



Select Health Medicare | 2027

Formulary

LIST OF COVERED DRUGS

This formulary was updated on 01/01/2027 .

For more recent information or other questions, please contact Select Health Member Services at **855-442-9900** (TTY users should call **711**), during the following dates and times:

October 1 to March 31:

Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.

April 1 to September 30:

Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday.

Outside these hours of operation, please leave a message. Your call will be returned within one business day, or visit selecthealth.org/medicare.

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Select Health Medicare 2027 Formulary List of Covered Drugs

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE
COVER IN THIS PLAN.**

For more recent information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call **800-442-9900 (TTY 711)** or consult the online pharmacy directory at **selecthealth.org/medicare/pharmacy**.

HPMS Approved Formulary File Submission ID 27009 Version 13

Notice of Nondiscrimination

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, veteran status, and/or any other characteristic protected by applicable federal or state law.

We provide free:

- Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).
- Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call:

- Select Health Member Services: **1-800-538-5038 (TTY: 711)**
- Select Health Medicare Member Services: **1-855-442-9900 (TTY: 711)**
- Select Health Medicaid Member Services: **1-855-442-3234 (TTY: 711)**
- Select Health FEHB Member Services: **1-844-345-3342 (TTY: 711)**

If you feel you've been treated unfairly, you can reach the Select Health 504/Civil Rights Coordinator by:

Phone: **1-844-208-9012 (TTY Users: 711)**;
Compliance Hotline: **1-800-442-4845**

Mail: Select Health (Attn: Civil Rights Coordinator)
5381 South Green Street
Murray, UT 84123

Email: **ContactCompliance@imail.org**

You may also contact the Office for Civil Rights at:

Online: **ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

Phone: **1-800-368-1019**; TTY Users: **1-800-537-7697**

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F,
HHH Building, Washington, D.C. 20201

HHS complaint forms are available at:
hhs.gov/ocr/complaints/index.html

This notice is available at: **selecthealth.org/
disclaimers/non-discrimination**

Notice of Availability

ATTENTION: We provide free language assistance services. We also offer free auxiliary aids and services when needed. Call **1-800-538-5038 (TTY Users: 711)**.

ATENCIÓN: Ofrecemos servicios gratuitos de asistencia con el idioma. También brindamos servicios y ayudas auxiliares gratuitos cuando los necesite. Llame a Select Health.

注意：我們提供免費的語言協助服務。如有需要，我們也免費提供輔助工具及服務。請致電 Select Health。

CHÚ Ý: Chúng tôi cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Chúng tôi cũng cung cấp miễn phí các phương tiện và dịch vụ hỗ trợ bổ sung khi cần. Gọi Select Health.

알림: 저희는 무료 언어 지원 서비스와 필요한 경우 무료 보조 장비 및 서비스를 제공하고 있습니다. Select Health로 전화해 주십시오.

ध्यान दिनुहोस्: हामी भाषासम्बन्धी सहायता सेवा निःशुल्क रूपमा प्रदान गर्छौं। आवश्यक परेमा निःशुल्क सहायक सामग्री तथा सेवाहरू पनि उपलब्ध गराउँछौं। Select Health मा फोन गर्नुहोस्।

PAUNAWA: Nagbibigay kami ng mga serbisyo ng tulong sa wika nang walang bayad. Nag-aalok din kami ng mga karagdagang tulong at serbisyo (auxiliary aids) nang walang bayad kung kinakailangan. Tumawag sa Select Health.

ACHTUNG: Wir bieten kostenlose Sprachunterstützung an. Bei Bedarf stellen wir Ihnen auch kostenlose Hilfsmittel und Dienstleistungen zur Verfügung. Rufen Sie Select Health an.

ВНИМАНИЕ. Мы предоставляем бесплатные услуги языковой поддержки. При необходимости мы также предлагаем бесплатные вспомогательные средства и услуги. Позвоните в Select Health.

ATTENTION: Nous fournissons des services d'assistance linguistique gratuits. Nous offrons également des aides et services auxiliaires gratuits en cas de besoin. Appelez Select Health.

注意事項：無料の言語支援サービスを提供しています。また、必要に応じて無料の補助的手段やサービスも提供しています。Select Healthまでお電話ください。

ማሳሰቢያ: ነጻ የቋንቋ ድጋፍ አገልግሎቶች እና ቀርባላን፡፡ እንዲሁም አስፈላጊ ሲሆን ነጻ የተገባበት መርጃ መሣሪያዎችን እና አገልግሎቶችን እና ቀርባላን፡፡ ወደ Select Health ይደውሉ፡፡

ПАЖНЬА: Ако говорите српски, биће вам доступне бесплатне услуге језичке подршке. Такође пружамо бесплатна помоћна средства и услуге када су потребни. Контактирајте Select Health.

تنبيه: نقدم خدمات المساعدة اللغوية مجاناً. كما نوفر وسائل وخدمات مساعدة مجانية عند الحاجة. يُرجى الاتصال بـ Select Health.

توجه: ما خدمات رایگان کمک زبانی ارائه می‌کنیم. همچنین، در صورت نیاز، خدمات و تجهیزات کمکی رایگان ارائه می‌دهیم. با Select Health تماس بگیرید.

โปรดทราบ: เราให้บริการช่วยเหลือด้านภาษาฟรี นอกจากนี้ เรายังมีบริการและอุปกรณ์ช่วยเหลือเพิ่มเติมฟรีเมื่อจำเป็น โทรติดต่อ Select Health

Select Health: **1-800-538-5038 (TTY Users: 711)**

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (formulary) refers to “we,” “us,” or “our,” it means Select Health. When it refers to “plan” or “our plan,” it means Select Health Medicare.

This document includes the Drug List (formulary) for our plan which is current as of October 1, 2026. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2027, and from time to time during the year.

What is the Select Health Medicare Formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by Select Health in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Select Health will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Select Health Medicare network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your ***Evidence of Coverage***.

Can the formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: selecthealth.org/medicare/pharmacy.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Select Health Medicare formulary?”

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a new generic drug to replace a brand-name drug currently on the formulary, or add a new biosimilar to replace an original biological product currently on the formulary, or add new restrictions or move a drug we are keeping on the formulary to a higher cost-sharing tier or both after we add a corresponding drug. We may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least **30 days** before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 60-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Select Health Medicare formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2027 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2027 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year

about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of October 1, 2026. To get updated information about the drugs covered by Select Health Medicare, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes throughout the plan year, Select Health may make changes via errata sheets mailed to you. Additionally, you may visit selecthealth.org/medicare for a link to the errata sheet.

How do I use the formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on **page 1**. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, Cardiovascular Drugs/Hypotensive Agents. If you know what your drug is used for, look for the category name in the list that begins on **page 135**. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on **page 135**. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Select Health Medicare covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

For discussion of drug types, please see the **Evidence of Coverage**, Chapter 1 Section 3.4, “The ‘Drug List’ tells which Part D drugs are covered.”

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Select Health requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Select Health before you fill your prescriptions. If you don’t get approval, Select Health may not cover the drug.
- **Quantity Limits:** For certain drugs, Select Health limits the amount of the drug that Select Health will cover. For example, Select Health provides 60 tablets per prescription for lovastatin. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Select Health requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Select Health may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Select Health will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on **page 1**. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Select Health to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Select Health Medicare formulary?” on **page IX** for information about how to request an exception.

What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Select Health pays for certain OTC drugs through your Select Health Medicare Benefits Mastercard® Prepaid Card (Flex Card). Please see your **Evidence of Coverage** for additional details on your OTC drug coverage. The cost to Select Health of these OTC drugs will not count toward your total Part D drug costs.

What if my drug is not on the formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that Select Health Medicare does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Select Health Medicare. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Select Health Medicare.
- You can ask Select Health to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Select Health Medicare formulary?

You can ask Select Health to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Select Health limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Select Health will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or formulary exception, including an exception to a coverage restriction. ***When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.*** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to

a maximum 30-day supply of medication. If coverage is not approved, after your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you experience a change in your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary or if your ability to get your drugs is limited, we will cover a one-time temporary supply for up to 30 days (or 31 days if you are a long-term care resident) when you use a network pharmacy. During this period, you should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

For more information

For more detailed information about your Select Health Medicare prescription drug coverage, please review your **Evidence of Coverage** and other plan materials.

If you have questions about Select Health, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at **1-800-MEDICARE (1-800-633-4227)** 24 hours a day/7 days a week. TTY users should call **1-877-486-2048**. Or visit **www.medicare.gov**.

Select Health Medicare formulary

The formulary that begins on **page 1** provides coverage information about the drugs covered by Select Health Medicare. If you have trouble finding your drug in the list, turn to the Index that begins on **page 1**.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ADVAIR) and generic drugs are listed in lower-case italics (e.g., *simvastatin*).

The second column of the chart lists the Drug Tier. The Drug Tier column lets you know the type of copayment or coinsurance you will be responsible for at the pharmacy.

The information in the **Requirements/Limits** column tells you if Select Health has any special requirements for coverage of your drug.

PA – We require you or your physician to get prior authorization for certain drugs before you fill your prescriptions.

QL – We limit the amount of the drug covered in a specific time period.

ST – We require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

LA – This drug requires special handling or has special dispensing requirements. This prescription may be available only at certain pharmacies. For more information, consult your **Provider and Pharmacy Directory** or call Member Services toll-free at **855-442-9900**. TTY users should call **711**.

NM – This drug is not available through our mail order pharmacy.

HI – This prescription drug is covered under our medical benefit. For more information, call Member Services at **855-442-9900**, Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m. TTY users should call **711**.

BvsD – This drug may be covered under the Part B or Part D Medicare benefit.

Please refer to your **Evidence of Coverage** for more information regarding how much you will pay for your prescription drugs. The tables below tell you the annual deductible and copayment/coinsurance amount for drugs in each tier by service area/plan name.

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ANALGESICS		
ANALGESICS COMBINATIONS		
<i>acetaminophen-codeine (300-15 mg tab, 300-30 mg tab, 300-60 mg tab)</i>	3	QL (390 PER 30 DAYS), (Excluded from Auto Extension)
<i>ascomp-codeine 50-325-40-30 mg cap</i>	3	QL (180 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>bac (butalbital-acetamin-caff) 50-325-40 mg tab</i>	3	QL (60 PER 30 DAYS), NM (Non- Mail Order)
<i>butalbital-apap-caff-cod (50-300-40-30 mg cap, 50-325-40-30 mg cap)</i>	3	QL (60 PER 30 DAYS), NM (Non- Mail Order), (Excluded from Auto Extension)
<i>butalbital-apap-caffeine (50-300-40 mg cap, 50-325-40 mg cap, 50-325-40 mg tab)</i>	3	QL (60 PER 30 DAYS), NM (Non- Mail Order)
<i>butalbital-asa-caff-codeine 50-325-40-30 mg cap</i>	3	QL (60 PER 30 DAYS), NM (Non- Mail Order), (Excluded from Auto Extension)
<i>butalbital-aspirin-caffeine 50-325-40 mg cap</i>	3	QL (60 PER 30 DAYS), NM (Non- Mail Order)
<i>hydrocodone-acetaminophen (5-325 mg tab, 7.5-325 mg tab, 10-325 mg tab)</i>	3	QL (240 PER 30 DAYS), (Excluded from Auto Extension)
HYDROCODONE-ACETAMINOPHEN 2.5-325 MG TAB	3	QL (240 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>oxycodone-acetaminophen (2.5-325 mg tab, 5- 325 mg tab, 7.5-325 mg tab, 10-325 mg tab)</i>	3	QL (180 PER 30 DAYS), (Excluded from Auto Extension)
<i>tramadol-acetaminophen 37.5-325 mg tab</i>	3	QL (120 PER 30 DAYS), (Excluded from Auto Extension)
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
<i>cataflam 50 mg tab</i>	2	
<i>celecoxib (50 mg cap, 100 mg cap, 200 mg cap, 400 mg cap)</i>	2	
<i>diclofenac potassium 50 mg tab</i>	2	

PA: Prior authorization, QL: Quantity Limitations, ST: Step Therapy

LA: Limited Access, HI: Home Infusion, NM: Non-Mail Order

BvD: This drug may be covered under Part B or Part D

You can find information on what the symbols and abbreviations on this table
mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>diclofenac sodium (25 mg tab dr, 50 mg tab dr, 75 mg tab dr)</i>	2	
<i>diclofenac sodium 1.5 % solution</i>	3	QL (450 PER 30 DAYS)
<i>diclofenac sodium 3 % gel</i>	3	
<i>diclofenac sodium er 100 mg tab 24h</i>	2	
<i>diflunisal 500 mg tab</i>	2	QL (90 PER 30 DAYS)
<i>etodolac (200 mg cap, 300 mg cap, 400 mg tab, 500 mg tab)</i>	2	
<i>etodolac er (er 400 mg tab er, er 500 mg tab er)</i>	2	QL (60 PER 30 DAYS)
<i>etodolac er 600 mg tab 24h</i>	2	QL (30 PER 30 DAYS)
<i>fenoprofen calcium (fenoprofen calcium 400 mg cap, fenoprofen calcium 400 mg cap)</i>	2	
<i>flurbiprofen (flurbiprofen 100 mg tab, flurbiprofen 100 mg tab)</i>	2	
<i>ibu (600 mg tab, 800 mg tab)</i>	2	
<i>ibuprofen (400 mg tab, 600 mg tab, 800 mg tab)</i>	2	
<i>indomethacin (25 mg cap, 50 mg cap)</i>	2	
MECLOFENAMATE SODIUM 100 MG CAP	2	QL (120 PER 30 DAYS)
MECLOFENAMATE SODIUM 50 MG CAP	2	QL (240 PER 30 DAYS)
<i>meloxicam (7.5 mg tab, 15 mg tab)</i>	2	
<i>nabumetone (500 mg tab, 750 mg tab)</i>	2	
<i>naproxen (125 mg/5ml suspension, 250 mg tab, 375 mg tab, 500 mg tab)</i>	2	
<i>naproxen sodium (275 mg tab, 550 mg tab)</i>	2	
<i>piroxicam (10 mg cap, 20 mg cap)</i>	2	
<i>sulindac (150 mg tab, 200 mg tab)</i>	2	

PA: Prior authorization, QL: Quantity Limitations, ST: Step Therapy

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BvD: This drug may be covered under Part B or Part D

You can find information on what the symbols and abbreviations on this table mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
OPIOID ANALGESICS		
<i>buprenorphine (5 mcg/hr patch wk, 7.5 mcg/hr patch wk, 10 mcg/hr patch wk, 15 mcg/hr patch wk, 20 mcg/hr patch wk)</i>	3	QL (4 PER 28 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>fentanyl (12 mcg/hr patch, 25 mcg/hr patch, 50 mcg/hr patch, 75 mcg/hr patch, 100 mcg/hr patch)</i>	3	QL (10 PER 30 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)</i>	3	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>methadone hcl (5 mg tab, 10 mg tab)</i>	3	QL (90 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>morphine sulfate (morphine sulfate 30 mg tab, morphine sulfate 15 mg tab, morphine sulfate 30 mg tab, morphine sulfate 15 mg tab)</i>	3	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>morphine sulfate er (er 30 mg tab er, er 60 mg tab er, er 100 mg tab er, er 200 mg tab er)</i>	3	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>morphine sulfate er 15 mg tab</i>	3	QL (90 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>oxycodone hcl (5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)</i>	3	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>tramadol hcl 100 mg tab</i>	3	QL (120 PER 30 DAYS), (Excluded from Auto Extension)
<i>tramadol hcl 50 mg tab</i>	3	QL (240 PER 30 DAYS), (Excluded from Auto Extension)
<i>tramadol hcl er 100 mg tab 24h</i>	3	QL (120 PER 30 DAYS), (Excluded from Auto Extension)
<i>tramadol hcl er 200 mg tab 24h</i>	3	QL (60 PER 30 DAYS), (Excluded from Auto Extension)
<i>tramadol hcl er 300 mg tab 24h</i>	3	QL (30 PER 30 DAYS), (Excluded from Auto Extension)

