Harvard Pilgrim Prescription Drug List

PREMIUM FORMULARY
FOUR-TIER DRUG LIST
BY CATEGORY

LAST UPDATED : 12/01/2015

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	* Prior authorization required. * Quantity Limitations. * Prior authorization required. Quantity Limitations.
acetaminophen/codeine	1		
acetaminophen/codeine 300mg-60mg	2		
acetaminophen/tramadol	2		
Actiq	4	Max. 120 lozenges/30 days.	* Prior authorization required. * Quantity Limitations. * Prior authorization required. Quantity Limitations.
Avinza	4	Max. 2 caps/daily	* Quantity Limitations. * Quantity Limitations.
butorphanol	2		
Butrans	3	Max. 4 patches/28-day supply	* Quantity Limitations. * Quantity Limitations.
codeine sulfate	2		
Conzip	4		
Demerol	4		
dihydrocodeine/acetaminophen/ caffeine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
dihydrocodeine/aspirin/caffeine	2		
Dilaudid	4		
Dolophine	4		
Duragesic	4	Max 15 patches/30-day supply	* Quantity Limitations. * Quantity Limitations.
Embeda	4	Max. 3 caps/daily	* Quantity Limitations. * Quantity Limitations.
Endocet	2		
Endocet 5mg-325mg	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
Endocet 7.5mg-325mg	1		
Exalgo	4	Max. 60 tabs/30 day-supply	* Quantity Limitations. * Quantity Limitations.
fentanyl	2	Max. 15 patches/30-day supply	* Quantity Limitations. * Quantity Limitations.
fentanyl citrate (lozenge)	2	Max. 120 lozenges/30-day supply.	* Prior authorization required. * Quantity Limitations. * Prior authorization required. Quantity Limitations.
Fentora	4	Max. 120 lozenges/30-day supply	* Prior authorization required. * Quantity Limitations. * Quantity Limitations.
Hycet	4		
hydrocodone/acetaminophen	2		
hydrocodone/acetaminophen 5mg-500mg	1		
hydrocodone/acetaminophen 7.5mg-650mg	2		
hydrocodone/acetaminophen 7.5mg-750mg	1		
hydrocodone/acetaminophen oral solution	2		*
hydromorphone	2		
hydromorphone (liquid)	2		
hydromorphone tab ER 24H	2	Max. 60 tabs/30- day supply	* Quantity Limitations. * Quantity Limitations.
Hysingla ER 20mg, 30mg	4	Max: 60 tabs/30 day-supply.	* Prior authorization required. * Quantity Limitations. * Prior authorization required. Quantity Limitations.
Hysingla ER 40mg, 60mg, 80mg, 100mg, 120mg	4	Max: 30 tabs/30 day-supply.	* Prior authorization required. * Quantity Limitations. * Prior authorization required. Quantity Limitations.
Kadian 10mg, 20mg, 30mg, 50mg, 60mg, 80mg, 100mg	4	Max. 2 caps/daily	* Quantity Limitations. * Quantity Limitations.

DRUG NAME	TIER	LIMITATIONS	NOTES
Kadian 40mg, 70mg, 130mg, 150mg, 200mg	3	Max. 2 caps/daily	* Quantity Limitations. * Quantity Limitations.
Lazanda	4	Max. 15 bottles/30-day supply Effective 1/1/15, Prior authorization required.	* Quantity Limitations. * Quantity Limitations.
levorphanol	2		
Lortab	4		
meperidine	2		
methadone	2		
morphine SR	2	Max. 3 tabs/daily	* Quantity Limitations. * Quantity Limitations.
morphine sulfate	2	Max. 3 tabs/daily	* Quantity Limitations. * Quantity Limitations.
morphine sulfate (Roxane) 15mg, 30mg	3	Max. 2 caps/daily	* Quantity Limitations. * Quantity Limitations.
morphine sulfate cap ER 10mg, 20mg, 30mg, 50mg, 60mg, 80mg, 100mg	2	Max. 2 caps/daily	* Quantity Limitations. * Quantity Limitations.
morphine sulfate ER	2	Max. 2 caps/daily	* Quantity Limitations. * Quantity Limitations.
MS Contin	4	Max. 3 tabs/daily	* Quantity Limitations. * Quantity Limitations.
MSIR	4		
Norco	4		
Nucynta	3		
Nucynta ER	3	Max. 60 tabs/30-day supply	* Quantity Limitations. * Quantity Limitations.
Opana	4		
Opana ER	4	Max. 90 tabs/30-day supply	* Quantity Limitations. * Quantity Limitations.
opium tincture	2		
Oxecta	4		
oxycodone	2		
oxycodone hcl er	2	Max. 4 tabs/day (inclusive of all strengths)	* Quantity Limitations. * Quantity Limitations.

DRUG NAME	TIER	LIMITATIONS	NOTES
oxycodone/acetaminophen	2		
oxycodone/acetaminophen 5mg-325mg	1		
oxycodone/aspirin	2		
oxycodone/ibuprofen	2		
Oxycontin	3	Max. 4 tabs/day (inclusive of all strengths)	* Quantity Limitations. * Quantity Limitations.
oxymorphone	2		
oxymorphone tab ER 12h	2	Max. 90 tabs/30 day-supply	* Quantity Limitations. * Quantity Limitations.
pentazocine/acetaminophen	2		
pentazocine/naloxone	2		
Percocet	4		
Percodan	4		
Reprexain	2		
Roxicet	2		
Roxicet 5mg-325mg	1		
Roxicodone	4		
Subsys	4	Max. 120 sprays/30-day supply	* Quantity Limitations. * Quantity Limitations.
Synalgos-DC	4		
tramadol	2		
tramadol ER	2		
tramadol hcl er	2		
Trezix	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Tylenol with Codeine	4		
Ultracet	4		
Ultram	4		
Ultram ER	4		
Vicodin	2		
Vicodin ES	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Vicodin HP	2		
Vicoprofen	4		
Xartemis XR	4	Max. 4 tabs/daily	* Quantity Limitations. * Quantity Limitations.
Xodol	4		
Zamicet	4		
Zohydro ER	4	Max. 60 tabs/30-day supply	* Prior authorization required. * Quantity Limitations. * Prior authorization required. Quantity Limitations.
ANTI-EMETICS			
5HT-3 Antagonists			
Anzemet	4	50mg: Max. 6 tabs/copay; 100mg: Max. 3 tabs/copay	* Quantity Limitations. * Quantity Limitations.
granisetron	2	Max. 6 tabs/copay	* Quantity Limitations.
Granisol	2	Max. 30mL/copay	* Quantity Limitations.
ondansetron	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay; 4mg/5mL: Max. 100mL (2 bottles)/copay	* Quantity Limitations. * Quantity Limitations.
ondansetron ODT	2	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Quantity Limitations. * Quantity Limitations.
Sancuso	4	4 patches/copay	* Quantity Limitations.
Zofran	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay; 24mg: Max. 3 tabs/copay, 4mg/5mL: Max. 100mL (2 bottles)/copay	* Quantity Limitations. * Quantity Limitations.
Zofran ODT	4	4mg: Max. 18 tabs/copay; 8mg: Max. 9 tabs/copay	* Quantity Limitations. * Quantity Limitations.
Zuplenz	4	4mg: Max. 18 films/copay; 8mg: Max. 9 films/copay	* Quantity Limitations. * Quantity Limitations.

