly-Mycin S	4		
Dermotic (drops)	4		
Floxin Otic	4		
neomycin-polymyxin-hydrocortisone	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
ofloxacin, otic	2		
Vosol HC	4		
RESPIRATORY AGENTS			
Antihistamines			
Astelin	4		
Astepro	4		
azelastine	2		
azelastine, nasal	2		
cetirizine oral solution	2		
Clarinex	4		
Clarinex D 24hr	4		
Clarinex Reditab	4		
clemastine	2		
cyproheptadine	2		
desloratadine	2		
desloratadine; oral-disintegrating tablet	2		
diphenhydramine	1		
hydroxyzine	2		
hydroxyzine pamoate	2		
Karbinal ER	4		
levocetirizine	2		
Palgic Liquid	2		
Semprex-D	4		
Vistaril	4		
Xyzal	4		
Antileukotrienes			
Accolate	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
montelukast	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Singulair	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
zafirlukast	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Zyflo CR	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

Antitussives and Expectorants

benzonatate	2		
Cheratussin AC 100-10mg/5	1		
Gani-Tuss NR 100-10mg/5	1		
guaifenesin-codeine 100-10mg/5	1		
Guiatuss AC 100-10mg/5	1		
hydrocodone/chlorpheniramine (suspension)	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
hydrocodone/homatropine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
Hydromet	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Iophen-C NR 100-10mg/5	1		
Mytussin AC 100-10mg/5	1		
Obredon	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
promethazine DM 15-6.25/5	2		
promethazine/codeine	2		
pseudoephedrine/hydrocodone/ chlorpheniramine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tessalon	4		
Tussicaps	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tussionex	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vi-Q-Tuss 100-5mg/5	1		
Vituz	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Zonatuss	4		
Zutripro	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

Bronchodilators, Anticholinergic

Atrovent HFA	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Incruse Ellipta	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
ipratropium solution	2		
Spiriva	3	Max. 1 unit (30 blisters)/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Spiriva Respimat	3	Max. 1 inhaler/30 day-supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Tudorza Pressair	3	Max. 1 unit/30 day-supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

Bronchodilators, Sympathomimetics

albuterol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that 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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Arcapta Neohaler	4	Max 1 unit (30 capsules)/ 30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Brovana	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Combivent Respimat	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Duoneb	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Foradil	3	Max. 1 unit (60 caps)/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
ipratropium/albuterol (nebulizer solution)	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
isoetharine	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
levalbuterol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Maxair Autohaler	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
metaproterenol	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Perforomist	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
ProAir HFA	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
ProAir Respiclick	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Proventil HFA	4		* HSA Preventive drug. The Preventive Drug Benefit enables

DRUG NAME	TIER	LIMITATIONS	NOTES
			access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Serevent Diskus	3	Max. 1 unit (60 blisters)/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Striverdi Respimat	4	Max. 1 inhaler/30-day supply	
terbutaline	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Ventolin HFA	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vospire ER	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Xopenex	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Xopenex HFA	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Bronchodilators, Xanthines			
Theo 24	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
theophylline	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Inhaled Corticosteroids			
Advair Diskus	3	Max. 1 unit (60 blisters)/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Advair HFA	3	Max. 1 unit/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Aerospan	4		
Alvesco	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Anoro Ellipta	4	Max. 1 unit/30-day supply	
Asmanex	3		* HSA Preventive drug. The Preventive Drug Benefit enables

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Pulmicort Respule	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
QVAR	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Symbicort	3	Max. 1 inhaler(120 doses)/30-day supply	* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Mast-Cell Stabilizers			
cromolyn sodium	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Nasal Inhalers			
Arnuity Ellipta	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Atrovent Nasal	4		
Beconase AQ	4		
budesonide aqueous, nasal	2		
Children’s QNASL	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Dymista	3		
Flonase	4		
flunisolide nasal spray	2		
fluticasone nasal spray	2		
Nasacort AQ	4		
Nasonex	3		
olopatadine nasal spray	2		
Omnaris	4		
Patanase Nasal Spray	4		
QNASL	4		
Rhinocort AQUA	4		
triamcinolone acetonide aqueous, nasal	2		
Veramyst	3		
Zetonna	4		

Pulmonary Arterial Hypertension Agents

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			mail servicePrior authorization required
Kitabis Pak	4		* Kitabis Pak includes nebulizer.
Nebusal	4		
Ofev	4	Max. 60 caps/30 day-supply	* Covered through Specialty Pharmacy Program. Must use Walgreens Specialty Pharmacy. * Sole Source Pharmacy: Walgreens Specialty 800-420-3228 Not available through Mail Service
Pulmozyme	3		
sodium chloride vial-neb	2		
Tobi	4		* Covered through Specialty Pharmacy Program. Must use Accredo.
Tobi Podhaler	3		* Covered through Specialty Pharmacy Program. Use Accredo.
tobramycin (inh neb)	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Tyzine	4		
Xolair	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through mail service. Prior authorization required.
SEDATIVES and HYPNOTICS			
Sedative and Hypnotic Agents			
Ambien	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Robaxin	4		
Skelaxin	4		
Soma	4		
tizanidine	2		
Zanaflex	4		
THERAPEUTIC NUTRIENTS, MINERALS AND ELECTROLYTES			
Electrolytes/Minerals			
calcium acetate	2		
Carnitor	4		
Cytra-2	4		
Cytra-3	2		
Eliphos	2		
K-Lor	3		
K-Phos Neutral	4		
K-Phos Original	4		
K-Tab	3		
Kaochlor	4		
Klor-Con	4		
Micro-K	4		
PhosLo	4		
Phoslyra	3		
potassium chloride	2		
potassium citrate	2		
sodium citrate/citric acid	2		
Urocit-K	4		
zinc sulfate	2		
Prenatal Vitamins			
Bal-Care DHA Essential	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Cadeau DHA	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal DHA 27	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal Harmony	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal Rx	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Concept DHA	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Concept OB	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Duet DHA Balanced	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