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You can find information on what the symbols and abbreviations on this table mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
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ANESTHETICS

LOCAL ANESTHETICS

AGONEAZE 2.5-2.5 % KIT	3	
<i>lidocaine 5 % patch</i>	3	
<i>lidocaine-prilocaine 2.5-2.5 % cream</i>	3	
<i>lidocaine-prilocaine 2.5-2.5 % kit</i>	3	
<i>lidocan 5 % patch</i>	3	
LIVIXIL PAK 2.5-2.5 % KIT	3	
PRILOVIX 2.5-2.5 % KIT	3	
<i>prilovix lite 2.5-2.5 % kit</i>	3	
<i>prilovix lite plus 2.5-2.5 % kit</i>	3	
PRILOVIX PLUS 2.5-2.5 % KIT	3	
<i>prilovix ultralite 2.5-2.5 % kit</i>	3	
<i>prilovix ultralite plus 2.5-2.5 % kit</i>	3	

ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

<i>acamprosate calcium 333 mg tab dr</i>	3	
<i>buprenorphine hcl 2 mg sl tab</i>	3	QL (210 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>buprenorphine hcl 8 mg sl tab</i>	3	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>buprenorphine hcl-naloxone hcl (2-0.5 mg tab, 8-2 mg tab)</i>	2	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>buprenorphine hcl-naloxone hcl (2-0.5 mg, 4-1 mg, 8-2 mg, 12-3 mg)</i>	3	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>bupropion hcl er (smoking det) 150 mg tab 12h</i>	2	
<i>disulfiram (250 mg tab, 500 mg tab)</i>	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
KLOXXADO 8 MG/0.1ML LIQUID	3	QL (2 PER 30 OVER TIME)
<i>lofexidine hcl 0.18 mg tab</i>	5	PA, QL (224 PER 30 OVER TIME)
<i>naloxone hcl (naloxone hcl 2 mg/2ml soln prsyr, naloxone hcl 0.4 mg/ml soln cart, naloxone hcl 0.4 mg/ml solution, naloxone hcl 4 mg/10ml solution)</i>	2	
<i>naloxone hcl 0.4 mg/ml soln prsyr</i>	2	
<i>naltrexone hcl 50 mg tab</i>	2	
NICOTROL NS 10 MG/ML SOLUTION	4	PA, QL (360 PER 30 DAYS)
<i>varenicline tartrate (starter) 0.5 mg x 11 & 1 mg x 42 tab thpk</i>	3	
<i>varenicline tartrate 0.5 mg tab</i>	3	
<i>varenicline tartrate 1 mg tab</i>	3	
<i>varenicline tartrate(continue) 1 mg tab</i>	3	

ANTIBACTERIALS

<i>amikacin sulfate 500 mg/2ml solution</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>amoxicillin (125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml)</i>	2	(Excluded from Auto Extension)
<i>amoxicillin (amoxicillin 125 mg chew tab, amoxicillin 500 mg cap, amoxicillin 250 mg chew tab, amoxicillin 250 mg cap, amoxicillin 500 mg tab, amoxicillin 875 mg tab)</i>	2	(Excluded from Auto Extension)
<i>amoxicillin trihydrate 250 mg/5ml recon susp</i>	2	
<i>amoxicillin-pot clavulanate (200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml)</i>	2	(Excluded from Auto Extension)

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You can find information on what the symbols and abbreviations on this table mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>amoxicillin-pot clavulanate (amoxicillin-pot clavulanate 400-57 mg chew tab, amoxicillin-pot clavulanate 875-125 mg tab, amoxicillin-pot clavulanate 200-28.5 mg chew tab, amoxicillin-pot clavulanate 250-125 mg tab, amoxicillin-pot clavulanate 250-62.5 mg/5ml recon susp, amoxicillin-pot clavulanate 500-125 mg tab)</i>	2	(Excluded from Auto Extension)
<i>ampicillin 500 mg cap</i>	2	(Excluded from Auto Extension)
<i>ampicillin sodium (1 gm soln, 10 gm soln)</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>ampicillin sodium 2 gm recon soln</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>ampicillin-sulbactam sodium (1.5 (1-0.5) gm soln, 3 (2-1) gm soln, 15 (10-5) gm soln)</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
ARIKAYCE 590 MG/8.4ML SUSPENSION	5	QL (252 PER 30 DAYS), (Excluded from Auto Extension)
<i>azithromycin (100 mg/5ml, 200 mg/5ml)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>azithromycin (500 mg tab, 600 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>azithromycin 250 mg tab</i>	2	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>azithromycin 500 mg recon soln</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>aztreonam (1 gm soln, 2 gm soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
BAXDELA 300 MG RECON SOLN	5	QL (28 PER 14 DAYS), HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)

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You can find information on what the symbols and abbreviations on this table mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
BAXDELA 450 MG TAB	5	QL (28 PER 14 DAYS), NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
BICILLIN C-R 1200000 UNIT/2ML SUSPENSION	4	NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
BICILLIN C-R 900/300 900000-300000 UNIT/2ML SUSPENSION	4	NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
BICILLIN L-A (600000 UNIT/ML SUSP PRSYR, 1200000 UNIT/2ML SUSP PRSYR, 2400000 UNIT/4ML SUSP PRSYR)	4	NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
CAYSTON 75 MG RECON SOLN	5	PA, QL (280 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
CEFACLOR (250 MG CAP, 500 MG CAP)	2	NM (Non-Mail Order), (Excluded from Auto Extension)
CEFACLOR ER 500 MG TAB 12H	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>cefadroxil (cefadroxil 500 mg/5ml recon susp, cefadroxil 1 gm tab, cefadroxil 250 mg/5ml recon susp, cefadroxil 500 mg cap)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>cefazolin sodium (1 gm soln, 10 gm soln, 500 mg soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>cefdinir (125 mg/5ml, 250 mg/5ml)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>cefdinir 300 mg cap</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>cefepime hcl (1 gm soln, 2 gm soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>cefixime (cefixime 100 mg/5ml recon susp, cefixime 100 mg/5ml recon susp, cefixime 200 mg/5ml recon susp)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>cefixime 400 mg cap</i>	3	QL (60 PER 30 DAYS), (Excluded from Auto Extension)
<i>cefoxitin sodium (1 gm soln, 2 gm soln, 10 gm soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
CEFPODOXIME PROXETIL (CEFPODOXIME PROXETIL 200 MG TAB, CEFPODOXIME PROXETIL 50 MG/5ML RECON SUSP, CEFPODOXIME PROXETIL 100 MG TAB, CEFPODOXIME PROXETIL 100 MG/5ML RECON SUSP)	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>cefprozil (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>ceftaroline fosamil (400 mg soln, 600 mg soln)</i>	4	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
CEFTAZIDIME (CEFTAZIDIME 6 GM RECON SOLN, CEFTAZIDIME 1 GM RECON SOLN, CEFTAZIDIME 2 GM RECON SOLN)	2	HI, NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>ceftriaxone sodium (1 gm soln, 2 gm soln, 10 gm soln, 250 mg soln, 500 mg soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>cefuroxime axetil (250 mg tab, 500 mg tab)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>cefuroxime sodium (1.5 gm soln, 750 mg soln)</i>	3	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>cephalexin (125 mg/5ml, 250 mg/5ml)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>cephalexin (250 mg cap, 250 mg tab, 500 mg cap, 500 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>ciprofloxacin hcl (250 mg tab, 500 mg tab, 750 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>ciprofloxacin in d5w (ciprofloxacin in d5w 200 mg/100ml solution, ciprofloxacin in d5w 200 mg/100ml solution)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>clarithromycin (clarithromycin 250 mg/5ml recon susp, clarithromycin 250 mg tab, clarithromycin 500 mg tab, clarithromycin 125 mg/5ml recon susp)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>clarithromycin er 500 mg tab 24h</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>clindamycin hcl (75 mg cap, 150 mg cap, 300 mg cap)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>clindamycin palmitate hcl 75 mg/5ml recon soln</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>clindamycin phosphate (300 mg/2ml, 600 mg/4ml)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>clindamycin phosphate (9 gm/60ml, 900 mg/6ml)</i>	2	HI, NM (Non-Mail Order), (Excluded from Auto Extension)
<i>clindamycin phosphate in d5w (300 mg/50ml, 600 mg/50ml, 900 mg/50ml)</i>	2	HI, NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>colistimethate sodium (cba) 150 mg recon soln</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>dalbavancin hcl 500 mg recon soln</i>	4	HI
<i>daptomycin (daptomycin 350 mg recon soln, daptomycin 350 mg recon soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
DAPTOMYCIN 350 MG RECON SOLN	2	(Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>daptomycin 500 mg recon soln</i>	2	QL (150 PER 30 DAYS), HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
DAPTOMYCIN 500 MG RECON SOLN	2	(Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>dicloxacillin sodium (250 mg cap, 500 mg cap)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
DIFICID 40 MG/ML RECON SUSP	5	ST, QL (136 PER 10 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>doxy 100 mg recon soln</i>	4	HI, NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>doxycycline hyclate (50 mg cap, 100 mg cap, 100 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>doxycycline hyclate 100 mg recon soln</i>	4	HI, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>doxycycline hyclate 20 mg tab</i>	2	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>doxycycline monohydrate (25 mg/5ml recon susp, 50 mg cap, 50 mg tab, 75 mg tab, 100 mg cap, 100 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>ertapenem sodium 1 gm recon soln</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>erythrocin lactobionate (erythrocin lactobionate 500 mg recon soln, erythrocin lactobionate 500 mg recon soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>erythromycin base (250 mg tab, 500 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>erythromycin base (erythromycin base 500 mg tab dr, erythromycin base 250 mg cp dr part, erythromycin base 250 mg tab dr, erythromycin base 333 mg tab dr)</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>erythromycin ethylsuccinate 200 mg/5ml recon susp</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>erythromycin ethylsuccinate 400 mg/5ml recon susp</i>	2	(Excluded from Auto Extension)
<i>erythromycin lactobionate 500 mg recon soln</i>	2	(Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>fidaxomicin 200 mg tab</i>	5	ST, QL (20 PER 10 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
FIRVANQ 25 MG/ML RECON SOLN	3	QL (450 PER 30 DAYS), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
FIRVANQ 50 MG/ML RECON SOLN	3	QL (450 PER 30 DAYS), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>fosfomycin tromethamine 3 gm packet</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
GENTAMICIN IN SALINE (0.8-0.9 MG/ML-% SOLUTION, 1-0.9 MG/ML-% SOLUTION, 1.2-0.9 MG/ML-% SOLUTION, 1.6-0.9 MG/ML-% SOLUTION)	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>gentamicin sulfate 40 mg/ml solution</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>imipenem-cilastatin (imipenem-cilastatin 500 mg recon soln, imipenem-cilastatin 250 mg recon soln)</i>	4	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>levofloxacin in d5w (in 500 mg/100ml, in 750 mg/150ml)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>linezolid 100 mg/5ml recon susp</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>linezolid 600 mg tab</i>	3	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>linezolid 600 mg/300ml solution</i>	3	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>meropenem (1 gm soln, 500 mg soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>methenamine hippurate 1 gm tab</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>metronidazole (250 mg tab, 375 mg cap)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>metronidazole (metronidazole 500 mg/100ml solution, metronidazole 500 mg/100ml solution)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>metronidazole 500 mg tab</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>moxifloxacin hcl 400 mg tab</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
MOXIFLOXACIN HCL IN NAACL 400 MG/250ML SOLUTION	3	HI, NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>nafcillin sodium (1 gm soln, 2 gm soln, 10 gm soln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>neomycin sulfate 500 mg tab</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>nitrofurantoin (25 mg/5ml suspension, 50 mg/10ml suspension)</i>	3	PA, NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>nitrofurantoin macrocrystal (25 mg cap, 50 mg cap, 100 mg cap)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>nitrofurantoin monohyd macro 100 mg cap</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>ofloxacin (ofloxacin 400 mg tab, ofloxacin 400 mg tab)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
PENICILLIN G POT IN DEXTROSE (40000 UNIT/ML SOLUTION, 60000 UNIT/ML SOLUTION)	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>penicillin g potassium 20000000 unit recon soln</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
PENICILLIN G SODIUM 5000000 UNIT RECON SOLN	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>penicillin v potassium (penicillin v potassium 125 mg/5ml recon soln, penicillin v potassium 250 mg/5ml recon soln, penicillin v potassium 250 mg tab, penicillin v potassium 500 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>piperacillin sod-tazobactam so (2.25 (2-0.25) gm ln, 3-0.375 gm ln, 3.375 (3-0.375) gm ln, 4-0.5 gm ln, 4.5 (4-0.5) gm ln, 40.5 (36-4.5) gm ln)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>piperacillin sod-tazobactam so 13.5 (12-1.5) gm recon ln</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
SIVEXTRO 200 MG RECON SOLN	4	QL (6 PER 30 OVER TIME), HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
SIVEXTRO 200 MG TAB	4	QL (6 PER 30 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
STREPTOMYCIN SULFATE 1 GM RECON SOLN	2	BvD, NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>sulfadiazine 500 mg tab</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 800-160 mg/20ml suspension)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>sulfamethoxazole-trimethoprim (400-80 mg tab, 800-160 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>tetracycline hcl (250 mg cap, 500 mg cap)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>tigecycline 50 mg recon soln</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>tinidazole (250 mg tab, 500 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>tobramycin 300 mg/5ml nebu soln</i>	5	PA, NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>tobramycin sulfate (tobramycin sulfate 1.2 gm recon soln, tobramycin sulfate 1.2 gm/30ml solution, tobramycin sulfate 10 mg/ml solution, tobramycin sulfate 1.2 gm recon soln, tobramycin sulfate 80 mg/2ml solution)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>trimethoprim (trimethoprim 100 mg tab, trimethoprim 100 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>vancomycin hcl (1 gm soln, 10 gm soln, 750 mg soln)</i>	4	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>vancomycin hcl (125 mg cap, 250 mg cap)</i>	4	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>vancomycin hcl (50 mg/ml soln, 250 mg/5ml soln)</i>	4	QL (450 PER 30 DAYS), NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>vancomycin hcl 25 mg/ml recon soln</i>	4	QL (450 PER 30 DAYS), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)

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You can find information on what the symbols and abbreviations on this table mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>vancomycin hcl 500 mg recon soln</i>	4	HI, NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
VANCOMYCIN HCL 750 MG RECON SOLN	4	(Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
XIFAXAN 200 MG TAB	3	PA, QL (180 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
XIFAXAN 550 MG TAB	3	PA, QL (90 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)