Anti-Emetics, Fixed-Dose Combination

DRUG NAME	TIER	LIMITATIONS	NOTES
Akynzeo	4	Max. 1 cap/copay, Max. 3 caps/28 day-supply	* Not available through Mail Service. * Quantity Limitations.
Anti-Emetics, Other			
Cesamet	4	Max. 18 tabs/copay	* Not available through Mail Service. * Quantity Limitations. * Max. 30-day supply as required by state & federal law or benefit plan design.
Compazine	4		
Diclegis	4		
dronabinol	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Marinol	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
prochlorperazine	1		
prochlorperazine (suppository)	2		
promethazine	2		
Transderm-Scop	3	Max. 1 box (4 patches)/ copay	* Not available through Mail Service. * Quantity Limitations.
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. * Quantity Limitations.
Varubi	4	Max. 2 tabs/copay	* Quantity Limitations. * Quantity Limitations.
ANTI-INFLAMMATORY AGENTS			
Antirheumatic Agents			
Arava	4		
hydroxychloroquine	2		
Kineret	4		* Prior authorization required. * Sole Source Pharmacy:

DRUG NAME	TIER	LIMITATIONS	NOTES
			Omnicare/RX Crossroads, 866-547-0644
leflunomide	2		
Plaquenil	4		
Ridaura	4		

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		* Prior authorization required. * Prior authorization required.
EC-Naprosyn	4		
etodolac	2		
Feldene	4		
Flector	3		
flurbiprofen	2		
ibuprofen	2		
ibuprofen 100mg/5mL (suspension)	2		
Indocin	4		
Indocin Rectal Suppository	3		
indomethacin	2		
ketoprofen	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
ketoprofen 50mg caps	1		
ketorolac, oral	2	Max. 5-days supply / 20 tabs per fill	* Not available through Mail Service. * Quantity Limitations.
meclofenamate	2		
mefenamic acid	2		
meloxicam	1		
misoprostol/diclofenac	2		
Mobic	4		
Motrin	4		
nabumetone	2		
Nalfon	4		
Naprelan	4		
Naprosyn	4		
naproxen	1		
naproxen 550mg	2		
NAPROXEN SODIUM 275 MG TAB	1		
naproxen sodium 550mg	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. * Quantity Limitations.
Sulfamylon	4		
sulindac	2		
Tivorbex	4		
tolmetin	2		
Vimovo	4		* Prior authorization required. * Prior authorization required.
Voltaren	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Voltaren Gel	4		
Voltaren XR	4		
Zipsor	4		
Zorvolex	3		
ANTIBACTERIALS			
Antibacterials, Other			
Cayston	4		* Not available through Mail Service. * Sole source through: IV Solutions 1-800-658-6046
Cleocin	4		
clindamycin	2		
Dapsone	2		
Flagyl	4		
Flagyl ER	4		
Furadantin	4		
Hiprex	4		
linezolid	2		
Lithostat	4		
Macrobid	4		
Macrodantin	4		
methenamine hippurate	2		
metronidazole tabs	2		
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. * Quantity Limitations. *
trimethoprim	2		
Vancocin	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
vancomycin	2		
Vandazole	4		
Xifaxan 200mg	4	Max. 9 tabs/copay	* Not available through Mail Service. * Quantity Limitations.
Xifaxan 550mg	3		
Zyvox	4		
Cephalosporins			
Cedax (capsule)	4		
Cedax (suspension)	4		
cefaclor	2		
cefadroxil	2		
cefdinir	2		
cefditoren pivoxil	2		
cefixime	2		
cefpodoxime	2		
cefprozil	2		
ceftibuten	2		
Ceftin (suspension)	4		
Ceftin (tablet)	4		
cefuroxime axetil	2		
cephalexin	2		
Keflex	4		
Spectracef	4		
Suprax	4		
Macrolides			
azithromycin	2		
Biaxin	4		
Biaxin XL	4		
clarithromycin	2		
Dificid	3	Max. 20 tabs/10-day supply, one fill per 30 days	* Not available through Mail Service. * Quantity Limitations.

DRUG NAME	TIER	LIMITATIONS	NOTES
Ery-Tab	2		
Ery-Tab 333mg	3		
Eryped	3		
erythromycin base, filmtab	2		
erythromycin ethylsuccinate	2		
erythromycin ethylsuccinate 200mg suspension	2		
erythromycin ethylsuccinate/ sulfisoxazole	2		
Ketek	4		
PCE	4		
Zithromax Tabs/Susp/Tri-Pack/Z-Pack	4		

Penicillins

amoxicillin	1		
amoxicillin (chewable)	2		
amoxicillin 200mg/5mL (suspension)	2		
amoxicillin 500mg (tablet)	2		
amoxicillin trihydrate ER	2		
amoxicillin trihydrate/clavulanic acid ES 600mg (suspension)	2		
amoxicillin trihydrate/clavulanic acid suspension	2		
amoxicillin trihydrate/clavulanic acid tabs	2		
amoxicillin trihydrate/clavulanic acid tabs XR	2		
ampicillin	2		
Augmentin (suspension)	4		
Augmentin (tablets)	4		
Augmentin 125-31.25mg (suspension)	3		

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

Quinolones

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

Sulfonamides

Bactrim	4		
Bactrim DS	4		
Septra	4		
Septra DS	4		
trimethoprim/sulfamethoxazole	1		
trimethoprim/sulfamethoxazole DS	1		

Tetracyclines

DRUG NAME	TIER	LIMITATIONS	NOTES
Acticlate	4		
Adoxa	4		
Benoxyldoxy	4		
demeclocycline	2		
Doryx	4		
doxycycline hyclate	2		
doxycycline hyclate 20mg & 75mg	2		
doxycycline hyclate 50mg & 100mg	2		
doxycycline monohydrate	2		
doxycycline monohydrate 40mg	2		
Dynacin	4		
Minocin	4		
minocycline	2		
Monodox	4		
Ocudox	4		
Oracea	4		
Periostat	4		
Solodyn	4		* Prior authorization required. * Prior authorization required
tetracycline	1		
Vibramycin	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	* Prior authorization required.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
valproic acid	2		

Glutamate Reducing Agents

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

Sodium Channel Inhibitors

Aptiom	4		
Banzel	3		
carbamazepine	2		
carbamazepine ER	2		
Carbatrol	4		
Dilantin	4		
Dilantin Infatab	4		
Equetro	4		
oxcarbazepine	2		
oxcarbazepine suspension	2		
Oxtellar XR	4		
Peganone	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Phenytek	4		
phenytoin	2		
phenytoin sodium ER	2		
phenytoin tab chew	2		
Tegretol	4		
Tegretol XR	4		
Trileptal	4		
Trileptal Suspension	4		
ANTIDEMENTIA			
Antidementia Agents, Other			
Ergoloid	2		
Namzaric	4		
Cholinesterase Inhibitors			
Aricept	4		
Aricept ODT	4		
donepezil	2		
donepezil ODT	2		
Exelon	4		
Exelon Patch	4		
galantamine	2		
galantamine ER	2		
Razadyne	4		
Razadyne ER	4		
rivastigmine	2		
rivastigmine patch	2		
Glutamate Pathway Modifiers			
memantine	2		
Namenda	4		
Namenda XR	4		
ANTIDEPRESSANTS			

DRUG NAME	TIER	LIMITATIONS	NOTES
Antidepressants, Other			
Aplenzin	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
budeprion SR	2		
budeprion XL	2		
bupropion	2		
bupropion SR	2		
bupropion XL	2		
Forfivo XL	3		
maprotiline	2		
mirtazapine	2		
mirtazapine 15mg	1		
nefazodone	2		
olanzapine/fluoxetine	2		
Oleptro ER	4		
Remeron	4		
Symbyax	4		
trazodone	1		
trazodone 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Wellbutrin SR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Wellbutrin XL	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over
Monoamine Oxidase Inhibitors			
EMSAM	4		
Marplan	4		
Nardil	4		
Parnate	4		
phenelzine	2		
tranylcypromine	2		
Serotonin/Norepinephrine Reuptake Inhibitors			
Brintellix	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Celexa	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
citalopram hydrobromide tabs	1		
Cymbalta	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.
desvenlafaxine ER	2		
desvenlafaxine ER	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
desvenlafaxine fumarate ER	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy for members 18 years and over.
duloxetine	2		
duloxetine hcl 40mg	2		
Effexor XR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
escitalopram	2		
Fetzima	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
fluoxetine	1		
fluoxetine (oral solution)	2		
fluoxetine 20mg (tablet)	2		
fluoxetine 40mg (capsule)	2		
Fluoxetine 60mg tabs	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.
fluoxetine 90mg (weekly)	2		
fluvoxamine	2		
fluvoxamine er 24h	2		
Irenka	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Khedezla	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Lexapro	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Luvox CR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
paroxetine	2		
Paxil	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * Step Therapy: For members 18 and over.
Paxil (liquid)	3		
Paxil CR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug

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

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

Tricyclics

amitriptyline	1		
Anafranil	4		
clomipramine	2		
desipramine	2		
doxepin	2		
doxepin 10mg/mL (oral concentrate)	2		
doxepin 150mg (capsule)	2		
imipramine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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. * Quantity Limitations.
Chemet	3		
Epipen	3	Max. 2 units/copay	* Not available through Mail Service. * Quantity Limitations.
Epipen Jr.	3	Max. 2 units/copay	* Not available through Mail Service. * Quantity Limitations.
Evzio	4	Max. 2 units/copay; Max.4 units/30-day supply	* Not available through Mail Service. * Quantity Limitations.
Exjade	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Ferriprox	4		* Sole source through Centric Health. 866-758-7071
Jadenu	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Kayexalate	4		
leucovorin	2		
Mesnex	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Naloxone HCl syringe	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Available at a retail pharmacy.
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	* Quantity Limitations. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
buprenorphine	2		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
buprenorphine/naloxone	2		* Max. 30-day supply as required by state & federal law or benefit plan design
Campral calcium	4		
disulfiram	2		
naltrexone	2		
Revia	4		
Suboxone Film	3		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Subutex	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Vivitrol	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.

DRUG NAME	TIER	LIMITATIONS	NOTES
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. * Quantity Limitations.
bupropion, smoking cessation	2	Annual Limit: Max. 360 tabs/180-day supply	* Not available through Mail Service. * Quantity Limitations.
Chantix	3	Annual limit of 26 weeks	* Not available through Mail Service. * Quantity Limitations.
Nicotrol Inhaler	4	Max. 168 units/fill; Limit 180-day supply per year	* Not available through Mail Service. * Quantity Limitations. * Not available through Mail Service. Quantity Limitations.
Nicotrol NS	4	Max. 4 units/fill; Limit 180 day-supply per year	* Not available through Mail Service. * Quantity Limitations. * Not available through Mail Service. Quantity Limitations.
Zyban	4	Max. 60 tabs/fill; Max 360 tabs/year	* Not available through Mail Service. * Quantity Limitations.
ANTIFUNGALS			
Antifungals - Oral			
Ancobon	4		
clotrimazole (troche)	2		
Cresemba	4		* Not available through Mail Service.
Diflucan	4		
fluconazole	1		
flucytosine	2		
Grifulvin V	4		
Gris-Peg	4		
griseofulvin	2		
griseofulvin ultramicro	2		
itraconazole	2	Max. 168 caps/year	* Prior authorization required. * Not available through Mail

DRUG NAME	TIER	LIMITATIONS	NOTES
			Service. * Quantity Limitations. * Prior authorization required
ketoconazole	2		
Lamisil	4	Max. 28 tabs/fill; Max. 84 tabs/year	* Not available through Mail Service. * Quantity Limitations.
Lamisil Granules	4	Max. 28 packets/fill; Max. 84 packets/year	* Not available through Mail Service. * Quantity Limitations.
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	* Prior authorization required. * Not available through Mail Service. * Quantity Limitations. * Prior authorization required.
Oravig	4		
Sporanox	4	Max. 168 caps/year	* Prior authorization required. * Not available through Mail Service. * Quantity Limitations. * Prior authorization required.
Sporanox (solution)	4		
terbinafine	2	Max. 28 tabs/fill, Max. 84 tabs/year	* Not available through Mail Service. * Quantity Limitations.
Vfend	4		
voriconazole	2		
ANTIGOUT			
Antigout Agents			
allopurinol	1		
colchicine (capsule)	2		
colchicine (tablet)	2		
Colcrys	4		
Mitigare	4		
probenecid	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
probenecid/colchicine	2		
Uloric	3		
Zyloprim	4		
ANTIMIGRAINE AGENTS			
Abortive			
almotriptan malate	2	6.25mg: Max. 12 tabs/copay; 12.5mg: Max. 6 tabs/copay	* Not available through Mail Service. * Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Alsuma	4	Max. 6 injections/copay	* Not available through Mail Service. * Quantity Limitations.
Amerge	4	1mg: Max. 15 tabs/copay; 2.5mg: Max. 6 tabs/copay	* Not available through Mail Service. * Quantity Limitations. * 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. * Quantity Limitations. * 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. * Quantity Limitations. * 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.
Imitrex (injection)	4	Max. 3 boxes (6 inj)/copay	* Not available through Mail Service. * Quantity Limitations.
Imitrex (nasal spray)	4	Max. 6 sprays/copay	* Not available through Mail Service. * Quantity Limitations.
Imitrex (tablets)	4	25mg: Max. 24 tabs/copay; 50mg: Max. 12 tabs/copay, 100mg: Max. 6 tabs/copay	* Not available through Mail Service. * Quantity Limitations. * 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. * Quantity Limitations. * 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. * Quantity Limitations. * 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. * Quantity Limitations.
Relpax	3	20mg: Max. 12 tabs/copay; 40mg: Max. 6 tabs/copay	* Not available through Mail Service. * Quantity Limitations.
rizatriptan	2	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	* Not available through Mail Service. * Quantity Limitations.
rizatriptan; oral-disintegrating tablet	2	5mg: Max. 18 tabs/copay; 10mg: Max. 9 tabs/copay	* Not available through Mail Service. * Quantity Limitations.

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

Antimigraine, Other

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Arimidex	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Aromasin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
bicalutamide	2		
Bosulif	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
capecitabine	2		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Caprelsa	4		* Not available through Mail Service.
Casodex	4		
CEENU	4		
Cometriq	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
Costellic	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
cyclophosphamide	2		
cyclophosphamide capsules (Roxane)	3		
Emcyt	3		
Erivedge	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
etoposide	2		
exemestane	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * This medication may be eligible for a $0 co-pay under certain benefit plans.
Fareston	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * This medication may be eligible for a $0 co-pay under certain benefit plans.
Farydak	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Femara	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
flutamide	2		
Gilotrif	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Gleevec	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Gleostine	4		
Hexalen	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
Hycamtin	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.
Hydrea	4		
hydroxyurea	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.
Ibrance	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Imbruvica	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
Inlyta	4		* This medication is eligible for a $0 co-pay under certain benefit plans. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service. This medication is eligible for a $0 co-pay under certain benefit plans.
Iressa	4		* This medication may be eligible for a $0 co-pay under certain benefit plans.
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.