DRUG NAME	TIER	LIMITATIONS	NOTES
			drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Duet DHA EC	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Folet DHA	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Gesticare DHA	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Hemenatal OB	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Hemenatal OB + DHA	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Infanate Plus	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Natalcare PIC	1		

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
OB Complete	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete 400	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete One	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
OB Complete Premier	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
PNV-DHA	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
PNV-Select	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Prefera-OB	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Prenaplus 27mg-1mg	1		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Prenatabs FA 29mg-1mg	1		
Prenatal 1 Plus 1 27mg-1mg	1		
Prenatal Low Iron 27mg-1mg	1		
Prenatal MTR 27mg-1mg	1		
Prenatal Plus	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that 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. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Elite	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Prenate Enhance	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Vitafol Nano	2		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol Ultra	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol-One	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vitafol-Plus	4		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vitamed MD One Rx	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vitamed MD Plus Rx	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to your plan deductible. Applicable copayment will apply.
Vitamed MD RediChew Rx	3		* HSA Preventive drug. The Preventive Drug Benefit enables access to covered preventive drugs that will not be subject to

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			your plan deductible. Applicable copayment will apply.
Renax	2		
TL G-Fol OS	2		
Vitamins - Vitamin B			
cyanocobalamin (injection)	1		
folic acid	1		
Foltrate	4		
hydroxycobalamin 1,000 mcg (injection)	2		
Nascobal	4		
Vitamins - Vitamin D			
calcitriol	2		
doxercalciferol	2		
Drisdol	4		
ergocalciferol	2		
Hectorol	4		
paricalcitol	2		
Rocaltrol	4		
Rocaltrol Solution	3		
Vitamin D 50,000 Unit (capsule)	1		
Zemplar	4		
Vitamins - Vitamin K			
Mephyton	3		
UNCLASSIFIED			
Cosmetic			
Aclaro	NC		* This drug is not covered.
Avage	NC		* This drug is not covered.
Epiquin Micro	NC		* This drug is not covered.
Genadur	NC		* This drug is not covered.
Latisse	NC		* This drug is not covered.

DRUG NAME	TIER	LIMITATIONS	NOTES
Lustra	NC		* This drug is not covered.
OBAGI-C	NC		* This drug is not covered.
Pliaglis	NC		* This drug is not covered.
Propecia	NC		* This drug is not covered.
Renova	NC		* This drug is not covered.
tretinoin 0.05%, emollient	NC		* This drug is not covered.
Tri-Luma	NC		* This drug is not covered.
Vaniqa	NC		* This drug is not covered.
Diagnostics			
Thyrogen	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Unclassified			
Ampyra	4	Max. 60 tabs/30-day supply	* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Botox	Medical	Prior authorization required for members 17 and older	* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Brisdelle	4		
Dysport	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.Prior authorization required.

DRUG NAME	TIER	LIMITATIONS	NOTES
Grastek	4	Max. 30 tabs/30-day supply	* Not available through Mail Service.
Myalept	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Myobloc	Medical	Prior authorization required for members 17 and older	* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Oralair	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Orfadin	4		* Sole Source Pharmacy: Dohmen Life Sciences 1-800-305-7881
Osphena	4		
Potaba	4		
Prolia	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Ragwitek	4	Max. 30 tabs/30-day supply	* Not available through Mail Service.
Sodium Chloride	2		
Soliris	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail Service.
Xeomin	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through

DRUG NAME	TIER	LIMITATIONS	NOTES
			Specialty Pharmacy Program. Must use ICORE Healthcare. * Not available through Mail ServicePrior authorization required
Xgeva	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use ICORE Healthcare.
Xiaflex	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Managed Distribution Xiaflex Xperience http://www.xiaflex.com/procedure_training.jsp For the treatment of Peyronie's Disease contact US Bioservices at 800-801-1140
Weight Loss Agents			
Adipex-P	NC		* This drug is not covered.
Belviq	NC		* This drug is not covered.
Contrave ER	NC		* This drug is not covered.
Didrex	NC		* This drug is not covered.
Ionamin	NC		* This drug is not covered.
phentermine	NC		* This drug is not covered. *
Qsymia	NC		* This drug is not covered.
Suprenza ODT	NC		* This drug is not covered.
Xenical	NC		* This drug is not covered.