ANTICONVULSANTS

<i>brivaracetam (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)</i>	5	ST, QL (60 PER 30 DAYS)
<i>brivaracetam 10 mg/ml solution</i>	5	ST, QL (600 PER 30 DAYS)
<i>carbamazepine (100 mg chew tab, 100 mg/5ml suspension, 200 mg tab)</i>	2	
CARBAMAZEPINE 200 MG CHEW TAB	3	QL (240 PER 30 DAYS)
<i>carbamazepine er (er 100 mg cap er, er 100 mg tab er, er 200 mg cap er, er 200 mg tab er, er 300 mg cap er, er 400 mg tab er)</i>	3	
<i>clobazam (10 mg tab, 20 mg tab)</i>	2	QL (60 PER 30 DAYS)
<i>clobazam 2.5 mg/ml suspension</i>	2	QL (480 PER 30 DAYS)
<i>clonazepam (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	2	QL (300 PER 30 DAYS)
<i>clonazepam (clonazepam 0.125 mg tab disp, clonazepam 0.5 mg tab disp, clonazepam 0.25 mg tab, clonazepam 0.25 mg tab disp, clonazepam 1 mg tab disp, clonazepam 2 mg tab disp)</i>	3	QL (300 PER 30 DAYS)
DIACOMIT (250 MG CAP, 250 MG PACKET, 500 MG CAP, 500 MG PACKET)	4	PA, LA, QL (300 PER 30 DAYS)
<i>diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
DILANTIN 100 MG CAP	4	QL (300 PER 30 DAYS)
DILANTIN 125 MG/5ML SUSPENSION	4	QL (750 PER 30 DAYS)
DILANTIN 30 MG CAP	4	
DILANTIN INFATABS 50 MG CHEW	4	QL (600 PER 30 DAYS)
DILANTIN-125 MG/5ML SUSPENSION	4	QL (750 PER 30 DAYS)
<i>divalproex sodium (125 mg cap dr, 125 mg tab dr, 250 mg tab dr, 500 mg tab dr)</i>	2	
<i>divalproex sodium er (er 250 mg tab er, er 500 mg tab er)</i>	2	
EPIDIOLEX 100 MG/ML SOLUTION	5	PA, QL (900 PER 30 DAYS)
EPRONTIA 25 MG/ML SOLUTION	4	QL (480 PER 30 DAYS)
<i>eslicarbazepine acetate (200 mg tab, 400 mg tab)</i>	4	ST, QL (30 PER 30 DAYS)
<i>eslicarbazepine acetate (600 mg tab, 800 mg tab)</i>	4	ST, QL (60 PER 30 DAYS)
<i>ethosuximide 250 mg cap</i>	2	
<i>ethosuximide 250 mg/5ml solution</i>	2	
<i>felbamate (400 mg tab, 600 mg tab)</i>	3	
<i>felbamate 600 mg/5ml suspension</i>	3	
FINTEPLA 2.2 MG/ML SOLUTION	5	PA, LA, QL (360 PER 30 DAYS)
<i>gabapentin (250 mg/5ml, 300 mg/6ml)</i>	2	QL (2160 PER 30 DAYS)
<i>gabapentin 100 mg cap</i>	2	QL (960 PER 30 DAYS)
<i>gabapentin 200 mg cap</i>	4	
<i>gabapentin 300 mg cap</i>	2	QL (330 PER 30 DAYS)
<i>gabapentin 400 mg cap</i>	2	QL (270 PER 30 DAYS)
<i>gabapentin 600 mg tab</i>	2	QL (180 PER 30 DAYS)
<i>gabapentin 800 mg tab</i>	2	QL (120 PER 30 DAYS)
<i>lacosamide (10 mg/ml, 50 mg/5ml, 100 mg/10ml)</i>	4	QL (1200 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>lacosamide (50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	2	QL (60 PER 30 DAYS)
LAMICTAL ODT 100 MG TAB DISP	4	QL (60 PER 30 DAYS)
LAMICTAL ODT 200 MG TAB DISP	4	QL (90 PER 30 DAYS)
<i>lamotrigine (25 mg tab disp, 50 mg tab disp, 100 mg tab disp, 200 mg tab disp)</i>	3	
<i>lamotrigine (5 mg chew tab, 25 mg chew tab, 25 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	2	
<i>lamotrigine 21 x 25 mg & 7 x 50 mg kit</i>	4	QL (28 PER 180 OVER TIME)
<i>lamotrigine 25 & 50 & 100 mg kit</i>	4	QL (70 PER 365 OVER TIME)
<i>lamotrigine 42 x 50 mg & 14x100 mg kit</i>	4	QL (56 PER 365 OVER TIME)
<i>lamotrigine er (er 25 mg tab er, er 50 mg tab er, er 100 mg tab er, er 200 mg tab er, er 250 mg tab er, er 300 mg tab er)</i>	3	
<i>lamotrigine odt (odt 25 mg tab disp, odt 50 mg tab disp, odt 100 mg tab disp, odt 200 mg tab disp)</i>	3	
<i>lamotrigine starter kit-blue 35 x 25 mg</i>	4	
<i>lamotrigine starter kit-green 84 x 25 mg & 14x100 mg</i>	4	
<i>lamotrigine starter kit-orange 42 x 25 mg & 7 x 100 mg</i>	4	
<i>levetiracetam (100 mg/ml, 500 mg/5ml)</i>	3	QL (900 PER 30 DAYS)
<i>levetiracetam (750 mg tab, 1000 mg tab)</i>	2	QL (120 PER 30 DAYS)
<i>levetiracetam 250 mg tab</i>	2	QL (480 PER 30 DAYS)
<i>levetiracetam 500 mg tab</i>	2	QL (240 PER 30 DAYS)
<i>levetiracetam er (er 500 mg tab er, er 750 mg tab er)</i>	3	QL (120 PER 30 DAYS)
<i>methsuximide 300 mg cap</i>	4	QL (120 PER 30 DAYS)
NAYZILAM 5 MG/0.1ML SOLUTION	4	QL (10 PER 30 OVER TIME)
<i>oxcarbazepine (150 mg tab, 300 mg tab, 600 mg tab)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>oxcarbazepine 300 mg/5ml suspension</i>	3	
<i>oxcarbazepine er 150 mg tab 24h</i>	4	ST, QL (480 PER 30 DAYS)
<i>oxcarbazepine er 300 mg tab 24h</i>	4	ST, QL (240 PER 30 DAYS)
<i>oxcarbazepine er 600 mg tab 24h</i>	4	ST, QL (120 PER 30 DAYS)
<i>perampanel (2 mg tab, 4 mg tab, 6 mg tab, 8 mg tab, 10 mg tab, 12 mg tab)</i>	4	ST, QL (30 PER 30 DAYS)
<i>perampanel 0.5 mg/ml suspension</i>	5	ST, QL (720 PER 30 DAYS)
<i>phenobarbital (phenobarbital 15 mg tab, phenobarbital 97.2 mg tab, phenobarbital 60 mg/15ml elixir, phenobarbital 64.8 mg tab, phenobarbital 16.2 mg tab, phenobarbital 20 mg/5ml elixir, phenobarbital 30 mg tab, phenobarbital 32.4 mg tab, phenobarbital 60 mg tab, phenobarbital 64.8 mg tab, phenobarbital 100 mg tab, phenobarbital 15 mg tab, phenobarbital 16.2 mg tab, phenobarbital 20 mg/5ml elixir, phenobarbital 30 mg tab, phenobarbital 30 mg/7.5ml elixir, phenobarbital 32.4 mg tab, phenobarbital 60 mg tab, phenobarbital 97.2 mg tab, phenobarbital 100 mg tab)</i>	2	
<i>phenytek (200 mg cap, 300 mg cap)</i>	2	
<i>phenytoin (100 mg/4ml suspension, 125 mg/5ml suspension)</i>	2	
<i>phenytoin 50 mg chew tab</i>	2	
<i>phenytoin infatabs infas 50 mg chew</i>	2	
<i>phenytoin sodium extended 100 mg cap</i>	2	
<i>pregabalin (20 mg/ml solution, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap, 225 mg cap, 300 mg cap)</i>	2	
<i>primidone (primidone 50 mg tab, primidone 125 mg tab, primidone 250 mg tab)</i>	2	
<i>rufinamide 200 mg tab</i>	4	QL (120 PER 30 DAYS)
<i>rufinamide 40 mg/ml suspension</i>	5	QL (2400 PER 30 DAYS)
<i>rufinamide 400 mg tab</i>	5	QL (240 PER 30 DAYS)
SPRITAM (250 MG TAB, 500 MG TAB)	4	ST, QL (180 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
SUBVENITE 10 MG/ML SUSPENSION	5	ST, QL (1500 PER 30 DAYS)
SYMPAZAN (10 MG FILM, 20 MG FILM)	5	PA, QL (60 PER 30 DAYS)
SYMPAZAN 5 MG FILM	4	PA, QL (60 PER 30 DAYS)
<i>tiagabine hcl (tiagabine hcl 12 mg tab, tiagabine hcl 12 mg tab)</i>	4	QL (120 PER 30 DAYS)
<i>tiagabine hcl (tiagabine hcl 16 mg tab, tiagabine hcl 16 mg tab)</i>	4	QL (90 PER 30 DAYS)
<i>tiagabine hcl 2 mg tab</i>	4	QL (840 PER 30 DAYS)
<i>tiagabine hcl 4 mg tab</i>	4	QL (420 PER 30 DAYS)
<i>topiramate (15 mg cap, 25 mg cap)</i>	2	
<i>topiramate (25 mg/ml solution, 50 mg cap sprinkle)</i>	4	
<i>topiramate 100 mg tab</i>	2	QL (180 PER 30 DAYS)
<i>topiramate 200 mg tab</i>	2	QL (60 PER 30 DAYS)
<i>topiramate 25 mg tab</i>	2	QL (720 PER 30 DAYS)
<i>topiramate 50 mg tab</i>	2	QL (360 PER 30 DAYS)
<i>valproic acid (250 mg cap, 250 mg/5ml solution, 500 mg/10ml solution)</i>	2	
VALTOCO 10 MG DOSE /0.1ML LIQUID	4	QL (10 PER 30 OVER TIME)
VALTOCO 15 MG DOSE 2 X 7.5 /0.1ML LIQD THPK	4	QL (10 PER 30 OVER TIME)
VALTOCO 20 MG DOSE 0 X 10 /0.1ML LIQD THPK	4	QL (10 PER 30 OVER TIME)
VALTOCO 5 MG DOSE /0.1ML LIQUID	4	QL (10 PER 30 OVER TIME)
<i>vigabatrin 500 mg packet</i>	5	PA, QL (9000 PER 30 DAYS)
<i>vigabatrin 500 mg tab</i>	5	PA, QL (180 PER 30 DAYS)
<i>vigadrone 500 mg packet</i>	5	PA, QL (180 PER 30 DAYS)
VIGAFYDE 100 MG/ML SOLUTION	5	PA, LA, QL (750 PER 30 OVER TIME)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
XCOPRI (25 MG TAB, 50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB)	5	ST, QL (60 PER 30 DAYS)
XCOPRI (250 MG DAILY DOSE) 100 & 150 TAB THPK	5	ST, QL (56 PER 28 DAYS)
XCOPRI (350 MG DAILY DOSE) 150 & 200 TAB THPK	5	ST, QL (56 PER 28 DAYS)
XCOPRI (COPRI 14 150 MG 14 200 MG TAB THPK, COPRI 14 50 MG 14 100 MG TAB THPK)	5	ST, QL (28 PER 28 DAYS)
XCOPRI COPRI 14 12.5 MG & 14 25 MG TAB THPK	4	ST, QL (28 PER 28 DAYS)
ZONISADE 100 MG/5ML SUSPENSION	5	PA
<i>zonisamide (25 mg cap, 50 mg cap, 100 mg cap)</i>	2	
ZTALMY 50 MG/ML SUSPENSION	5	PA, LA, QL (1080 PER 30 DAYS)

ANTIDEMENTIA AGENTS

<i>donepezil hcl (5 mg tab, 5 mg tab disp, 10 mg tab, 10 mg tab disp, 23 mg tab)</i>	2	
<i>galantamine hydrobromide (4 mg tab, 8 mg tab, 12 mg tab)</i>	2	
GALANTAMINE HYDROBROMIDE 4 MG/ML SOLUTION	3	
<i>galantamine hydrobromide er (er 8 mg cap er, er 16 mg cap er, er 24 mg cap er)</i>	3	
LEQEMBI IQLIK (500 MG DOSE) 2 X 250 /1.25ML SOLN A-INJ	5	PA
LEQEMBI IQLIK 360 MG/1.8ML SOLN A-INJ	5	PA
<i>memantine hcl (2 mg/ml, 10 mg/5ml)</i>	3	
<i>memantine hcl (5 mg tab, 10 mg tab)</i>	2	QL (60 PER 30 DAYS)
<i>memantine hcl er (er 7 mg cap er, er 14 mg cap er, er 21 mg cap er, er 28 mg cap er)</i>	2	QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>rivastigmine (4.6 mg/patch, 9.5 mg/patch, 13.3 mg/patch)</i>	3	
<i>rivastigmine tartrate (1.5 mg cap, 3 mg cap, 4.5 mg cap, 6 mg cap)</i>	2	