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Temodar	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
temozolomide	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Thioguanine	3		
Tykerb	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Votrient	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Xalkori	4	Max. 60 caps/30-day supply	* Quantity Limitations. * Covered through Specialty Pharmacy Program. Use Accredo. * This medication may be eligible for a $0 co-pay under certain benefit plans.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Zydelig	4		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Zykadia	4		* Covered through Specialty Pharmacy Program. Must 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. * Quantity Limitations.
Daraprim	3		
Malarone	4		
mefloquine	2		
Mepron	4		
paromomycin	2		
Primaquine	4		

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
aripiprazole	2		
aripiprazole ODT	2		
clozapine	2		* Not available through Mail Service.
clozapine ODT	2		
Clozaril	4		* Not available through Mail Service.
Fanapt	4		
Fazaclo	4		* Not available through Mail Service.
Geodon	4		
Invega	4		
Invega Sustenna	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Latuda	3		
olanzapine	2		
olanzapine ODT	2		* Covered through Specialty Pharmacy Program. Must use Accredo.
paliperidone ER	2		
quetiapine	2		
Rexulti	4	Max. 30 tabs/30-day supply	* Quantity Limitations. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Risperdal	4		
Risperdal Consta	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
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.
Genvoya	4		
Isentress	3		
Prezcobix	4		
Selzentry	3		
Stribild	4		
Tivicay	4		
Truvada	3		
Tybost	4		
Viread	3		
Vitekta	4		
Anti-HIV, NNRTI			
Edurant	4		
Intelence	4		
nevirapine	2		
nevirapine ER 400mg	2		
Rescriptor	3		
Sustiva	3		
Viramune	4		
Viramune XR	4		
Viramune XR 400mg	4		
Anti-HIV, NRTI			

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
Invirase	3		
Kaletra	3		
Lexiva	3		
Norvir	3		
Prezista	3		
Reyataz	3		
Viracept	3		

Anti-Influenza Agents

amantadine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Flumadine	4		
Relenza	4	Max. 1 package per fill	* Quantity Limitations.
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. * Quantity Limitations.
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. * Quantity Limitations.
valacyclovir	2		
Valtrex	4		
Xerese	4		
Zovirax	4		
Zovirax (Cream)	4		
Zovirax (ointment)	4		
Zovirax (Suspension)	4		
Antivirals, Other			
adefovir	2		
Baraclude (tablet)	4		
Copegus	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
ribavirin	2		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Sovaldi	3	Max. 28 tabs/28-day supply	* Prior authorization required. * Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required. Not available through Mail Service.
Technivie	4	Max. 56 tabs/28-day supply	* Prior authorization required. * Quantity Limitations. * 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.	* Prior authorization required. * Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
CMV Agents			
ganciclovir	2		
Valcyte	4		
valganciclovir	2		
ANXIOLYTICS			
Anxiolytics, Other			
buspirone	2		
buspirone 5mg tab	1		
meprobamate	2		
Benzodiazepines			
alprazolam	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
alprazolam (rapid dissolve tablet)	2		
alprazolam ER	2		
alprazolam Intensol	4		
Ativan	4		
chlordiazepoxide	1		
chlordiazepoxide/amitriptyline	2		
clonazepam	1		
clonazepam (rapid dissolve)	2		
clorazepate	2		
Diastat Acudial 5-7, 5-10mg	3		
Diastat Acudial, 12.5mg, 15mg, 20mg	4		
diazepam	1		
diazepam (solution) (concentrate)	2		
diazepam rectal gel 12.5mg, 15mg, 20mg	2		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
BIPOLAR AGENTS			
Bipolar Agents			
Eskalith	4		
lithium carbonate	2		
lithium carbonate SR	2		
lithium citrate	2		
Lithobid	4		
BLOOD GLUCOSE REGULATORS			
Alpha Glucosidase Inhibitors			
acarbose	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glyset	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Precose	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Amylinomimetics			
SymlinPen	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Antiglycemic agent, Misc			

DRUG NAME	TIER	LIMITATIONS	NOTES
Cycloset	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Korlym	4		* Covered through Specialty Pharmacy Program. Must use Centric Health Resource.
Biguanides			
Fortamet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glucophage	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glucophage XR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Glumetza	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metformin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
metformin ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Riomet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
DPP-4 inhibitor			
Januvia	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nesina	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Onglyza	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be

DRUG NAME	TIER	LIMITATIONS	NOTES
			subject to your plan deductible. Applicable copayment will apply.
Tradjenta	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fixed-Dose Combination Agents			
Actoplus Met	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Actoplus Met XR	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avandamet	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avandaryl	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Duetact	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Jentadueto	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Kazano	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Kombiglyze XR	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Oseni	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone/glimepiride	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pioglitazone/metformin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			is not tried, prior authorization is required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Insulins			
Afrezza	4	4 & 8 unit single strength kits, Max. 180 cartridges/30-day supply. 4 & 8 unit combo product, Max. 450 cartridges/30-day supply.	* Prior authorization required. * Not available through Mail Service. * Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required.
Apidra	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humalog	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humalog Mix	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Humulin 70/30	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			subject to your plan deductible. Applicable copayment will apply.
Meglitinides			
nateglinide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prandin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
repaglinide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Starlix	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
SGLT2 Inhibitors			
Farxiga	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Invokana	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

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

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Must use Accredo.
Jantoven	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lovenox	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Accredo.
Pradaxa	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Savaysa	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
warfarin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Xarelto	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Antihemophilia			
Advate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alphanate	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alphanine SD	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Alprolix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Benefix	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
			* Covered through Specialty Pharmacy Program. Must use 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 Accredo or Caremark. * Not available through Mail Service.
Hemofil-M	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Humate-P	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * Not available through Mail Service.
Ixinity	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Caremark.
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.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			* Covered through Specialty Pharmacy Program. Must use Accredo or Caremark. * 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			
Aranesp	4	Max. 4 vials or syringes/fill	* Prior authorization required. * Quantity Limitations. * Covered through Specialty Pharmacy Program. Use Accredo or

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
dipyridamole/aspirin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Durlaza	4		* Prior authorization required. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Effient	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Plavix	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Pletal	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ticlopidine	2		* HSA Preventive drug. If your plan includes the Preventive Drug

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

DRUG NAME	TIER	LIMITATIONS	NOTES
enalapril	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Epaned	4		
fosinopril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
lisinopril	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lotensin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Mavik	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
moexipril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Monopril	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
perindopril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prinivil	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
quinapril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
ramipril 5mg, 10mg	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
trandolapril	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Univasc	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vasotec	4		* HSA Preventive drug. If your plan includes the Preventive Drug

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
doxazosin mesylate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
doxazosin mesylate 1mg	2		
doxazosin mesylate 2mg	2		
Minipress	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
phenoxybenzamine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
prazosin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
terazosin	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
terazosin 10mg	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered

DRUG NAME	TIER	LIMITATIONS	NOTES
			preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Angiotensin II Receptor Antagonists			
Atacand	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avapro	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Benicar	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
candesartan	2		
Cozaar	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Diovan	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Edarbi	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

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

Anti-Arrhythmics

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Beta Adrenergic Blocking Agents			
acebutolol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
atenolol	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
betaxolol, oral	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
bisoprolol fumarate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Bystolic	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
carvedilol	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Coreg	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
labetalol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Levatol	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lopressor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metoprolol succinate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
metoprolol tartrate	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nadolol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
pindolol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
propranolol	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
propranolol (oral solution)	2		
propranolol 24hr SA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
propranolol 60mg	2		
Sectral	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tenormin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Toprol XL	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Trandate	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
diltiazem 24hr ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem CD	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
diltiazem SR	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
felodipine ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
isradipine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Matzim LA	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nicardipine	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
verapamil ER PM	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
verapamil SR	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Verelan	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Verelan PM	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cardiovascular, Other			
Corlanor	4	Max. 60 tabs/30-day supply	* Prior authorization required. * Quantity Limitations. * Prior authorization required.
digoxin	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
digoxin (solution)	3		
eplerenone	2		* HSA Preventive drug. If your plan includes the Preventive Drug

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
acetazolamide capsule ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Aldactazide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Aldactone	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amiloride	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
amiloride/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
bumetanide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
chlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
chlorthalidone	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Demadex	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Diamox Sequels	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dyazide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dyrenium	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Edecrin	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
furosemide	1		* HSA Preventive drug. If your plan includes the Preventive Drug

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Microzide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Naturetin-5	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
spironolactone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
spironolactone/ hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
torsemide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
triamterene/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
triamterene/hydrochlorothiazide 50mg-25mg	2		

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
gemfibrozil	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lipofen	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
LoFibra	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lopid	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
TriCor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Triglide	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Trilipix	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Prevalite	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Questran	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Questran Light	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Repatha	3		* Prior authorization required. * Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Walgreens Specialty Pharmacy. * Not available through Mail Service. Prior authorization required.
Vascepa	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Vytorin	4	Max. 30 tabs/30-day supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Welchol (tablets)	3		* HSA Preventive drug. If your plan includes the Preventive Drug