ANTIDEPRESSANTS

<i>amitriptyline hcl (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab, 150 mg tab)</i>	2	
<i>amoxapine (25 mg tab, 50 mg tab, 100 mg tab, 150 mg tab)</i>	2	
APLENZIN (174 MG TAB ER 24H, 348 MG TAB ER 24H, 522 MG TAB ER 24H)	4	ST, QL (30 PER 30 DAYS)
AUVELITY 45-105 MG TAB ER	5	ST, QL (60 PER 30 DAYS)
<i>bupropion hcl (75 mg tab, 100 mg tab)</i>	2	
<i>bupropion hcl er (sr) (er 100 mg tab er, er 150 mg tab er, er 200 mg tab er)</i>	2	
<i>bupropion hcl er (xl) (er 150 mg tab er, er 300 mg tab er)</i>	2	
BUPROPION HCL ER (XL) 450 MG TAB 24H	4	ST
<i>citalopram hydrobromide (10 mg tab, 20 mg tab, 40 mg tab)</i>	1	
<i>citalopram hydrobromide (10 mg/5ml, 20 mg/10ml)</i>	2	
<i>citalopram hydrobromide (citalopram hydrobromide 30 mg cap, citalopram hydrobromide 30 mg cap)</i>	3	
<i>clomipramine hcl (25 mg cap, 50 mg cap, 75 mg cap)</i>	3	
<i>desipramine hcl (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab, 150 mg tab)</i>	2	
DESVENLAFAXINE ER (ER 50 MG TAB ER 24H, ER 100 MG TAB ER 24H)	2	
<i>desvenlafaxine succinate er (er 25 mg tab er, er 50 mg tab er, er 100 mg tab er)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>doxepin hcl (doxepin hcl 10 mg/ml conc, doxepin hcl 10 mg/ml conc)</i>	2	
<i>doxepin hcl (doxepin hcl 150 mg cap, doxepin hcl 10 mg cap, doxepin hcl 25 mg cap, doxepin hcl 50 mg cap, doxepin hcl 75 mg cap, doxepin hcl 100 mg cap, doxepin hcl 150 mg cap)</i>	2	
DRIZALMA SPRINKLE (20 MG CAP DR, 30 MG CAP DR, 40 MG CAP DR, 60 MG CAP DR)	4	ST, QL (60 PER 30 DAYS)
<i>duloxetine hcl (20 mg dr, 30 mg dr, 60 mg dr)</i>	2	
DULOXETINE HCL (80 MG CP DR PART, 90 MG CP DR PART, 120 MG CP DR PART)	4	
<i>duloxetine hcl 40 mg cp dr part</i>	2	QL (60 PER 30 DAYS)
EMSAM (6 MG/24HR PATCH 24HR, 9 MG/24HR PATCH 24HR, 12 MG/24HR PATCH 24HR)	5	ST, QL (30 PER 30 DAYS)
<i>escitalopram oxalate (5 mg tab, 10 mg tab, 20 mg tab)</i>	1	
<i>escitalopram oxalate (escitalopram oxalate 5 mg/5ml solution, escitalopram oxalate 10 mg/10ml solution, escitalopram oxalate 15 mg cap)</i>	2	
EXXUA (36.3 MG TAB ER 24H, 54.5 MG TAB ER 24H, 72.6 MG TAB ER 24H)	5	ST, QL (30 PER 30 DAYS)
EXXUA 18.2 MG TAB ER 24H	5	ST, QL (60 PER 30 DAYS)
EXXUA TITRATION PACK 18.2 MG TAB ER 24H	5	ST, QL (32 PER 180 OVER TIME)
FETZIMA (20 MG CAP ER 24H, 40 MG CAP ER 24H, 80 MG CAP ER 24H, 120 MG CAP ER 24H)	4	ST, QL (30 PER 30 DAYS)
FETZIMA TITRATION 20 & 40 MG CP24 THPK	4	ST, QL (30 PER 30 DAYS)
<i>fluoxetine hcl (10 mg cap, 20 mg cap, 40 mg cap)</i>	1	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>fluoxetine hcl (fluoxetine hcl 10 mg tab, fluoxetine hcl 20 mg tab, fluoxetine hcl 60 mg tab, fluoxetine hcl 60 mg tab)</i>	3	
FLUOXETINE HCL (PMDD) (10 MG TAB, 20 MG TAB)	3	
<i>fluoxetine hcl 20 mg/5ml solution</i>	2	
FLUOXETINE HCL 90 MG CAP DR	3	QL (4 PER 28 OVER TIME)
<i>fluvoxamine maleate (25 mg tab, 50 mg tab, 100 mg tab)</i>	2	
<i>fluvoxamine maleate er (er 100 mg cap er, er 150 mg cap er)</i>	3	
<i>imipramine hcl (10 mg tab, 25 mg tab, 50 mg tab)</i>	2	
<i>imipramine pamoate (75 mg cap, 100 mg cap, 125 mg cap, 150 mg cap)</i>	2	
MARPLAN 10 MG TAB	4	
<i>mirtazapine (15 mg tab disp, 30 mg tab disp, 45 mg tab disp)</i>	2	QL (30 PER 30 DAYS)
<i>mirtazapine (7.5 mg tab, 15 mg tab, 30 mg tab, 45 mg tab)</i>	2	
NEFAZODONE HCL (50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB, 250 MG TAB)	3	
<i>nortriptyline hcl (10 mg cap, 10 mg/5ml solution, 25 mg cap, 50 mg cap, 75 mg cap)</i>	2	
<i>olanzapine-fluoxetine hcl (3-25 mg cap, 6-25 mg cap, 6-50 mg cap, 12-25 mg cap, 12-50 mg cap)</i>	4	
<i>paroxetine hcl (10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)</i>	2	
PAROXETINE HCL 10 MG/5ML SUSPENSION	2	QL (900 PER 30 DAYS)
<i>paroxetine hcl er (er 12.5 mg tab er, er 37.5 mg tab er)</i>	2	QL (30 PER 30 DAYS)
<i>paroxetine hcl er 25 mg tab 24h</i>	2	QL (90 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
PERPHENAZINE-AMITRIPTYLINE (2-10 MG TAB, 2-25 MG TAB, 4-10 MG TAB, 4-25 MG TAB, 4-50 MG TAB)	4	
PHENELZINE SULFATE 15 MG TAB	2	
<i>protriptyline hcl (5 mg tab, 10 mg tab)</i>	4	ST
RALDESY 10 MG/ML SOLUTION	4	ST
<i>sertraline hcl (25 mg tab, 50 mg tab, 100 mg tab)</i>	1	
<i>sertraline hcl 20 mg/ml conc</i>	2	QL (300 PER 30 DAYS)
<i>tranylcypromine sulfate 10 mg tab</i>	3	
TRAZODONE HCL (25 MG TAB, 75 MG TAB)	2	
<i>trazodone hcl (50 mg tab, 100 mg tab, 150 mg tab, 300 mg tab)</i>	1	
<i>trimipramine maleate (25 mg cap, 50 mg cap, 100 mg cap)</i>	4	ST
TRINTELLIX (5 MG TAB, 10 MG TAB, 20 MG TAB)	4	ST, QL (30 PER 30 DAYS)
VENLAFAXINE BESYLATE ER 112.5 MG TAB 24H	4	ST
<i>venlafaxine hcl (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)</i>	2	
<i>venlafaxine hcl er (er 37.5 mg cap er, er 75 mg cap er, er 150 mg cap er)</i>	2	
<i>vilazodone hcl (10 mg tab, 20 mg tab, 40 mg tab)</i>	3	
ZURZUVAE (20 MG CAP, 25 MG CAP, 30 MG CAP)	5	PA, QL (28 PER 14 DAYS)

ANTIEMETICS

<i>aprepitant 125 mg cap</i>	3	QL (3 PER 30 OVER TIME), BVD, (Route to BVSD with an AWD note.)
<i>aprepitant 40 mg cap</i>	3	QL (1 PER 30 OVER TIME), BVD, (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>aprepitant 80 & 125 mg cap thpk</i>	3	QL (9 PER 30 OVER TIME), BVD, (Route to BVSD with an AWD note.)
<i>aprepitant 80 mg cap</i>	3	QL (6 PER 30 OVER TIME), BVD, (Route to BVSD with an AWD note.)
<i>dronabinol (2.5 mg cap, 5 mg cap, 10 mg cap)</i>	3	PA, QL (60 PER 30 DAYS), (Route to BVSD with an AWD note.)
<i>granisetron hcl 1 mg tab</i>	3	BVD, (Route to BVSD with an AWD note.)
<i>hydroxyzine hcl (10 mg tab, 25 mg tab, 50 mg tab)</i>	2	
<i>hydroxyzine pamoate (hydroxyzine pamoate 50 mg cap, hydroxyzine pamoate 100 mg cap, hydroxyzine pamoate 25 mg cap)</i>	2	
<i>metoclopramide hcl (5 mg tab, 10 mg tab)</i>	2	
<i>metoclopramide hcl (5 mg/5ml, 10 mg/10ml)</i>	3	
<i>ondansetron 4 mg tab disp</i>	2	QL (240 PER 30 DAYS), BVD, (Part B Home Infusion Benefit when billed with G0068, G0069 or G0070)
<i>ondansetron 8 mg tab disp</i>	2	QL (240 PER 30 DAYS), BVD, (Route to BVSD with an AWD note.)
<i>ondansetron hcl 4 mg tab</i>	2	QL (240 PER 30 DAYS), BVD, (Route to BVSD with an AWD note.)
<i>ondansetron hcl 4 mg/5ml solution</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>ondansetron hcl 8 mg tab</i>	2	QL (240 PER 30 DAYS), BVD, (Part B Home Infusion Benefit when billed with G0068, G0069 or G0070)
<i>promethazine hcl (12.5 mg suppos, 25 mg suppos)</i>	3	(Route to BVSD with an AWD note.)
<i>promethazine hcl (6.25 mg/5ml solution, 12.5 mg tab, 12.5 mg/10ml solution, 25 mg tab, 50 mg tab)</i>	2	(Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
PROMETHEGAN (PROMETHEGAN 50 MG SUPPOS, PROMETHEGAN 25 MG SUPPOS)	3	(Route to BVSD with an AWD note.)
<i>scopolamine 1 mg/3days patch 72hr</i>	3	QL (10 PER 28 OVER TIME)
VARUBI (180 MG DOSE) 2 X 90 TAB THPK	4	QL (4 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)

ANTIFUNGALS

AMPHOTERICIN B 50 MG RECON SOLN	4	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>amphotericin b liposome 50 mg recon susp</i>	4	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>caspofungin acetate (50 mg soln, 70 mg soln)</i>	4	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>clotrimazole (1 % cream, 1 % solution)</i>	2	
<i>clotrimazole 10 mg troche</i>	2	
<i>clotrimazole-betamethasone (clotrimazole-betamethasone 1-0.05 % lotion, clotrimazole-betamethasone 1-0.05 % cream, clotrimazole-betamethasone 1-0.05 % lotion)</i>	3	
CRESEMBA (74.5 MG CAP, 186 MG CAP)	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>econazole nitrate 1 % cream</i>	3	
<i>fluconazole (10 mg/ml, 40 mg/ml)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>fluconazole (50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>fluconazole in sodium chloride (in 200-0.9 mg/100ml-%, in 400-0.9 mg/200ml-%)</i>	2	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>flucytosine (250 mg cap, 500 mg cap)</i>	5	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>griseofulvin ultramicrosize (125 mg tab, 250 mg tab)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>itraconazole 10 mg/ml solution</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>itraconazole 100 mg cap</i>	3	QL (126 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>ketoconazole (2 % cream, 2 % shampoo)</i>	3	
<i>ketoconazole 200 mg tab</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>klayesta 100000 unit/gm powder</i>	2	
<i>miconazole sodium (50 mg soln, 100 mg soln)</i>	2	BVD, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
MICONAZOLE 3 200 MG SUPPOS	4	
NOXAFIL 300 MG PACKET	5	PA, QL (31 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>nyamyc 100000 unit/gm powder</i>	2	
<i>nystatin (100000 unit/gm cream, 100000 unit/gm ointment)</i>	2	
<i>nystatin 100000 unit/gm powder</i>	2	
<i>nystatin 100000 unit/ml suspension</i>	2	NM (Non-Mail Order)
<i>nystatin 500000 unit tab</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>nystatin-triamcinolone (100000-0.1 unit/gm-% cream, 100000-0.1 unit/gm-% ointment)</i>	3	
<i>nystop 100000 unit/gm powder</i>	2	
<i>oxiconazole nitrate 1 % cream</i>	3	
<i>posaconazole 100 mg tab dr</i>	5	QL (240 PER 30 DAYS), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>posaconazole 40 mg/ml suspension</i>	5	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>terbinafine hcl 250 mg tab</i>	2	QL (90 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>terconazole (0.4 %, 0.8 %)</i>	3	
<i>terconazole 80 mg suppos</i>	3	
<i>voriconazole (voriconazole 200 mg recon soln, voriconazole 200 mg recon soln)</i>	3	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>voriconazole 200 mg tab</i>	3	QL (90 PER 30 DAYS), NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>voriconazole 40 mg/ml recon susp</i>	3	QL (450 PER 30 DAYS), NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>voriconazole 50 mg tab</i>	3	QL (360 PER 30 DAYS), NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)

ANTIGOUT AGENTS

<i>allopurinol (100 mg tab, 300 mg tab)</i>	1	
<i>colchicine 0.6 mg tab</i>	3	QL (120 PER 30 DAYS)
<i>colchicine-probenecid 0.5-500 mg tab</i>	3	
<i>febuxostat (40 mg tab, 80 mg tab)</i>	2	QL (30 PER 30 DAYS)
<i>probenecid 500 mg tab</i>	3	

ANTIMIGRAINE AGENTS

AJOVY 225 MG/1.5ML SOLN A-INJ	3	QL (4.5 PER 84 OVER TIME)
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DRUG NAME	TIER	REQUIREMENTS/LIMITS
AJOVY 225 MG/1.5ML SOLN PRSYR	3	QL (4.5 PER 84 OVER TIME)
<i>diclofenac potassium(migraine) 50 mg packet</i>	3	ST, QL (9 PER 30 OVER TIME)
<i>dihydroergotamine mesylate 4 mg/ml solution</i>	3	PA, (Excluded from Auto Extension)
<i>eletriptan hydrobromide 20 mg tab</i>	2	QL (9 PER 30 OVER TIME)
<i>eletriptan hydrobromide 40 mg tab</i>	2	QL (9 PER 30 OVER TIME)
EMGALITY (120 MG/ML SOLN A-INJ, 120 MG/ML SOLN PRSYR)	3	QL (5 PER 84 OVER TIME)
EMGALITY (300 MG DOSE) 100 /ML SOLN PRSYR	3	QL (3 PER 30 OVER TIME)
<i>frovatriptan succinate 2.5 mg tab</i>	4	ST, QL (12 PER 30 OVER TIME)
<i>naratriptan hcl (1 mg tab, 2.5 mg tab)</i>	3	QL (9 PER 30 OVER TIME)
NURTEC 75 MG TAB DISP	3	PA, QL (8 PER 30 OVER TIME)
<i>rizatriptan benzoate (5 mg tab disp, 10 mg tab, 10 mg tab disp)</i>	2	QL (18 PER 30 OVER TIME)
<i>rizatriptan benzoate 5 mg tab</i>	2	QL (18 PER 30 OVER TIME)
<i>sumatriptan (5 mg/act, 20 mg/act)</i>	3	ST, QL (12 PER 30 OVER TIME)
<i>sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)</i>	2	QL (9 PER 30 OVER TIME)
<i>sumatriptan succinate (6 mg/0.5ml soln a-inj, 6 mg/0.5ml solution)</i>	3	QL (4 PER 30 OVER TIME)
<i>zolmitriptan (2.5 mg tab, 2.5 mg tab disp, 5 mg tab, 5 mg tab disp)</i>	3	QL (9 PER 30 OVER TIME)
<i>zolmitriptan 5 mg solution</i>	4	ST, QL (8 PER 30 OVER TIME)

ANTIMYCOBACTERIALS

<i>dapsone (25 mg tab, 100 mg tab)</i>	3	(Excluded from Auto Extension)
<i>ethambutol hcl (100 mg tab, 400 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>isoniazid (100 mg tab, 300 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
PRETOMANID 200 MG TAB	3	PA, QL (30 PER 30 DAYS), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>pyrazinamide 500 mg tab</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>rifabutin 150 mg cap</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>rifampin (150 mg cap, 300 mg cap)</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>rifampin 600 mg recon soln</i>	3	HI, NM (Non-Mail Order), (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>rifapentine 150 mg tab</i>	4	QL (32 PER 28 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
SIRTURO (20 MG TAB, 100 MG TAB)	5	PA, NM (Non-Mail Order), (Excluded from Auto Extension)

ANTINEOPLASTICS

<i>abiraterone acetate 250 mg tab</i>	3	QL (120 PER 30 DAYS)
<i>abirtega 250 mg tab</i>	3	QL (120 PER 30 DAYS)
ACTIMMUNE 100 MCG/0.5ML SOLUTION	5	PA, (Route to BVSD with an AWD note.)
AKEEGA (50-500 MG TAB, 100-500 MG TAB)	5	PA, QL (60 PER 30 DAYS)
ALECENSA 150 MG CAP	5	PA, QL (240 PER 30 DAYS)
ALUNBRIG (90 MG TAB, 180 MG TAB)	5	PA, QL (30 PER 30 DAYS)
ALUNBRIG 30 MG TAB	5	PA, QL (180 PER 30 DAYS)
ALUNBRIG 90 & 180 MG TAB THPK	5	PA, QL (30 PER 180 OVER TIME)
<i>anastrozole 1 mg tab</i>	2	QL (30 PER 30 DAYS)
AUGTYRO 160 MG CAP	5	PA, QL (60 PER 30 DAYS)
AUGTYRO 40 MG CAP	5	PA, QL (240 PER 30 DAYS)
AVMAPKI FAKZYNJA CO-PACK 0.8 & 200 MG THER	5	PA, QL (66 PER 28 OVER TIME)
AYVAKIT (25 MG TAB, 50 MG TAB, 100 MG TAB, 200 MG TAB, 300 MG TAB)	5	PA, QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
BALVERSA (3 MG TAB, 4 MG TAB, 5 MG TAB)	5	PA, QL (84 PER 28 DAYS)
BEQALZI (1 MG TAB, 5 MG TAB)	5	PA, QL (11 PER 7 DAYS)
BEQALZI 20 MG TAB	5	PA, QL (60 PER 30 DAYS)
BEQALZI 80 MG TAB	5	PA, QL (120 PER 30 DAYS)
BEQALZI STARTER PACK 1 & 5 & 20 & 80 MG TAB THPK	5	PA, QL (44 PER 180 OVER TIME)
BESREMI 500 MCG/ML SOLN PRSYR	5	PA, QL (2 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
BESREMI PEN 500 MCG/0.5ML SOLN	5	PA, QL (2 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
<i>bexarotene 1 % gel</i>	5	PA
<i>bexarotene 75 mg cap</i>	5	PA
<i>bicalutamide 50 mg tab</i>	2	QL (30 PER 30 DAYS)
BOSULIF (100 MG CAP, 100 MG TAB)	5	PA, QL (180 PER 30 DAYS)
BOSULIF 50 MG CAP	5	PA, QL (210 PER 30 DAYS)
BOSULIF 500 MG TAB	5	PA, QL (30 PER 30 DAYS)
<i>bosutinib 400 mg tab</i>	5	PA, QL (30 PER 30 DAYS)
BRAFTOVI 75 MG CAP	5	PA, QL (180 PER 30 DAYS)
BRUKINSA 160 MG TAB	5	PA, QL (60 PER 30 DAYS)
CABOMETYX (20 MG TAB, 40 MG TAB, 60 MG TAB)	5	PA, QL (30 PER 30 DAYS)
CALQUENCE 100 MG TAB	5	PA, QL (60 PER 30 DAYS)
CAPRELSA (100 MG TAB, 300 MG TAB)	5	PA, LA, QL (30 PER 30 DAYS)
COMETRIQ (100 MG DAILY DOSE) 80 & 20 KIT	5	PA
COMETRIQ (140 MG DAILY DOSE) 3 X 20 & 80 KIT	5	PA
COMETRIQ (60 MG DAILY DOSE) 20 KIT	5	PA

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
COPIKTRA (15 MG CAP, 25 MG CAP)	5	PA, QL (60 PER 30 DAYS)
COTELLIC 20 MG TAB	5	PA, LA, QL (63 PER 28 DAYS)
CYCLOPHOSPHAMIDE (CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB)	2	BVD, (Route to BVSD with an AWD note.)
DANZITEN (71 MG TAB, 95 MG TAB)	5	PA, LA, QL (120 PER 30 DAYS)
<i>dasatinib (50 mg tab, 70 mg tab, 80 mg tab, 100 mg tab, 140 mg tab)</i>	4	QL (30 PER 30 DAYS)
<i>dasatinib 20 mg tab</i>	4	QL (90 PER 30 DAYS)
DAURISMO 100 MG TAB	5	PA, QL (30 PER 30 DAYS)
DAURISMO 25 MG TAB	5	PA, QL (90 PER 30 DAYS)
ELIGARD (7.5 MG KIT, 22.5 MG KIT, 30 MG KIT)	4	BVD, (Route to BVSD with an AWD note.)
ELIGARD 45 MG KIT	5	BVD, (Route to BVSD with an AWD note.)
ENSACOVE (25 MG CAP, 100 MG CAP)	5	PA, QL (60 PER 30 DAYS)
ERIVEDGE 150 MG CAP	5	PA, QL (30 PER 30 DAYS)
ERLEADA 240 MG TAB	5	PA, QL (30 PER 30 DAYS)
ERLEADA 60 MG TAB	5	PA, QL (120 PER 30 DAYS)
<i>erlotinib hcl (100 mg tab, 150 mg tab)</i>	5	PA, QL (30 PER 30 DAYS)
<i>erlotinib hcl 25 mg tab</i>	5	PA, QL (60 PER 30 DAYS)
ETCAMAH 75 MG TAB	5	PA, QL (30 PER 30 DAYS)
EULEXIN 125 MG CAP	5	PA, QL (180 PER 30 DAYS)
<i>everolimus (2 mg tab, 3 mg tab, 5 mg tab)</i>	5	PA, QL (60 PER 30 DAYS)
<i>everolimus (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab)</i>	5	PA, QL (30 PER 30 DAYS)
<i>exemestane 25 mg tab</i>	3	QL (60 PER 30 DAYS)
FIRMAGON (240 MG DOSE) 120 /VIAL RECON SOLN	5	BVD, (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
FIRMAGON 80 MG RECON SOLN	4	BVD, (Route to BVSD with an AWD note.)
FOTIVDA (0.89 MG CAP, 1.34 MG CAP)	5	PA, QL (21 PER 28 OVER TIME)
FRUZAQLA 1 MG CAP	5	PA, QL (84 PER 28 DAYS)
FRUZAQLA 5 MG CAP	5	PA, QL (21 PER 28 DAYS)
GAVRETO 100 MG CAP	5	PA, QL (120 PER 30 DAYS), (Available from Biologics by McKesson)
<i>gefitinib 250 mg tab</i>	5	PA, QL (30 PER 30 DAYS)
GILOTRIF (20 MG TAB, 30 MG TAB, 40 MG TAB)	5	PA, QL (30 PER 30 DAYS)
GOMEKLI (1 MG CAP, 1 MG TAB SOL)	5	PA, QL (240 PER 30 DAYS)
GOMEKLI 2 MG CAP	5	PA, QL (120 PER 30 DAYS)
HERNEXEOS 60 MG TAB	5	PA, QL (90 PER 30 DAYS)
<i>hydroxyurea 500 mg cap</i>	2	
HYRNUO 10 MG TAB	5	PA, QL (120 PER 30 DAYS)
IBRANCE (75 MG TAB, 100 MG TAB, 125 MG CAP, 125 MG TAB)	5	PA, QL (21 PER 28 OVER TIME)
IBTROZI 200 MG CAP	5	PA, QL (90 PER 30 DAYS)
ICLUSIG (10 MG TAB, 15 MG TAB, 30 MG TAB, 45 MG TAB)	5	PA, QL (30 PER 30 DAYS)
IDHIFA (50 MG TAB, 100 MG TAB)	5	PA, QL (30 PER 30 DAYS)
<i>imatinib mesylate 100 mg tab</i>	3	QL (90 PER 30 DAYS)
<i>imatinib mesylate 400 mg tab</i>	3	QL (60 PER 30 DAYS)
IMBRUVICA (70 MG CAP, 140 MG TAB, 280 MG TAB, 420 MG TAB)	5	PA, QL (30 PER 30 DAYS)
IMBRUVICA 140 MG CAP	5	PA, QL (120 PER 30 DAYS)
IMBRUVICA 70 MG/ML SUSPENSION	5	PA, QL (216 PER 30 DAYS)
IMKELDI 80 MG/ML SOLUTION	5	PA, QL (300 PER 30 DAYS)
INLURIYO 200 MG TAB	5	PA, QL (60 PER 30 DAYS), (Available from Biologics by McKesson)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
INLYTA 1 MG TAB	5	PA, QL (600 PER 30 DAYS)
INLYTA 5 MG TAB	5	PA, QL (120 PER 30 DAYS)
INQOVI 35-100 MG TAB	5	PA, QL (5 PER 28 OVER TIME)
INREBIC 100 MG CAP	5	PA, QL (120 PER 30 DAYS)
ITOVEBI 3 MG TAB	5	PA, QL (60 PER 30 DAYS)
ITOVEBI 9 MG TAB	5	PA, QL (30 PER 30 DAYS)
IWILFIN 192 MG TAB	5	PA, QL (240 PER 30 DAYS)
JAKAFI (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB, 25 MG TAB)	5	PA, QL (60 PER 30 DAYS)
JAKAFI XR (11 MG TAB ER 24H, 22 MG TAB ER 24H, 33 MG TAB ER 24H, 44 MG TAB ER 24H, 55 MG TAB ER 24H)	5	PA, QL (30 PER 30 DAYS)
JAYPIRCA 100 MG TAB	5	PA, QL (60 PER 30 DAYS)
JAYPIRCA 50 MG TAB	5	PA, QL (30 PER 30 DAYS)
JIDEYTRO 100 MG TAB	5	PA, QL (30 PER 30 DAYS)
JIDEYTRO 25 MG TAB	5	PA, QL (90 PER 30 DAYS)
KISQALI (200 MG DOSE) (TAB THPK	5	PA, QL (63 PER 28 DAYS)
KISQALI (400 MG DOSE) 200 TAB THPK	5	PA, QL (63 PER 28 DAYS)
KISQALI (600 MG DOSE) 200 TAB THPK	5	PA, QL (63 PER 28 DAYS)
KISQALI FEMARA (200 MG DOSE) (& 2.5 TAB THPK	5	PA, QL (49 PER 28 DAYS)
KISQALI FEMARA (400 MG DOSE) 200 & 2.5 TAB THPK	5	PA, QL (70 PER 28 DAYS)
KISQALI FEMARA (600 MG DOSE) 200 & 2.5 TAB THPK	5	PA, QL (91 PER 28 DAYS)
KOMZIFTI 200 MG CAP	5	PA, QL (90 PER 30 DAYS)
KOSELUGO (10 MG CAP, 25 MG CAP)	5	PA, QL (120 PER 30 DAYS)
KOSELUGO 5 MG CAP SPRINK	5	PA, QL (600 PER 30 DAYS)
KOSELUGO 7.5 MG CAP SPRINK	5	PA, QL (360 PER 30 DAYS)