DRUG NAME	TIER	LIMITATIONS	NOTES
			Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Welchol Powder Pack	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Zetia	3	Max. 30 tabs/30-day supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Dyslipidemics, Statins			
Altoprev	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
atorvastatin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Crestor	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
fluvastatin	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

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

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

Fixed-Dose Combination Agents - Cardiovascular

Accuretic	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Advicor	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs

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

DRUG NAME	TIER	LIMITATIONS	NOTES
atenolol/chlorthalidone	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Avalide	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Azor	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
benazepril/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Benicar HCT	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
bisoprolol/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Caduet	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			will not be subject to your plan deductible. Applicable copayment will apply.
moexipril/hydrochlorothiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
nadolol-bendroflumethiazide	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prestalia	4	Max. 30 tabs/30-day supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Simcor	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tarka	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tekamlo	3	150mg/5mg & 150mg/10mg: Max. 45 tabs/30 days; 300mg/5mg & 300mg/10mg: Max. 30 tabs/30 days	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

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

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

Renin Inhibitor, Direct

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
cevimeline	2		
clonidine ER	2		
Evoxac	4		
guanfacine ER	2		
Horizant	4		
Intuniv	4		
Kapvay	4		
Nuedexta	3		
Rilutek	4		
riluzole	2		
tetrabenazine	2		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Xenazine	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Xyrem	4		* 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			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 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,

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			through mail service and Maine pharmacies.
Focalin XR 25mg, 35mg	3		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Metadate CD	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Metadate ER	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Methylin	2		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, max 60-day supply allowed through mail service and Maine pharmacies.
Methylin (chew tab)	4		* Used for the treatment of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Narcolepsy, 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. * Quantity Limitations. * Prior authorization required.
Nuvigil	3	Max. 30 tabs/30-day supply	* Prior authorization required. * Quantity Limitations. * Prior authorization required
Provigil	4	Max. 30 tabs/30-day supply	* Prior authorization required. * Quantity Limitations. * 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.

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Benzamycin	4		* Not available through Mail Service.
Claravis	2		* Not available through Mail Service.
Cleocin T	4		
Clindacin Pac	4		
clindamycin phosphate	2		
clindamycin phosphate 1% foam	2		
clindamycin/benzoyl peroxide	2		* Not available through Mail Service.
Differin	4	Prior authorization required for members 30 and older	* Prior authorization required. * Quantity Limitations.
Duac	4		* Not available through Mail Service.
Epiduo	4	Prior authorization required for members 30 and older	* Prior authorization required. * Quantity Limitations.
Epiduo Forte	4	Prior authorization required for members 30 and over.	* Prior authorization required.
Erygel	4		
erythromycin/benzoyl peroxide	2		* Not available through Mail Service.
Evoclin	4		
Fabior	4	Prior authorization required for members 30 and older	* Prior authorization required.
Finacea	3		
Finacea (foam)	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.
Plexion (cleanser)	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
sulfacetamide sodium/sulfur 10%-2% cream	2		
sulfacetamide sodium/sulfur 10%-5% cream	2		
sulfacetamide sodium/sulfur 9.8%-4.8% (cleanser)	2		
sulfacetamide topical lotion	2		
Tazorac	4	Prior authorization required for members 30 and older	* Prior authorization required.
Veltin	4	Prior authorization required for members 30 and older	* Prior authorization required.
Zenatane	2		
Ziana	4	Prior authorization required for members 30 and older	* Prior authorization required. * Quantity Limitations.

Antipruritics

Alevicyn	4		

Corticosteroids - High Potency

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

Corticosteroids - Low Potency

alclometasone dipropionate	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		

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.

DRUG NAME	TIER	LIMITATIONS	NOTES
imiquimod	2		
Protopic	4		* Prior authorization required.
tacrolimus topical	2		* Prior authorization required. * Prior authorization required.
Zyclara	4		* Not available through Mail Service.
Dermatological, Antifungals			
Ciclodan	4		* Prior authorization required. * Not available through Mail Service. * Prior authorization required
ciclopirox	2		
ciclopirox (gel)	2		
ciclopirox (shampoo)	2		
ciclopirox 8.0% (solution)	2		* Prior authorization required. * Not available through Mail Service. * Prior authorization required
econazole nitrate	2		
Ecoza	4		
Ertaczo	4		
Exelderm	4		
Extina	4		
Jublia	4		* Prior authorization required. * Not available through Mail Service. * Prior authorization required.
Kerydin	4		* Prior authorization required. * Not available through Mail Service. * Prior authorization required.
ketoconazole cream	2		
ketoconazole shampoo	2		
Ketodan	4		
Loprox Shampoo	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Luzu	4		
Mentax	3		
naftifine	2		
Naftin	4		
Nizoral Shampoo 2%	4		
Oxistat	4		
Penlac	4		* Prior authorization required. * Not available through Mail Service. * Prior authorization required
Vusion	4		
Xolegel	4		
Dermatological, Misc.			
bexarotene	2		* Not available through Mail Service. * This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Bionect	4		
Carac	4		
Drysol	NC		* This drug is not covered. * This drug is not covered.
Efudex	4		
Fluoroplex	4		
fluorouracil cream	2		
Mirvaso	4		
Picato	3		* Not available through Mail Service.
Valchlor	4	Max 1 tube (60 gram)/30 days	* Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Vectical	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
lidocaine	2		
lidocaine patch	2		
lidocaine/prilocaine	2		
Lidoderm	4		
Regenecare	4		
Xylocaine Jelly	4		
Mitotic Inhibitors			
calcipotriene	2		
calcipotriene solution	2		
Dovonex	4		
Dovonex Solution	4		
selenium sulfide	2		
Selseb	4		
Sorilux	4		
Photochemotherapy Agents			
8-MOP	4		
methoxsalen	2		
Oxsoralen-Ultra	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Retinoids			
acitretin	2		
Atralin	4	Prior authorization required for members 30 and older	* Prior authorization required.
Avita	2	Prior authorization required for members 30 and older	* Prior authorization required.
Dermapak Plus	4		* Prior authorization required.
Panretin	4		* Not available through Mail Service.
Retin-A	4	Prior authorization required for members 30 and older	* Prior authorization required. * Quantity Limitations.
Retin-A Micro	4	Prior authorization required for members 30 and older	* Prior authorization required. * Quantity Limitations.
Soriatane	4		
Tretin-X	4	Prior authorization required for members 30 and older	* Prior authorization required.
tretinoin topical gel	2	Prior authorization required for members 30 and older	* Prior authorization required.
tretinoin, microspheres topical	2	Prior authorization required for members 30 and older	* Prior authorization required.
tretinoin, topical	2	Prior authorization required for members 30 and older	* Prior authorization required.
Topical, Anorectal Agents			
Anusol HC Cream	4		
Anusol HC Suppositories	3		
Cortifoam	4		
Epifoam	4		
hydrocortisone 1% (cream/ ointment)	1		
hydrocortisone 2.5% (cream/ ointment)	1		
Pramosone	3		
Procto-Pak 1% (cream)	1		
Proctofoam HC	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
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		
MB Hydrogel	2		
Neosalus Cream	4		
Neosalus Foam	4		
Nuvail	4		
Prutect	2		
Regranex	4	Annual limit 90 days; Max. 1 tube/30-day supply	* Not available through Mail Service. * Quantity Limitations.
Santyl	3		
Silvadene	4		
silver sulfadiazine AF cream	2		
Silvrstat	4		
Sonafine	4		
SSD Cream	4		* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
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 Accredo.
Aralast NP	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Berinert	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Buphenyl	4		
Carbaglu	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Cerdelga	3		* Covered through Specialty Pharmacy Program. Must use Accredo or Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Cerezyme	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Cinryze	Medical	Max. 20 vials/30-day supply	* Prior authorization required. * Covered under medical benefit. No pharmacy copayment applies. * Quantity Limitations. * 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 Accredo.
Elelyso	Medical		* Covered under medical benefit. No pharmacy copayment applies. * 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 Accredo.
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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Ravicti	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
sodium phenylbutyrate	2		
Strensiq	4		
Vpriv	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo.
Zavesca	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Zemaira	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. *
Enzymes, Pancreatic			
Creon	3		
Pancreaze	3		
Pancrelipase 5,000	2		
Pertzye	4		
Sucraid	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Ultresa	4		
Viokace	4		
Zenpep	3		
Zenpep 5K-17K-27K	4		
GASTROINTESTINAL DRUGS			
Antispasmodics			