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KRAZATI 200 MG TAB	5	PA, QL (180 PER 30 DAYS)
<i>lapatinib ditosylate 250 mg tab</i>	5	PA, QL (180 PER 30 DAYS)
LAZCLUZE 240 MG TAB	5	PA, QL (30 PER 30 DAYS)
LAZCLUZE 80 MG TAB	5	PA, QL (60 PER 30 DAYS)
LEDERLE LEUCOVORIN 5 MG TAB	3	
<i>lenalidomide (2.5 mg cap, 5 mg cap, 10 mg cap, 15 mg cap, 20 mg cap, 25 mg cap)</i>	5	PA, LA, QL (28 PER 28 DAYS), (Available from U of U, St. Lukes, Utah Cancer, Walgreens Specialty)
LENVIMA (10 MG DAILY DOSE) CAP THPK	5	PA, QL (90 PER 30 DAYS)
LENVIMA (12 MG DAILY DOSE) 3 X 4 CAP THPK	5	PA, QL (90 PER 30 DAYS)
LENVIMA (14 MG DAILY DOSE) (110 & CAP THPK	5	PA, QL (90 PER 30 DAYS)
LENVIMA (18 MG DAILY DOSE) 10 & 2 X 4 CAP THPK	5	PA, QL (90 PER 30 DAYS)
LENVIMA (20 MG DAILY DOSE) (0 X 10 CAP THPK	5	PA, QL (90 PER 30 DAYS)
LENVIMA (24 MG DAILY DOSE) (X 10 & CAP THPK	5	PA, QL (90 PER 30 DAYS)
LENVIMA (4 MG DAILY DOSE) (CAP THPK	5	PA, QL (90 PER 30 DAYS)
LENVIMA (8 MG DAILY DOSE) 2 X 4 CAP THPK	5	PA, QL (90 PER 30 DAYS)
<i>letrozole 2.5 mg tab</i>	2	QL (30 PER 30 DAYS)
<i>leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab)</i>	3	(Route to BVSD with an AWD note.)
LEUKERAN 2 MG TAB	5	PA
<i>leuprolide acetate 1 mg/0.2ml kit</i>	4	(Route to BVSD with an AWD note.)
LIFYORLI (125 MG DOSE) (X & X 00 CAP THPK	5	PA, QL (18 PER 28 OVER TIME)
LIFYORLI (150 MG DOSE) (50 2 X 25 & X 00 CAP THPK	5	PA, QL (28 PER 28 OVER TIME)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>lomustine (40 mg cap, 100 mg cap)</i>	5	PA
<i>lomustine 10 mg cap</i>	4	PA
LONSURF (15-6.14 MG TAB, 20-8.19 MG TAB)	5	PA, QL (80 PER 28 DAYS)
LORBRENA 100 MG TAB	5	PA, QL (30 PER 30 DAYS)
LORBRENA 25 MG TAB	5	PA, QL (90 PER 30 DAYS)
LUMAKRAS 120 MG TAB	5	PA, QL (240 PER 30 DAYS)
LUMAKRAS 240 MG TAB	5	PA, QL (120 PER 30 DAYS)
LUMAKRAS 320 MG TAB	5	PA, QL (90 PER 30 DAYS)
LUPRON DEPOT (1-MONTH) (3.75 MG KIT, 7.5 MG KIT)	5	BVD, (Route to BVSD with an AWD note.)
LUPRON DEPOT (3-MONTH) (11.25 MG KIT, 22.5 MG KIT)	5	BVD, (Route to BVSD with an AWD note.)
LUPRON DEPOT (4-MONTH) 30 MG KIT	5	BVD, (Route to BVSD with an AWD note.)
LUPRON DEPOT (6-MONTH) 45 MG KIT	5	BVD, (Route to BVSD with an AWD note.)
LUTRATE DEPOT 22.5 MG INJECTABLE	4	BVD, (Route to BVSD with an AWD note.)
LYNPARZA (100 MG TAB, 150 MG TAB)	5	PA, QL (120 PER 30 DAYS)
LYSODREN 500 MG TAB	5	
LYTGOBI (12 MG DAILY DOSE) 4 TAB THPK	5	PA, QL (150 PER 30 DAYS)
LYTGOBI (16 MG DAILY DOSE) 4 TAB THPK	5	PA, QL (150 PER 30 DAYS)
LYTGOBI (20 MG DAILY DOSE) 4 TAB THPK	5	PA, QL (150 PER 30 DAYS)
MATULANE 50 MG CAP	5	
<i>megestrol acetate (20 mg tab, 40 mg tab)</i>	2	
<i>megestrol acetate (40 mg/ml suspension, 400 mg/10ml suspension, 800 mg/20ml suspension)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
MEKINIST 0.05 MG/ML RECON SOLN	5	PA, QL (1200 PER 30 DAYS)
MEKINIST 0.5 MG TAB	5	PA, QL (90 PER 30 DAYS)
MEKINIST 2 MG TAB	5	PA, QL (30 PER 30 DAYS)
MEKTOVI 15 MG TAB	5	PA, QL (180 PER 30 DAYS)
<i>mercaptopurine 2000 mg/100ml suspension</i>	5	PA, QL (300 PER 30 DAYS)
<i>mercaptopurine 50 mg tab</i>	2	
<i>mesna 400 mg tab</i>	4	
<i>methotrexate sodium (pf) (methotrexate sodium (pf) 1 gm/40ml solution, methotrexate sodium (pf) 50 mg/2ml solution, methotrexate sodium (pf) 250 mg/10ml solution, methotrexate sodium (pf) 1 gm/40ml solution, methotrexate sodium (pf) 1000 mg/40ml solution)</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>methotrexate sodium 2.5 mg tab</i>	2	(Route to BVSD with an AWD note.)
METHOTREXATE SODIUM 250 MG/10ML SOLUTION	2	BVD, (Route to BVSD with an AWD note.)
METHOTREXATE SODIUM 50 MG/2ML SOLUTION	2	BVD, (Route to BVSD with an AWD note.)
MIMRYLO (9.5 MG RECON SOLN, 19 MG RECON SOLN, 28 MG RECON SOLN, 41 MG RECON SOLN, 54 MG RECON SOLN)	5	PA, QL (8 PER 28 OVER TIME)
MODEYSO 125 MG CAP	5	PA, LA, QL (20 PER 28 OVER TIME)
NERLYNX 40 MG TAB	5	PA, QL (180 PER 30 DAYS)
<i>nilotinib hcl (50 mg cap, 150 mg cap, 200 mg cap)</i>	5	PA, QL (120 PER 30 DAYS)
<i>nilutamide (nilutamide 150 mg tab, nilutamide 150 mg tab)</i>	5	
NINLARO (2.3 MG CAP, 3 MG CAP, 4 MG CAP)	5	PA, QL (3 PER 28 OVER TIME)
NUBEQA 300 MG TAB	5	PA, QL (120 PER 30 DAYS)
ODOMZO 200 MG CAP	5	PA, LA, QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
OGSIVEO (100 MG TAB, 150 MG TAB)	5	PA, QL (60 PER 30 DAYS)
OJEMDA 100 MG TAB	5	PA, QL (24 PER 28 OVER TIME)
OJEMDA 25 MG/ML RECON SUSP	5	PA, QL (96 PER 28 OVER TIME)
OJJAARA (100 MG TAB, 150 MG TAB, 200 MG TAB)	5	PA, QL (30 PER 30 DAYS)
ONUREG (200 MG TAB, 300 MG TAB)	5	PA, QL (14 PER 28 OVER TIME)
ORGOVYX 120 MG TAB	5	PA, QL (32 PER 30 DAYS)
ORSERDU 345 MG TAB	5	PA, LA, QL (30 PER 30 DAYS)
ORSERDU 86 MG TAB	5	PA, LA, QL (90 PER 30 DAYS)
PANRETIN 0.1 % GEL	5	PA, QL (60 PER 30 DAYS)
<i>pazopanib hcl 200 mg tab</i>	5	PA
PEMAZYRE (4.5 MG TAB, 9 MG TAB, 13.5 MG TAB)	5	PA, LA
PIQRAY (200 MG DAILY DOSE) (TAB THPK	5	PA, QL (30 PER 30 DAYS)
PIQRAY (250 MG DAILY DOSE) 200 & TAB THPK	5	PA, QL (60 PER 30 DAYS)
PIQRAY (300 MG DAILY DOSE) 2 X 150 TAB THPK	5	PA, QL (60 PER 30 DAYS)
<i>pomalidomide (1 mg cap, 2 mg cap, 3 mg cap, 4 mg cap)</i>	5	PA, QL (21 PER 28 DAYS)
POMALYST (1 MG CAP, 2 MG CAP, 3 MG CAP, 4 MG CAP)	5	PA, QL (21 PER 28 OVER TIME)
QINLOCK 50 MG TAB	5	PA, QL (90 PER 30 DAYS)
RASONQUE 100 MG TAB	5	PA, QL (90 TAB PER 30 DAYS), (Available from Biologics by McKesson and Onco360 Specialty)
RASONQUE 150 MG TAB	5	PA, QL (60 TAB PER 30 DAYS), (Available from Biologics by McKesson and Onco360 Specialty)
RETEVMO (120 MG TAB, 160 MG TAB)	5	PA, QL (60 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
RETEVMO 40 MG TAB	5	PA, QL (180 PER 30 DAYS)
RETEVMO 80 MG TAB	5	PA, QL (120 PER 30 DAYS)
REVUFORJ 110 MG TAB	5	PA, QL (120 PER 30 DAYS)
REVUFORJ 160 MG TAB	5	PA, QL (60 PER 30 DAYS)
REVUFORJ 25 MG TAB	5	PA, QL (240 PER 30 DAYS)
REZLIDHIA 150 MG CAP	5	PA, QL (60 PER 30 DAYS)
ROMVIMZA (14 MG CAP, 20 MG CAP, 30 MG CAP)	5	PA, QL (8 PER 28 OVER TIME)
ROZLYTREK 100 MG CAP	5	PA, QL (150 PER 30 DAYS)
ROZLYTREK 200 MG CAP	5	PA, QL (90 PER 30 DAYS)
ROZLYTREK 50 MG PACKET	5	PA, QL (360 PER 30 DAYS)
RUBRACA (200 MG TAB, 250 MG TAB, 300 MG TAB)	5	PA, QL (120 PER 30 DAYS)
RYDAPT 25 MG CAP	5	PA, QL (240 PER 30 DAYS)
SCSEMBLIX 100 MG TAB	5	PA, QL (120 PER 30 DAYS)
SCSEMBLIX 20 MG TAB	5	PA, QL (60 PER 30 DAYS)
SCSEMBLIX 40 MG TAB	5	PA, QL (300 PER 30 DAYS)
SOLTAMOX 10 MG/5ML SOLUTION	4	
<i>sorafenib tosylate 200 mg tab</i>	5	PA, QL (120 PER 30 DAYS)
STIVARGA 40 MG TAB	5	PA, QL (84 PER 21 DAYS)
<i>sunitinib malate (25 mg cap, 37.5 mg cap, 50 mg cap)</i>	5	PA, QL (30 PER 30 DAYS)
<i>sunitinib malate 12.5 mg cap</i>	5	PA, QL (90 PER 30 DAYS)
TABLOID LOID 40 MG	5	PA
TABRECTA (150 MG TAB, 200 MG TAB)	5	PA, QL (120 PER 30 DAYS)
TAFINLAR (50 MG CAP, 75 MG CAP)	5	PA, QL (120 PER 30 DAYS)
TAFINLAR 10 MG TAB SOL	5	PA, QL (900 PER 30 DAYS)
TAGRISSE (40 MG TAB, 80 MG TAB)	5	PA, LA, QL (30 PER 30 DAYS)
TALZENNA (0.1 MG CAP, 0.35 MG CAP, 0.5 MG CAP, 0.75 MG CAP, 1 MG CAP)	5	PA, QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
TALZENNA 0.25 MG CAP	5	PA, QL (90 PER 30 DAYS)
<i>tamoxifen citrate (10 mg tab, 20 mg tab)</i>	2	
TEPMETKO 225 MG TAB	5	PA, QL (60 PER 30 DAYS)
THALOMID 100 MG CAP	5	QL (120 PER 30 DAYS)
THALOMID 50 MG CAP	5	QL (240 PER 30 DAYS)
TIBSOVO 250 MG TAB	5	PA, QL (60 PER 30 DAYS)
<i>toremifene citrate 60 mg tab</i>	4	PA, QL (30 PER 30 DAYS)
<i>torpenz (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab)</i>	5	PA, LA, QL (30 PER 30 DAYS)
TRELSTAR MIXJECT (3.75 MG RECON SUSP, 11.25 MG RECON SUSP, 22.5 MG RECON SUSP)	4	BVD, (Route to BVSD with an AWD note.)
<i>tretinoin 10 mg cap</i>	5	QL (360 PER 30 DAYS)
TREXALL (5 MG TAB, 7.5 MG TAB, 10 MG TAB, 15 MG TAB)	3	(Route to BVSD with an AWD note.)
TRUQAP (160 MG TAB, 160 MG TAB THPK, 200 MG TAB, 200 MG TAB THPK)	5	PA, QL (64 PER 28 OVER TIME)
TUKYSA (50 MG TAB, 150 MG TAB)	5	PA, QL (120 PER 30 DAYS)
TURALIO 125 MG CAP	5	PA, LA, QL (120 PER 30 DAYS)
VANFLYTA 17.7 MG TAB	5	PA, QL (30 PER 30 DAYS)
VANFLYTA 26.5 MG TAB	5	PA, QL (60 PER 30 DAYS)
VENCLEXTA 10 MG TAB	4	PA, QL (120 PER 30 DAYS)
VENCLEXTA 100 MG TAB	5	PA, QL (240 PER 40 DAYS)
VENCLEXTA 50 MG TAB	5	PA, QL (120 PER 30 DAYS)
VENCLEXTA STARTING PACK 10 & 50 & 100 MG TAB THPK	5	PA, QL (120 PER 30 DAYS)
VEPPANU 100 MG TAB	5	PA, QL (60 PER 30 DAYS)
VEPPANU 200 MG TAB	5	PA, QL (30 PER 30 DAYS)
VERZENIO (50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB)	5	PA, QL (60 PER 30 DAYS)
VITRAKVI 100 MG CAP	5	PA, QL (60 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
VITRAKVI 20 MG/ML SOLUTION	5	PA, QL (300 PER 30 DAYS)
VITRAKVI 25 MG CAP	5	PA, QL (180 PER 30 DAYS)
VONJO 100 MG CAP	5	PA, QL (120 PER 30 DAYS)
VORANIGO 10 MG TAB	5	PA, QL (60 PER 30 DAYS)
VORANIGO 40 MG TAB	5	PA, QL (30 PER 30 DAYS)
WELIREG 40 MG TAB	5	PA, QL (90 PER 30 DAYS)
XALKORI (20 MG CAP SPRINK, 50 MG CAP SPRINK)	5	PA, QL (120 PER 30 DAYS)
XALKORI (200 MG CAP, 250 MG CAP)	5	PA, QL (60 PER 30 DAYS)
XALKORI 150 MG CAP SPRINK	5	PA, QL (180 PER 30 DAYS)
XOSPATA 40 MG TAB	5	PA, QL (90 PER 30 DAYS)
XPOVIO (100 MG ONCE WEEKLY) 50 TAB THPK	5	PA, QL (8 PER 28 OVER TIME)
XPOVIO (40 MG ONCE WEEKLY) 10 TAB THPK	5	PA, QL (16 PER 28 OVER TIME)
XPOVIO (40 MG ONCE WEEKLY) TAB THPK	5	PA, QL (4 PER 28 OVER TIME)
XPOVIO (40 MG TWICE WEEKLY) TAB THPK	5	PA, QL (8 PER 28 OVER TIME)
XPOVIO (60 MG ONCE WEEKLY) TAB THPK	5	PA, QL (4 PER 28 OVER TIME)
XPOVIO (60 MG TWICE WEEKLY) 20 TAB THPK	5	PA, QL (24 PER 28 OVER TIME)
XPOVIO (80 MG ONCE WEEKLY) 40 TAB THPK	5	PA, QL (8 PER 28 OVER TIME)
XPOVIO (80 MG ONCE WEEKLY) TAB THPK	5	PA, QL (4 PER 28 OVER TIME)
XPOVIO (80 MG TWICE WEEKLY) 20 TAB THPK	5	PA, QL (32 PER 28 OVER TIME)
XTANDI (40 MG CAP, 40 MG TAB, 80 MG TAB)	5	PA, QL (120 PER 30 DAYS)
YONSA 125 MG TAB	5	PA, QL (120 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>yulithira (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab)</i>	4	PA, QL (30 PER 30 DAYS)
ZEJULA (100 MG TAB, 200 MG TAB, 300 MG TAB)	5	PA, QL (30 PER 30 DAYS)
ZELBORAF 240 MG TAB	5	PA, QL (240 PER 30 DAYS)
ZENBEXUS (0.75 MG CAP, 1 MG CAP)	5	PA, QL (30 PER 30 DAYS)
ZOLINZA 100 MG CAP	5	PA, QL (120 PER 30 DAYS)
ZYKADIA 150 MG TAB	5	PA, QL (150 PER 30 DAYS)

ANTIPARASITICS

<i>albendazole 200 mg tab</i>	2	(Excluded from Auto Extension)
<i>atovaquone 750 mg/5ml suspension</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>atovaquone-proguanil hcl (62.5-25 mg tab, 250-100 mg tab)</i>	3	NM (Non-Mail Order)
<i>chloroquine phosphate (chloroquine phosphate 250 mg tab, chloroquine phosphate 250 mg tab, chloroquine phosphate 500 mg tab)</i>	2	NM (Non-Mail Order)
COARTEM 20-120 MG TAB	4	QL (24 PER 30 OVER TIME), NM (Non-Mail Order)
<i>hydroxychloroquine sulfate (hydroxychloroquine sulfate 100 mg tab, hydroxychloroquine sulfate 200 mg tab, hydroxychloroquine sulfate 300 mg tab, hydroxychloroquine sulfate 400 mg tab, hydroxychloroquine sulfate 100 mg tab, hydroxychloroquine sulfate 300 mg tab, hydroxychloroquine sulfate 400 mg tab)</i>	2	NM (Non-Mail Order)
<i>ivermectin 3 mg tab</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
KRINTAFEL 150 MG TAB	4	QL (4 PER 30 OVER TIME), NM (Non-Mail Order)
LAMPIT (30 MG TAB, 120 MG TAB)	4	PA, NM (Non-Mail Order), (Excluded from Auto Extension)
<i>mefloquine hcl 250 mg tab</i>	2	NM (Non-Mail Order)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>nitazoxanide 500 mg tab</i>	4	QL (20 PER 10 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>pentamidine isethionate 300 mg recon soln</i>	2	BVD, HI, NM (Non-Mail Order), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>praziquantel 600 mg tab</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>primaquine phosphate (primaquine phosphate 26.3 base mg tab, primaquine phosphate 26.3 base mg tab)</i>	2	NM (Non-Mail Order)
<i>pyrimethamine 25 mg tab</i>	5	
<i>quinine sulfate 324 mg cap</i>	3	NM (Non-Mail Order)

ANTIPARKINSON AGENTS

<i>amantadine hcl (50 mg/5ml solution, 100 mg tab, 100 mg/10ml solution)</i>	3	
<i>amantadine hcl 100 mg cap</i>	3	QL (120 PER 30 DAYS)
<i>apomorphine hcl 30 mg/3ml soln cart</i>	5	PA, (Route to BVSD with an AWD note.)
<i>benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	2	
<i>bromocriptine mesylate (2.5 mg tab, 5 mg cap)</i>	3	
<i>carbidopa 25 mg tab</i>	3	
<i>carbidopa-levodopa (10-100 mg tab, 10-100 mg tab disp, 25-100 mg tab, 25-100 mg tab disp, 25-250 mg tab, 25-250 mg tab disp)</i>	2	
<i>carbidopa-levodopa er (er 25-100 mg tab er, er 50-200 mg tab er)</i>	2	QL (360 PER 30 DAYS)
CARBIDOPA-LEVODOPA ER 23.75-95 MG CAP	3	ST, QL (750 PER 30 DAYS)
CARBIDOPA-LEVODOPA ER 36.25-145 MG CAP	3	ST, QL (480 PER 30 DAYS)
CARBIDOPA-LEVODOPA ER 48.75-195 MG CAP	3	ST, QL (360 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
CARBIDOPA-LEVODOPA ER 61.25-245 MG CAP	3	ST, QL (300 PER 30 DAYS)
<i>carbidopa-levodopa-entacapone (12.5-50-200 mg tab, 18.75-75-200 mg tab, 25-100-200 mg tab, 31.25-125-200 mg tab, 37.5-150-200 mg tab, 50-200-200 mg tab)</i>	3	
<i>entacapone 200 mg tab</i>	3	
<i>pramipexole dihydrochloride (0.125 mg tab, 0.25 mg tab, 0.5 mg tab, 0.75 mg tab, 1 mg tab, 1.5 mg tab)</i>	2	
<i>pramipexole dihydrochloride er (er 0.375 mg tab er, er 2.25 mg tab er, er 3 mg tab er, er 3.75 mg tab er, er 4.5 mg tab er)</i>	3	ST, QL (30 PER 30 DAYS)
<i>pramipexole dihydrochloride er (er 0.75 mg tab er, er 1.5 mg tab er)</i>	3	ST, QL (90 PER 30 DAYS)
<i>rasagiline mesylate (0.5 mg tab, 1 mg tab)</i>	3	
<i>ropinirole hcl (0.25 mg tab, 0.5 mg tab, 1 mg tab, 2 mg tab, 3 mg tab, 4 mg tab, 5 mg tab)</i>	2	
<i>ropinirole hcl er (er 2 mg tab er, er 4 mg tab er, er 6 mg tab er, er 8 mg tab er, er 12 mg tab er)</i>	3	QL (90 PER 30 DAYS)
<i>selegiline hcl (5 mg cap, 5 mg tab)</i>	3	
<i>trihexyphenidyl hcl (2 mg tab, 5 mg tab)</i>	2	QL (150 PER 30 DAYS)
<i>trihexyphenidyl hcl 0.4 mg/ml solution</i>	2	

ANTIPSYCHOTICS

ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR	5	QL (2.4 PER 56 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR	5	QL (3.2 PER 56 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG PRSYR, 400 MG SRER)	5	QL (2 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
<i>aripiprazole (10 mg tab disp, 15 mg tab disp)</i>	2	QL (60 PER 30 DAYS)
<i>aripiprazole (2 mg tab, 5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>aripiprazole 1 mg/ml solution</i>	2	QL (900 PER 30 DAYS)
ARISTADA 1064 MG/3.9ML PRSYR	5	QL (3.9 PER 56 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ARISTADA 441 MG/1.6ML PRSYR	5	QL (1.6 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ARISTADA 662 MG/2.4ML PRSYR	5	QL (2.4 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ARISTADA 882 MG/3.2ML PRSYR	5	QL (3.2 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ARISTADA INITIO 675 MG/2.4ML PRSYR	5	QL (2.4 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
<i>asenapine maleate (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	3	ST, QL (60 PER 30 DAYS)
BYSANTI (1 MG TAB, 2 MG TAB, 4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	5	PA, QL (60 PER 30 DAYS)
BYSANTI TITRATION PACK A BYSNTI TITRTION PCK 1 & 2 & 4 & 6 MG TB THPK	5	PA, QL (8 PER 180 OVER TIME)
BYSANTI TITRATION PACK B YSANTI 1 & 2 & 6 & 8 MG TATHPK	5	PA, QL (12 PER 180 OVER TIME)
BYSANTI TITRATION PACK C PAK 1 & 2 & 6 MG TAB THPK	5	PA, QL (8 PER 180 DAYS)
CAPLYTA (10.5 MG CAP, 21 MG CAP, 42 MG CAP)	5	PA, QL (30 PER 30 DAYS)
<i>chlorpromazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)</i>	2	
<i>chlorpromazine hcl (chlorpromazine hcl 100 mg/ml conc, chlorpromazine hcl 30 mg/ml conc, chlorpromazine hcl 30 mg/ml conc, chlorpromazine hcl 100 mg/ml conc)</i>	3	
<i>clozapine (100 mg tab, 150 mg tab disp, 200 mg tab disp)</i>	3	QL (180 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>clozapine (12.5 mg tab disp, 25 mg tab disp, 100 mg tab disp)</i>	3	QL (270 PER 30 DAYS)
<i>clozapine (25 mg tab, 50 mg tab)</i>	3	QL (90 PER 30 DAYS)
<i>clozapine 200 mg tab</i>	3	QL (135 PER 30 DAYS)
COBENFY (50-20 MG CAP, 100-20 MG CAP, 125-30 MG CAP)	5	PA, QL (60 PER 30 DAYS)
COBENFY STARTER PACK 50-20 & 100-20 MG CAP THPK	5	PA, QL (56 PER 180 OVER TIME)
<i>compro 25 mg suppos</i>	2	(Route to BVSD with an AWD note.)
EQUETRO (100 MG CAP ER 12H, 200 MG CAP ER 12H, 300 MG CAP ER 12H)	4	ST, QL (180 PER 30 DAYS)
ERZOFRI 117 MG/0.75ML SUSP PRSYR	5	QL (0.75 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ERZOFRI 156 MG/ML SUSP PRSYR	5	QL (1 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ERZOFRI 234 MG/1.5ML SUSP PRSYR	5	QL (1.5 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ERZOFRI 351 MG/2.25ML SUSP PRSYR	5	QL (2.25 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ERZOFRI 39 MG/0.25ML SUSP PRSYR	4	QL (0.25 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
ERZOFRI 78 MG/0.5ML SUSP PRSYR	5	QL (0.5 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	5	PA, QL (60 PER 30 DAYS)
FANAPT TITRATION PACK A FNPT TITRTION PCK 1 & 2 & 4 & 6 MG TB	4	PA, QL (8 PER 30 OVER TIME)
FANAPT TITRATION PACK B 1 & 2 & 6 & 8 MG TA	4	PA, QL (8 PER 30 OVER TIME)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
FANAPT TITRATION PACK C PAK 1 & 2 & 6 MG TAB	4	PA, QL (8 PER 30 OVER TIME)
<i>fluphenazine decanoate 25 mg/ml solution</i>	3	BVD, (Route to BVSD with an AWD note.)
<i>fluphenazine hcl (fluphenazine hcl 1 mg tab, fluphenazine hcl 2.5 mg tab, fluphenazine hcl 5 mg tab, fluphenazine hcl 10 mg tab, fluphenazine hcl 2.5 mg/5ml elixir, fluphenazine hcl 5 mg/ml conc)</i>	3	
FLUPHENAZINE HCL 2.5 MG/ML SOLUTION	3	BVD, (Route to BVSD with an AWD note.)
<i>haloperidol (0.5 mg tab, 1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	2	
<i>haloperidol decanoate (50 mg/ml, 100 mg/ml)</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>haloperidol lactate 2 mg/ml conc</i>	2	
<i>haloperidol lactate 5 mg/ml solution</i>	2	BVD, (Route to BVSD with an AWD note.)
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	5	QL (3.5 PER 180 OVER TIME), BVD, (Route to BVSD with an AWD note.)
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	5	QL (5 PER 180 OVER TIME), BVD, (Route to BVSD with an AWD note.)
INVEGA SUSTENNA (78 MG/0.5ML SUSP PRSYR, 117 MG/0.75ML SUSP PRSYR, 156 MG/ML SUSP PRSYR, 234 MG/1.5ML SUSP PRSYR)	5	BVD, (Route to BVSD with an AWD note.)
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	4	BVD, (Route to BVSD with an AWD note.)
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	5	QL (0.88 PER 90 OVER TIME), BVD, (Route to BVSD with an AWD note.)
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	5	QL (1.32 PER 90 OVER TIME), BVD, (Route to BVSD with an AWD note.)
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	5	QL (1.75 PER 90 OVER TIME), BVD, (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	5	QL (2.63 PER 90 OVER TIME), BVD, (Route to BVSD with an AWD note.)
<i>loxapine succinate (5 mg cap, 10 mg cap, 25 mg cap, 50 mg cap)</i>	2	
<i>lurasidone hcl (20 mg tab, 40 mg tab, 60 mg tab, 80 mg tab, 120 mg tab)</i>	2	
LYBALVI (5-10 MG TAB, 10-10 MG TAB, 15-10 MG TAB, 20-10 MG TAB)	5	PA, QL (30 PER 30 DAYS)
MOLINDONE HCL (5 MG TAB, 10 MG TAB, 25 MG TAB)	2	QL (270 PER 30 DAYS)
NUPLAZID (10 MG TAB, 34 MG CAP)	5	PA, QL (60 PER 30 DAYS)
<i>olanzapine (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab)</i>	2	
<i>olanzapine (5 mg tab disp, 10 mg tab disp, 15 mg tab disp, 20 mg tab disp)</i>	3	QL (30 PER 30 DAYS)
<i>olanzapine 10 mg recon soln</i>	2	BVD, (Route to BVSD with an AWD note.)
OPIPZA 10 MG FILM	5	PA, QL (90 PER 30 DAYS)
OPIPZA 2 MG FILM	5	PA, QL (30 PER 30 DAYS)
OPIPZA 5 MG FILM	5	PA, QL (180 PER 30 DAYS)
<i>paliperidone er (er 1.5 mg tab er, er 3 mg tab er, er 9 mg tab er)</i>	3	QL (30 PER 30 DAYS)
<i>paliperidone er 6 mg tab 24h</i>	3	QL (60 PER 30 DAYS)
<i>perphenazine (2 mg tab, 4 mg tab, 8 mg tab, 16 mg tab)</i>	2	
<i>pimozide (1 mg tab, 2 mg tab)</i>	2	
<i>prochlorperazine 25 mg suppos</i>	3	(Route to BVSD with an AWD note.)
<i>prochlorperazine maleate (5 mg tab, 10 mg tab)</i>	2	(Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>quetiapine fumarate (quetiapine fumarate 25 mg tab, quetiapine fumarate 50 mg tab, quetiapine fumarate 150 mg tab, quetiapine fumarate 100 mg tab, quetiapine fumarate 200 mg tab, quetiapine fumarate 300 mg tab, quetiapine fumarate 400 mg tab)</i>	2	
<i>quetiapine fumarate er (er 50 mg tab er, er 150 mg tab er, er 200 mg tab er, er 300 mg tab er, er 400 mg tab er)</i>	3	
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB, 2 MG TAB, 3 MG TAB, 4 MG TAB)	5	PA, QL (30 PER 30 DAYS)
<i>risperidone (0.5 mg tab disp, 1 mg tab disp, 2 mg tab disp, 3 mg tab disp, 4 mg tab disp)</i>	2	QL (60 PER 30 DAYS)
<i>risperidone (0.5 mg tab, 1 mg tab, 2 mg tab, 3 mg tab, 4 mg tab)</i>	2	
<i>risperidone 0.25 mg tab</i>	2	
RISPERIDONE 0.25 MG TAB DISP	2	QL (30 PER 30 DAYS)
<i>risperidone 1 mg/ml solution</i>	2	QL (240 PER 30 DAYS)
<i>risperidone microspheres er (er 12.5 mg, er 25 mg)</i>	4	BVD, (Route to BVSD with an AWD note.)
<i>risperidone microspheres er (er 37.5 mg, er 50 mg)</i>	5	BVD, (Route to BVSD with an AWD note.)
SECUADO (3.8 MG/24HR PATCH 24HR, 5.7 MG/24HR PATCH 24HR, 7.6 MG/24HR PATCH 24HR)	5	ST, QL (30 PER 30 DAYS)
<i>thioridazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)</i>	2	
<i>thiothixene (1 mg cap, 2 mg cap, 5 mg cap, 10 mg cap)</i>	2	
<i>trifluoperazine hcl (1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab)</i>	2	
UZEDY 100 MG/0.28ML SUSP PRSYR	5	QL (0.28 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
UZEDY 125 MG/0.35ML SUSP PRSYR	5	QL (0.35 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
UZEDY 150 MG/0.42ML SUSP PRSYR	5	QL (0.42 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
UZEDY 200 MG/0.56ML SUSP PRSYR	5	QL (0.56 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
UZEDY 250 MG/0.7ML SUSP PRSYR	5	QL (0.7 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
UZEDY 50 MG/0.14ML SUSP PRSYR	5	QL (0.14 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
UZEDY 75 MG/0.21ML SUSP PRSYR	5	QL (0.21 PER 28 OVER TIME), BVD, (Route to BVSD with an AWD note.)
VERSACLOZ 50 MG/ML SUSPENSION	5	PA, QL (600 PER 30 DAYS)
VRAYLAR (0.5 MG CAP, 0.75 MG CAP, 1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	3	ST, QL (30 PER 30 DAYS)
<i>ziprasidone hcl (20 mg cap, 40 mg cap, 60 mg cap, 80 mg cap)</i>	2	
<i>ziprasidone mesylate 20 mg recon soln</i>	2	BVD, (Route to BVSD with an AWD note.)

ANTIVIRALS

<i>abacavir sulfate 20 mg/ml solution</i>	4	(Excluded from Auto Extension)
<i>abacavir sulfate 300 mg tab</i>	4	QL (180 PER 30 DAYS), (Excluded from Auto Extension)
<i>abacavir sulfate-lamivudine 600-300 mg tab</i>	4	QL (30 PER 30 DAYS), (Excluded from Auto Extension)
<i>acyclovir (200 mg/5ml suspension, 800 mg/20ml suspension)</i>	2	(Excluded from Auto Extension)
<i>acyclovir (400 mg tab, 800 mg tab)</i>	1	(Excluded from Auto Extension)
<i>acyclovir 200 mg cap</i>	1	
<i>acyclovir 5 % ointment</i>	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>acyclovir sodium 50 mg/ml solution</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B), (Excluded from Auto Extension)
<i>adefovir dipivoxil 10 mg tab</i>	3	QL (30 PER 30 DAYS), (Excluded from Auto Extension)
APTIVUS 250 MG CAP	5	QL (120 PER 30 DAYS), (Excluded from Auto Extension)
<i>atazanavir sulfate (150 mg cap, 200 mg cap, 300 mg cap)</i>	3	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
BARACLUDE 0.05 MG/ML SOLUTION	4	NM (Non-Mail Order), (Excluded from Auto Extension)
BIKTARVY 30-120-15 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
BIKTARVY 50-200-25 MG TAB	5	QL (30 PER 30 DAYS)
CIMDUO 300-300 MG TAB	5	QL (30 PER 30 DAYS), (Excluded from Auto Extension)
<i>darunavir 600 mg tab</i>	4	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>darunavir 800 mg tab</i>	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
DELSTRIGO 100-300-300 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
DESCOVY (120-15 MG TAB, 200-25 MG TAB)	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
DOVATO 50-300 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
EDURANT PED 2.5 MG TAB SOL	5	QL (180 PER 30 DAYS)
<i>efavirenz 600 mg tab</i>	3	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>efavirenz-emtricitab-tenofo df 600-200-300 mg</i>	4	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>efavirenz-lamivudine-tenofovir (efavirenz-lamivudine-tenofovir 400-300-300 mg tab, efavirenz-lamivudine-tenofovir 600-300-300 mg tab)</i>	4	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>emtricitab-rilpivir-tenofov df 200-25-300 mg</i>	5	
<i>emtricitabine 200 mg cap</i>	4	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>emtricitabine-tenofovir df (100-150 mg tab, 133-200 mg tab, 167-250 mg tab, 200-300 mg tab)</i>	4	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
EMTRIVA 10 MG/ML SOLUTION	4	QL (720 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>entecavir 0.5 mg tab</i>	4	QL (30 PER 30 DAYS)
<i>entecavir 1 mg tab</i>	4	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>etravirine (100 mg tab, 200 mg tab)</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)
EVOTAZ 300-150 MG TAB	4	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>famciclovir (125 mg tab, 250 mg tab, 500 mg tab)</i>	2	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>fosamprenavir calcium 700 mg tab</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)
GENVOYA 150-150-200-10 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
IDVYNZO 100-0.25 MG TAB	5	QL (30 PER 30 DAYS)
INTELENCE 25 MG TAB	4	NM (Non-Mail Order), (Excluded from Auto Extension)
ISENTRESS 100 MG CHEW TAB	5	QL (180 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
ISENTRESS 100 MG PACKET	5	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
ISENTRESS 25 MG CHEW TAB	4	QL (180 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
ISENTRESS 400 MG TAB	5	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
ISENTRESS HD 600 MG TAB	5	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
JULUCA 50-25 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>lamivudine (10 mg/ml, 300 mg/30ml)</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)
<i>lamivudine (100 mg tab, 150 mg tab, 300 mg tab)</i>	4	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>lamivudine-zidovudine 150-300 mg tab</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)
LEDIPASVIR-SOFOSBUVIR 90-400 MG TAB	5	PA, QL (168 PER 365 OVER TIME), (Excluded from Auto Extension)
LIVTENCITY 200 MG TAB	5	PA, QL (336 PER 28 DAYS), (Excluded from Auto Extension)
<i>lopinavir-ritonavir 100-25 mg tab</i>	4	QL (300 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>lopinavir-ritonavir 200-50 mg tab</i>	4	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>maraviroc (150 mg tab, 300 mg tab)</i>	3	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
MAVYRET 100-40 MG TAB	5	PA, QL (84 PER 28 DAYS), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
MAVYRET 50-20 MG PACKET	5	PA, QL (140 PER 28 DAYS), (Excluded from Auto Extension)
<i>nevirapine 200 mg tab</i>	4	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
NEVIRAPINE 50 MG/5ML SUSPENSION	4	QL (1200 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>nevirapine er 400 mg tab 24h</i>	4	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
ODEFSEY 200-25-25 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>oseltamivir phosphate 30 mg cap</i>	3	QL (84 PER 180 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>oseltamivir phosphate 45 mg cap</i>	3	QL (42 PER 180 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>oseltamivir phosphate 6 mg/ml recon susp</i>	3	
<i>oseltamivir phosphate 75 mg cap</i>	3	QL (42 PER 180 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
PAXLOVID (150/100) MG & 0MG TAB THPK	3	QL (30 PER 60 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
PAXLOVID (300/100 & 150/100) 6 10 MG 100MG TAB THPK	3	QL (11 PER 60 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
PAXLOVID (300/100) 20 150 MG & 0MG TAB THPK	3	QL (30 PER 60 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
PEGASYS 180 MCG/0.5ML SOLN PRSYR	5	PA, QL (4 PER 30 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
PEGASYS 180 MCG/ML SOLUTION	5	PA, QL (4 PER 28 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
PIFELTRO 100 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
PREVYMIS (20 MG PACKET, 120 MG PACKET)	5	PA, QL (800 PER 365 OVER TIME), (Excluded from Auto Extension)
PREVYMIS (240 MG TAB, 480 MG TAB)	5	PA, QL (200 PER 365 OVER TIME), (Excluded from Auto Extension)
PREZCOBIX (675-150 MG TAB, 800-150 MG TAB)	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
PREZISTA 100 MG/ML SUSPENSION	5	QL (360 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
PREZISTA 150 MG TAB	5	QL (180 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
PREZISTA 75 MG TAB	4	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
RELENZA DISKHALER 5 MG/ACT AER POW BA	4	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
REYATAZ 50 MG PACKET	5	QL (240 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
RIBAVIRIN 200 MG CAP	3	QL (210 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
RIBAVIRIN 200 MG TAB	3	QL (210 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>rilpivirine hcl 25 mg tab</i>	5	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>ritonavir 100 mg tab</i>	4	QL (450 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
RUKOBIA 600 MG TAB ER 12H	5	QL (60 PER 30 DAYS), (Excluded from Auto Extension)
SOFOSBUVIR-VELPATASVIR 400-100 MG TAB	5	PA, QL (30 PER 30 DAYS), (Excluded from Auto Extension)
STRIBILD 150-150-200-300 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
SUNLENCA 300 MG TAB	5	QL (5 PER 28 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
SUNLENCA 4 X 300 MG TAB THPK	5	QL (4 PER 180 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
SUNLENCA 5 X 300 MG TAB THPK	5	QL (5 PER 180 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
SYMTUZA 800-150-200-10 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>tenofovir disoproxil fumarate 300 mg tab</i>	3	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
TIVICAY 50 MG TAB	5	QL (60 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
TIVICAY PD 5 MG TAB SOL	5	QL (180 PER 30 DAYS), (Excluded from Auto Extension)
TRIUMEQ 600-50-300 MG TAB	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
TRIUMEQ PD 60-5-30 MG TAB SOL	5	QL (180 PER 30 DAYS), (Excluded from Auto Extension)
<i>valacyclovir hcl (1 gm tab, 500 mg tab)</i>	2	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>valganciclovir hcl 450 mg tab</i>	3	QL (90 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>valganciclovir hcl 50 mg/ml recon soln</i>	3	NM (Non-Mail Order), (Excluded from Auto Extension)
VEMLIDY 25 MG TAB	5	PA, QL (30 PER 30 DAYS), (Excluded from Auto Extension)
VIRACEPT (250 MG TAB, 625 MG TAB)	5	NM (Non-Mail Order), (Excluded from Auto Extension)
VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB)	5	QL (30 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
VIREAD 40 MG/GM POWDER	5	NM (Non-Mail Order), (Excluded from Auto Extension)
VOSEVI 400-100-100 MG TAB	5	PA, QL (28 PER 28 DAYS), (Excluded from Auto Extension)
XOFLUZA (40 MG DOSE) OFLUZA 1 TAB THPK	4	QL (8 PER 365 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
XOFLUZA (80 MG DOSE) OFLUZA 1 TAB THPK	4	QL (8 PER 365 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
XOFLUZA (80 MG DOSE) OFLUZA 2 40 TAB THPK	4	QL (8 PER 365 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>zidovudine (50 mg/5ml syrup, 100 mg cap, 300 mg tab)</i>	4	NM (Non-Mail Order), (Excluded from Auto Extension)