DRUG NAME	TIER	LIMITATIONS	NOTES
Bentyl	4		
Cantil	4		
chlordiazepoxide/clidinium	2		
dicyclomine	2		
Librax	4		
methscopolamine bromide	2		
Pamine	4		
Gastrointestinal Agents, Other			
Actigall	4		
Chenodal	4		* Not available through Mail Service. * Sole source through Centric Health.
Cholbam	4		
CoLyte	4		
CoLyte with Flavor Packs	4		
cromolyn	2		
Cuvposa	4		* Available through Diplomat Pharmacy only 1.-877-977-9118
diphenoxylate/atropine	2		
Enulose	2		
Fulyzaq	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Gastrocrom	4		
Gavilyte-G	2		
Gavilyte-H and Bisacodyl	2		
Generlac	2		
Glycate	4		
glycopyrrolate	2		
Go-Lytely	4		
Kristalose	3		

DRUG NAME	TIER	LIMITATIONS	NOTES
lactulose	2		
lansoprazole/clarithromycin/ amoxicillin kit	2		
Lomotil	4		
metoclopramide	1		
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		
Seebri Neohaler	4		
Suclear	4		
Suprep	4		
Trilyte	2		
Urso	4		
ursodiol	2		

H2 Antagonists

Axid	4		
cimetidine	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
famotidine	1		
nizatidine	2		
Pepcid	4		
ranitidine (tablets)	2		
Tagamet	4		
Zantac	4		

Inflammatory Bowel Disease Agents

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

Irritable Bowel Syndrome Agents

alosetron	2	Covered for females only	
Amitiza	3		
Linzess	3		

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Detrol LA	4		
Ditropan XL	4		
Enablex	4		
flavoxate	2		
Gelnique	4	Max. 30 packets/30-day supply	* Quantity Limitations.
Gelnique Pump	4	Max. 1 pump bottle/30-day supply	* Quantity Limitations.
Myrbetriq	3		
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	* Quantity Limitations.
Avodart	4		
dutasteride	2		
finasteride 1mg	NC		* This drug is not covered.
finasteride 5mg	2		
Flomax	4		
Jalyn	3		
Proscar	4		
Rapaflo	4		
tamsulosin	2		
Uroxatral	4	Max. 30 tabs/30-day supply	* Quantity Limitations.

Erectile Dysfunction

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

Genitourinary Agents, Other

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
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	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Kariva	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Mircette	4		
Contraceptives, Other			
Implanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo or Magellan Health (formerly known as ICORE). *
Natazia	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
Nexplanon	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service. This medication is eligible for a $0 co-pay under certain benefit plans.
Emergency Contraceptive Agents			
Ella	$0	Max. 1 tab/copay	* Not available through Mail Service. * Quantity Limitations. * This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
My Way	2	Max. 1 unit/copay	* Not available through Mail Service. * Quantity Limitations. * 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. * Quantity Limitations. * 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. * Quantity Limitations. * 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. * Quantity Limitations. *

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			for a $0 co-pay under certain benefit plans.
Beyaz	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Brevicon	2		
Camrese	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Camrese lo	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
Cyclafem 1/35	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Desogen	4		
Emoquette	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 30 - desogestrel 0.15	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 35 - norethindrone 1	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.

DRUG NAME	TIER	LIMITATIONS	NOTES
ethinyl estradiol 35 – norgestimate 0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Femcon FE	4		
Generess FE	4		
Gianvi	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Jolessa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * Packaged as a 3 month supply. This medication is eligible for a $0 co-pay under certain benefit plans.
Junel 1/20	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Junel Fe	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Lessina	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Levlen	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Modicon	4		
Mononessa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Nordette	4		
Norinyl 1/35	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Norinyl 1/50	4		
Nortrel 0.5/35, 1/35, 7-7-7	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
NuvaRing	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ocella	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ogestrel	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ortho Cyclen	4		
Ortho Evra	4		
Ortho-Cept	4		
Ortho-Novum	4		
Ovcon -35	4		

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Xulane	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Yasmin	4		
Yaz	4		
Zarah	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Zeosa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Zovia	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Progestin Only			
Camila	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Errin	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Nor-QD	4		
Nora-Be	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible

DRUG NAME	TIER	LIMITATIONS	NOTES
			for a $0 co-pay under certain benefit plans.
norethindrone 0.35 mg	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Triphasic			
Aranelle	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Cyclafem 7-7-7	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Cyclessa	4		
Enpresse	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Estrostep FE	4		
ethinyl estradiol 25 - norgestimate 0.18/0.215/0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 35 - norethindrone 0.5/0.75/1	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
ethinyl estradiol 35 – norgestimate 0.18 / 0.215 / 0.25	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible

DRUG NAME	TIER	LIMITATIONS	NOTES
			for a $0 co-pay under certain benefit plans.
Necon	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Ortho Tri Cyclen	4		
Ortho Tri-Cyclen LO	4		
Ortho-Novum 7-7-7	4		
Tilia FE	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Estarylla	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Legest FE	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Linyah	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Norinyl	4		
Tri-Previfem	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Tri-Sprintec	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible

DRUG NAME	TIER	LIMITATIONS	NOTES
			for a $0 co-pay under certain benefit plans.
Trinessa	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Trivora	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
Velivet	$0		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
HORMONAL (FERTILITY AGENTS)			
Fertility Agents			
Bravelle	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Cetrotide	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
chorionic gonadotropin	4		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
clomiphene citrate	2		

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

DRUG NAME	TIER	LIMITATIONS	NOTES
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	4	5mg, 30mg, 150: Max. 1 tab/28-day supply; 35mg: Max. 4 tabs/28-day supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
alendronate solution	2	75ml oral solution bottle: 4 bottles/28 day supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
zoledronic acid	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
zoledronic acid	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE).
Calcimimetics			
Sensipar	4		* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.
Calcium Regulating Hormones			
calcitonin-salmon nasal spray	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Fortical	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Miacalcin	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

DRUG NAME	TIER	LIMITATIONS	NOTES
Parathyroid Hormone Analog			
Forteo	3	Max. 1 syringe/28-day supply	* Prior authorization required. * Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Covered through Specialty Pharmacy Program. Use Magellan Health (formerly known as ICORE).
Natpara	4	Max. 2 cartridges/28-day supply	* Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Selective Estrogen Receptor Modulators			
Evista	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
raloxifene	2		* This medication is eligible for a $0 co-pay under certain benefit plans. * This medication is eligible for a $0 co-pay under certain benefit plans.
HORMONAL (PITUITARY)			
Gonadotropin-releasing Hormone Analogs			
Eligard	4		* Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Lupaneta Pack	4		* Not available through Mail Service.

DRUG NAME	TIER	LIMITATIONS	NOTES
Supprelin LA	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Synarel	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Vantas	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through Mail Service.
Growth Hormone Analogs			
Egrifta	4		* Prior authorization required. * 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		* Prior authorization required. * Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through mail service
Genotropin MiniQuick	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			requiredNot available through mail service
Humatrope	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through mail service
Norditropin Flexpro/Nordiflex	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization requiredNot available through Mail Service.
Nutropin	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
Nutropin AQ	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
Nutropin AQ NuSpin	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
Omnitrope	2		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Saizen	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Use Accredo. * Prior authorization

DRUG NAME	TIER	LIMITATIONS	NOTES
			requiredNot available through Mail Service
Serostim	3		* Prior authorization required. * Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service
Zorbtive	4		* Prior authorization required. * 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		* Prior authorization required. * Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Increlex	3		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.Not available through Mail Service.
Lupron Depot/Lupron-Pedi	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.
octreotide	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty

DRUG NAME	TIER	LIMITATIONS	NOTES
			Pharmacy Program. Must use Magellan Health (formerly known as ICORE).
Samsca	4		* Not available through Mail Service.
Sandostatin/LAR	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.
Signifor	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service
Signifor LAR	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo.
Somatuline Depot	3		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Somavert	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Stimate	3		
HORMONAL (SEX HORMONES)			
Androgens			
Anadrol-50	4		* Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Androderm	3	Prior authorization required for members 18 and older. 2mg: Max. 60 patches/30-day supply 	* Prior authorization required. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.

DRUG NAME	TIER	LIMITATIONS	NOTES
		4mg: Max. 30 patches/30-day supply	
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	* Prior authorization required. * Quantity Limitations. * 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	* Prior authorization required. * Quantity Limitations. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Android	4		* Max. 30-day supply as required by state & federal law or benefit plan design
Axiron	3	90mL metered-dose pump: Max. 2/30 day-supply	* Prior authorization required. * Quantity Limitations. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design. Prior authorization required for members 18 and older.
danazol	2		
Depo-Testosterone	4	Prior authorization required for members 18 and older. 1mL vial: Max. 4 vials/30 day-supply 10mL vial: Max. 1 vial/30 day-supply	* Prior authorization required. * Quantity Limitations. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Fortesta	4	Prior authorization required for members 18 and older. Max. 2 pumps/30-day supply	* Prior authorization required. * Quantity Limitations. * Mail Service: Max. 30-day supply as

DRUG NAME	TIER	LIMITATIONS	NOTES
			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.
methyltestosterone	2		* 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	* Prior authorization required. * Quantity Limitations. * 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	* Prior authorization required. * Quantity Limitations. * 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	* Prior authorization required. * Quantity Limitations. * Mail Service: Max. 30-day supply as required by state & federal law or benefit plan design.
Testone CIK	4	Prior authorization required for members 18 and older. Max. 4 l ml vials/30-day supply.	* Prior authorization required. * Quantity Limitations. * 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	* Prior authorization required. * Quantity Limitations. * 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	* Prior authorization required. * Quantity Limitations. * Mail

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Activella	4		
Climara Pro	3		
Combipatch	3		
ethinyl estradiol/norethindrone acetate	2		
FemHRT	4		
Jinteli	2		
Mimvey	2		
Premphase	3		
Prempro	3		
Estrogens			
Alora	4		
Angeliq	4		
Cenestin	3		
Climara	4		
Divigel	3		
Elestrin	4		
Enjuvia	3		
Estrace	4		
Estrace (vaginal cream)	3		
estradiol	1		
estradiol (patch)	2		
Estring	3		* Packaged as a 90-day supply. Member pays 3 copayments at retail pharmacy.
Estrogel	4		
estropipate	2		
Evamist	4	Max. 1 bottle/copay	* Not available through Mail Service. * Quantity Limitations.
Femring	4		* Packaged as a 68-day supply. Member pays 3 copayments at retail pharmacy.
Femtrace	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Menest	4		
Menostar	4		
Minivelle patch	4		
Premarin	3		
Premarin (vaginal cream)	3		
Vagifem	3		
Vivelle-DOT	4		
Estrogens/SERM Combos			
Duavee	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Progestins			
Aygestin	4		
Crinone	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through Mail Service.
Endometrin	3		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy 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. * Not available through mail service.
medroxyprogesterone acetate (tablets)	1		

DRUG NAME	TIER	LIMITATIONS	NOTES
Micronor	4		
norethindrone acetate	2		* This medication is eligible for a $0 co-pay under certain benefit plans.
progesterone	2		
Progesterone In Oil [brand name]	4		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
progesterone in oil [generic]	2		* Covered through IVF Program. Must use Freedom Drug or Village Pharmacy or Walgreens Specialty Pharmacy for coverage. * Not available through mail service.
Prometrium	4		
Provera	4		
HORMONAL (THYROID AGENTS)			
Thyroid Agents			
Armour Thyroid	4		
Cytomel	4		
Levothroid	2		
levothyroxine	1		
Levoxyl	2		
liothyronine	2		
methimazole	2		
propylthiouracil	2		
Synthroid	3		
Tapazole	4		
Thyrolar	4		
Tirosint	4		
Unithroid	2		
IMMUNOLOGIC AGENTS			

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Immunomodulators			
Actimmune	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Aubagio	4	Max. 28 tabs/28 day-supply	* Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Avonex	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Betaseron	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Copaxone 20mg	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Copaxone 40mg	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Extavia	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Gilenya	3	Max. 28 caps/28 day supply	* Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo.
Glatopa 20mg	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Intron-A	3		* Covered through Specialty Pharmacy Program. Use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through mail service.
Peg-Intron	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Pegasys	3		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Plegridy	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Pomalyst	4		* Not available through Mail Service. * Covered through Specialty Pharmacy Program. Must use Accredo.
Rebif	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through mail service.
Rebif Rebi-Dose	4		* Covered through Specialty Pharmacy Program. Use Accredo. * Not available through Mail Service.
Revlimid	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Stelara	Medical		* Prior authorization required. * 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.

DRUG NAME	TIER	LIMITATIONS	NOTES
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	* Prior authorization required. * Not available through Mail Service. * Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
Astagraf XL	4		
Azasan	3		
azathioprine	2		
CellCept	4		
Cuprimine	3		
cyclosporine	2		
cyclosporine micro-emulsion	2		
Depen	4		
Envarsus XR	4		
Gengraf	2		
Hecoria	3		
Imuran	4		
methotrexate	2		
mycophenolate	2		
mycophenolate mofetil suspension	2		

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

Immunosuppressants, TNF Inhibitors

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

Vaccines/Serums

Micrhogam Ultra-Filtered Plus	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use

DRUG NAME	TIER	LIMITATIONS	NOTES
			Accredo. * Not available through Mail Service.
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. * May be dispensed at a retail pharmacy.
MEDICAL SUPPLIES			
Glucose Test Strips			
Accu-Chek Active Strips	4	204 test strips/30-day supply	* Prior authorization required. * Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization required. FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
Accu-Chek Aviva Plus	4	204 test strips/30-day supply	* Prior authorization required. * Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply. * Prior authorization

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

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

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products.
True Metrix BG Test Strips	4	Max. 204 strips/30-day supply	* Prior authorization required. * Quantity Limitations. * FreeStyle and Precision test strips; and FreeStyle Freedom, FreeStyle Lite, FreeStyle Insulinx and Precision Xtra meters are Harvard Pilgrim's preferred Diabetes care products. Prior authorization required. Quantity Limitations.
Insulin Delivery Systems			
V-Go	4	Max. 30 units/30 day supply	* Quantity Limitations.
Needles and Syringes			
BD Micro-Fine Insulin Syringe	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
BD Ultra-Fine Insulin Syringe	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
BD Ultra-Fine Pen Needles	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Lancets	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

DRUG NAME	TIER	LIMITATIONS	NOTES
			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		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	1		
timolol XE (ophthalmic gel)	2		
Timoptic	4		
Timoptic-XE	4		
Trusopt	4		

Ophthalmic Anti-Allergy

Alocril	4		
Alomide	4		
azelastine, ophthalmic	2		
Bepreve	4		
Elestat	4		
Emadine	4		
epinastine	2		
Lastacaft	4		
Optivar	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Pataday	3		
Patanol	3		
Pazeo	4		

Ophthalmic Anti-Inflammatory

Acular/LS	4		
Acuvail	4	Max. 30 units/30-day supply * Quantity Limitations.	
Alrex	4		
Blephamide	3		
bromfenac	2		
Decadron (ophthalmic)	4		
dexamethasone (ophthalmic)	2		
diclofenac (ophthalmic)	2		
Durezol	4		
Flarex	4		
fluorometholone, ophthalmic	2		
flurbiprofen, ophthalmic	2		
FML	4		
Ilevro	4		
ketorolac tromethamine	2		
Lotemax	3		
Maxidex	4		
neomycin-polymixin-hc	2		
neomycin-polymyxin-dexamethasone	2		
Ocufen	4		
Omnipred	4		
Pred Forte	4		
Pred Mild	3		
prednisolone acetate	2		
Prolensa	4		
Vexol	4		

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Tobrex (ointment)	3		
Vigamox	4		
Zylet	3		
Zymaxid	4		
Ophthalmic Antivirals			
trifluridine	2		
Viroptic	4		
Zirgan	4		
Ophthalmic Lubricating Agents			
Lacrisert	3		
Ophthalmic Prostaglandins			
bimatoprost 0.03%	2		
latanoprost	2		
Lumigan 0.01%	3		
Rescula	4		
Travatan Z	3		
travoprost	2		
Xalatan	4		
Zioptan	4		
Ophthalmic, Other			
Alcaine	2		
Cystaran	4		* Sole source pharmacy. Members must use Walgreens Specialty Pharmacy. CYSTARAN Hotline: 1-877-534-9627
Eylea	Medical		* Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
I-Lid	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
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	* Quantity Limitations.
tetracaine	2		
OTIC			
Otic Agents			
Acetasol HC	2		
Cetraxal	4		
Cipro HC	4		
Ciprodex	3		
Coly-Mycin S	4		
Dermotic (drops)	4		
Floxin Otic	4		
neomycin-polymyxin-hydrocortisone	2		
ofloxacin, otic	2		
Vosol HC	4		
RESPIRATORY AGENTS			
Antihistamines			
Astelin	4		
Astepro	4		
azelastine	2		
azelastine, nasal	2		
cetirizine oral solution	2		
Clarinex	4		
Clarinex D 24hr	4		
Clarinex Reditab	4		

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

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

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

Bronchodilators, Anticholinergic

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Spiriva	3	Max. 1 unit (30 blisters)/30-day supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Spiriva Respimat	3	Max. 1 inhaler/30 day-supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Stiolto Respimat	4	Max. 1 unit/30-day supply	* Quantity Limitations.
Tudorza Pressair	3	Max. 1 unit/30 day-supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Utibron Neohaler	4	Max. 1 unit (60 blisters)/30-day supply	* Quantity Limitations. * Quantity Limitations.
Bronchodilators, Sympathomimetics			
albuterol	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
albuterol 2mg & 4mg (tablet)	1		
albuterol 2mg/5mL (syrup)	1		
albuterol sulfate ER	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.

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

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

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Pulmicort Flexhaler	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Pulmicort Respule	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
QVAR	3		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Symbicort	3	Max. 1 inhaler(120 doses)/30-day supply	* Quantity Limitations. * HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Mast-Cell Stabilizers			
cromolyn sodium	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Nasal Inhalers			
Atrovent Nasal	4		
Beconase AQ	4		
budesonide aqueous, nasal	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Children's QNASL	4		
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	* Prior authorization required. * Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization required.
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.

DRUG NAME	TIER	LIMITATIONS	NOTES
Orenitram ER	4		* Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through Mail Service.
Revatio	4		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo. * Prior authorization requiredNot available through Mail Service
sildenafil (PAH)	2		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo.
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	3	Max.270 caps/30 day-supply	* Not available through Mail Service. * Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo.
Hyper-Sal	4		

DRUG NAME	TIER	LIMITATIONS	NOTES
Kalydeco	3		* Prior authorization required. * Covered through Specialty Pharmacy Program. Must use Accredo. * Not available through mail service.
Kitabis Pak	4		* Kitabis Pak includes nebulizer.
Nebusal	4		
Ofev	3	Max. 60 caps/30 day-supply	* Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Accredo or Walgreens Specialty Pharmacy. *
Orkambi	4	Max. 112 tabs/28 days	* Prior authorization required. * Not available through Mail Service. * Quantity Limitations. * Prior authorization required. 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.
tobramycin/nebulizer	2		
Tyzine	4		
Xolair	Medical		* Prior authorization required. * Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * Not available through mail service.

DRUG NAME	TIER	LIMITATIONS	NOTES
SEDATIVES and HYPNOTICS			
Sedative and Hypnotic Agents			
Ambien	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Ambien CR	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Belsomra	4	Max. 1 tab/daily	* Quantity Limitations. * 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	* Prior authorization required. * Not available through Mail Service. * Quantity Limitations. * 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

DRUG NAME	TIER	LIMITATIONS	NOTES
			coverage begins. If first level drug is not tried, prior authorization is required.
Rozerem	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
Silenor	4		* Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
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	* Quantity Limitations. * Step Therapy: First level drug treatment required before coverage begins. If first level drug is not tried, prior authorization is required.
SKELETAL MUSCLE RELAXANTS			
Skeletal Muscle Relaxant Agents			
Amrix	4		
baclofen	2		
carisoprodol	2		
carisoprodol with aspirin	2		
chlorzoxazone	1		
cyclobenzaprine 5mg, 10mg	1		
cyclobenzaprine 7.5mg	2		

DRUG NAME	TIER	LIMITATIONS	NOTES
Dantrium	4		
dantrolene	2		
Fexmid	4		
Lorzone	4		
metaxalone	2		
methocarbamol	2		
orphenadrine citrate	2		
orphenadrine citrate/aspirin/ caffeine	2		
Robaxin	4		
Skelaxin	4		
Soma	4		
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		

DRUG NAME	TIER	LIMITATIONS	NOTES
sodium citrate/citric acid	2		
Urocit-K	4		
zinc sulfate	2		
Prenatal Vitamins			
Bal-Care DHA Essential	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Cadeau DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal DHA 27	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal Harmony	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Citranatal Rx	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Concept DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan

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

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
Prenaissance Balance	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenaissance Next	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenaissance Next-B	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenaplus 27mg-1mg	1		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenatabs FA 29mg-1mg	1		
Prenatal 1 Plus 1 27mg-1mg	1		
Prenatal Low Iron 27mg-1mg	1		
Prenatal MTR 27mg-1mg	1		
Prenatal Plus	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Prenatal Plus 27mg-1mg	1		
Prenatal Rx 1 60mg-1mg	1		
Prenatal Z 65mg-1mg	1		
Prenate Chewable	4		

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			deductible. Applicable copayment will apply.
Rovin-A DHA	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Select-OB	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Strovite One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
TL Folate	2		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tricare	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Tricare Prenatal DHA One	4		* HSA Preventive drug. If your plan includes the Preventive Drug Benefit, covered preventive drugs will not be subject to your plan deductible. Applicable copayment will apply.
Trinate 28mg-1mg	2		

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

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

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

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

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

DRUG NAME	TIER	LIMITATIONS	NOTES
			Magellan Health (formerly known as ICORE).
Brisdelle	4		
Dysport	Medical		* Prior authorization required. * Covered under medical benefit. No pharmacy copayment applies. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE).
Grastek	4	Max. 30 tabs/30-day supply	* Not available through Mail Service. * Quantity Limitations.
Keveyis	4		* Covered through Specialty Pharmacy Program. Must use Diplomat Pharmacy.
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	* Prior authorization required. * Covered under medical benefit. No pharmacy copayment applies. * Quantity Limitations. * Covered through Specialty Pharmacy Program. Must use Magellan Health (formerly known as ICORE). * 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.

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

Weight Loss Agents

Adipex-P	NC		* This drug is not covered.

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