ANXIOLYTICS

<i>alprazolam (0.25 mg tab disp, 0.5 mg tab disp, 1 mg tab disp, 2 mg tab disp)</i>	3	QL (150 PER 30 DAYS)
<i>alprazolam (0.25 mg tab, 0.5 mg tab, 1 mg tab, 2 mg tab)</i>	2	QL (150 PER 30 DAYS)
<i>alprazolam er (er 0.5 mg tab er, er 1 mg tab er, er 2 mg tab er, er 3 mg tab er)</i>	3	QL (90 PER 30 DAYS)
ALPRAZOLAM INTENSOL 1 MG/ML CONC	2	QL (300 PER 30 DAYS)
<i>alprazolam xr (0.5 mg tab er, 1 mg tab er, 2 mg tab er, 3 mg tab er)</i>	3	QL (90 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>buspirone hcl (5 mg tab, 7.5 mg tab, 10 mg tab, 15 mg tab, 30 mg tab)</i>	2	
<i>clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)</i>	3	QL (90 PER 30 DAYS)
<i>clorazepate dipotassium 15 mg tab</i>	3	QL (180 PER 30 DAYS)
<i>diazepam (2 mg tab, 5 mg tab, 10 mg tab)</i>	2	QL (120 PER 30 DAYS)
<i>diazepam 5 mg/5ml solution</i>	2	QL (1200 PER 30 DAYS)
<i>diazepam 5 mg/ml conc</i>	2	QL (240 PER 30 DAYS)
<i>diazepam intensol 5 mg/ml conc</i>	2	QL (240 PER 30 DAYS)
<i>lorazepam (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	2	QL (150 PER 30 DAYS)
<i>lorazepam 2 mg/ml conc</i>	2	QL (150 PER 30 DAYS)
<i>lorazepam intensol 2 mg/ml conc</i>	2	QL (150 PER 30 DAYS)

BIPOLAR AGENTS

MOOD STABILIZERS

<i>lithium 8 meq/5ml solution</i>	2	
<i>lithium carbonate (lithium carbonate 150 mg cap, lithium carbonate 300 mg cap, lithium carbonate 300 mg tab, lithium carbonate 600 mg cap, lithium carbonate 150 mg cap, lithium carbonate 300 mg cap, lithium carbonate 600 mg cap)</i>	2	
<i>lithium carbonate er (er 300 mg tab er, er 450 mg tab er)</i>	2	

BLOOD GLUCOSE REGULATORS

ANTIDIABETIC AGENTS

<i>acarbose (25 mg tab, 50 mg tab, 100 mg tab)</i>	1	QL (90 PER 30 DAYS)
ALOGLIPTIN BENZOATE (6.25 MG TAB, 12.5 MG TAB, 25 MG TAB)	1	QL (30 PER 30 DAYS)
ALOGLIPTIN-METFORMIN HCL (12.5-1000 MG TAB, 12.5-500 MG TAB)	1	QL (60 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
ALOGLIPTIN-PIOGLITAZONE (12.5-30 MG TAB, 25-15 MG TAB, 25-30 MG TAB, 25-45 MG TAB)	1	QL (30 PER 30 DAYS)
<i>dapaglifloz base-metformin er (er 10-1000 mg tab er, er 10-500 mg tab er)</i>	1	QL (30 PER 30 DAYS)
<i>dapaglifloz base-metformin er (er 5-1000 mg tab er, er 5-500 mg tab er)</i>	1	QL (60 PER 30 DAYS)
<i>dapagliflozin (5 mg tab, 10 mg tab)</i>	1	QL (30 PER 30 DAYS)
FARXIGA (5 MG TAB, 10 MG TAB)	3	QL (30 PER 30 DAYS)
<i>glimepiride (1 mg tab, 2 mg tab, 4 mg tab)</i>	1	
<i>glipizide (glipizide 2.5 mg tab, glipizide 15 mg tab, glipizide 5 mg tab, glipizide 10 mg tab)</i>	1	
<i>glipizide er (er 2.5 mg tab er, er 5 mg tab er, er 10 mg tab er)</i>	1	
<i>glipizide xl (2.5 mg tab er, 5 mg tab er, 10 mg tab er)</i>	1	
<i>glipizide-metformin hcl (2.5-250 mg tab, 2.5-500 mg tab, 5-500 mg tab)</i>	1	
<i>glyburide-metformin (1.25-250 mg tab, 2.5-500 mg tab, 5-500 mg tab)</i>	1	QL (120 PER 30 DAYS)
GLYXAMBI (10-5 MG TAB, 25-5 MG TAB)	3	QL (30 PER 30 DAYS)
JANUMET (50-1000 MG TAB, 50-500 MG TAB)	3	QL (60 PER 30 DAYS)
JANUMET XR (50-1000 MG TAB ER 24H, 50-500 MG TAB ER 24H)	3	QL (60 PER 30 DAYS)
JANUMET XR 100-1000 MG TAB ER 24H	3	QL (30 PER 30 DAYS)
JANUVIA (25 MG TAB, 50 MG TAB, 100 MG TAB)	3	QL (30 PER 30 DAYS)
JARDIANCE (10 MG TAB, 25 MG TAB)	3	QL (30 PER 30 DAYS)
JENTADUETO 2.5-1000 MG TAB	3	QL (60 PER 30 DAYS)
JENTADUETO 2.5-500 MG TAB	3	QL (120 PER 30 DAYS)
JENTADUETO XR 2.5-1000 MG TAB ER 24H	3	QL (60 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
JENTADUETO XR 5-1000 MG TAB ER 24H	3	QL (30 PER 30 DAYS)
<i>metformin hcl (500 mg tab, 500 mg/5ml solution, 850 mg tab, 1000 mg tab)</i>	1	
<i>metformin hcl er (er 500 mg tab er, er 750 mg tab er)</i>	1	
MIGLITOL (25 MG TAB, 50 MG TAB, 100 MG TAB)	2	
MOUNJARO (2.5 MG/0.5ML SOLN A- INJ, 5 MG/0.5ML SOLN A-INJ, 7.5 MG/0.5ML SOLN A-INJ, 10 MG/0.5ML SOLN A-INJ, 12.5 MG/0.5ML SOLN A- INJ, 15 MG/0.5ML SOLN A-INJ)	3	PA, QL (2 PER 28 OVER TIME)
<i>nateglinide (60 mg tab, 120 mg tab)</i>	1	
OZEMPIC (0.25 OR 0.5 MG/DOSE) (MG/3ML SOLN PEN	3	PA, QL (3 PER 28 OVER TIME)
OZEMPIC (1 MG/DOSE) 4 MG/3ML SOLN PEN	3	PA, QL (3 PER 28 OVER TIME)
OZEMPIC (1.5 MG TAB, 4 MG TAB, 9 MG TAB)	3	PA, QL (30 PER 30 DAYS)
OZEMPIC (2 MG/DOSE) 8 MG/3ML SOLN PEN	3	PA, QL (3 PER 28 OVER TIME)
<i>pioglitazone hcl (15 mg tab, 30 mg tab, 45 mg tab)</i>	1	QL (30 PER 30 DAYS)
<i>pioglitazone hcl-glimepiride (30-2 mg tab, 30-4 mg tab)</i>	1	QL (30 PER 30 DAYS)
<i>pioglitazone hcl-metformin hcl (15-500 mg tab, 15-850 mg tab)</i>	1	QL (90 PER 30 DAYS)
<i>repaglinide (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1	
<i>saxagliptin hcl (2.5 mg tab, 5 mg tab)</i>	1	QL (30 PER 30 DAYS)
<i>saxagliptin-metformin er (er 5-1000 mg tab er, er 5-500 mg tab er)</i>	1	QL (30 PER 30 DAYS)
<i>saxagliptin-metformin er 2.5-1000 mg tab 24h</i>	1	QL (60 PER 30 DAYS)
SEGLUROMET (2.5-1000 MG TAB, 2.5-500 MG TAB, 7.5-1000 MG TAB, 7.5-500 MG TAB)	4	ST, QL (60 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
SITAGLIPT BASE-METFORM HCL ER (ER 50-1000 MG TAB ER 24H, ER 50-500 MG TAB ER 24H)	1	QL (60 PER 30 DAYS)
SITAGLIPT BASE-METFORM HCL ER 100-1000 MG TAB 24H	1	QL (30 PER 30 DAYS)
SITAGLIPTIN (25 MG TAB, 50 MG TAB, 100 MG TAB)	1	QL (30 PER 30 DAYS)
SITAGLIPTIN BASE-METFORMIN HCL (50-1000 MG TAB, 50-500 MG TAB)	1	QL (60 PER 30 DAYS)
SOLIQUA 100-33 UNT-MCG/ML SOLN PEN	3	QL (18 PER 30 OVER TIME), \$35 (\$35/30)
STEGLATRO (5 MG TAB, 15 MG TAB)	4	ST, QL (30 PER 30 DAYS)
SYNJARDY (5-1000 MG TAB, 5-500 MG TAB, 12.5-1000 MG TAB, 12.5-500 MG TAB)	3	QL (60 PER 30 DAYS)
SYNJARDY XR (5-1000 MG TAB ER 24H, 10-1000 MG TAB ER 24H, 12.5-1000 MG TAB ER 24H)	3	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1000 MG TAB ER 24H	3	QL (30 PER 30 DAYS)
TRADJENTA 5 MG TAB	3	QL (30 PER 30 DAYS)
TRIJARDY XR (5-2.5-1000 MG TAB ER 24H, 10-5-1000 MG TAB ER 24H, 12.5-2.5-1000 MG TAB ER 24H, 25-5-1000 MG TAB ER 24H)	3	
TRULICITY (0.75 MG/0.5ML SOLN A-INJ, 1.5 MG/0.5ML SOLN A-INJ, 3 MG/0.5ML SOLN A-INJ, 4.5 MG/0.5ML SOLN A-INJ)	3	PA, QL (4 PER 28 OVER TIME)
XIGDUO XR (2.5-1000 MG TAB ER 24H, 5-1000 MG TAB ER 24H)	3	QL (60 PER 30 DAYS)
XIGDUO XR (5-500 MG TAB ER 24H, 10-1000 MG TAB ER 24H, 10-500 MG TAB ER 24H)	3	QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
GLYCEMIC AGENTS		
BAQSIMI ONE PACK 3 MG/DOSE POWDER	3	
BAQSIMI TWO PACK 3 MG/DOSE POWDER	3	
<i>diazoxide 50 mg/ml suspension</i>	5	
<i>glucagon emergency (glucagon emergency 1 mg recon soln, glucagon emergency 1 mg recon soln)</i>	3	
GVOKE HYPOPEN 1-PACK (0.5 MG/0.1ML SOLN A-INJ, 1 MG/0.2ML SOLN A-INJ)	3	
GVOKE HYPOPEN 2-PACK (0.5 MG/0.1ML SOLN A-INJ, 1 MG/0.2ML SOLN A-INJ)	3	
GVOKE KIT 1 MG/0.2ML SOLUTION	3	
GVOKE PFS 1 MG/0.2ML SOLN PRSYR	3	
<i>mifepristone 300 mg tab</i>	5	PA, QL (120 PER 30 DAYS)
INSULINS		
FIASP 100 UNIT/ML SOLUTION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
FIASP FLEXTOUCH 100 UNIT/ML SOLN PEN	3	\$35 (\$35/30)
FIASP PENFILL 100 UNIT/ML SOLN CART	3	\$35 (\$35/30)
HUMALOG (100 UNIT/ML SOLN CART, 100 UNIT/ML SOLUTION)	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
HUMALOG JUNIOR KWIKPEN KWIK100 UNIT/ML SOLN	3	\$35 (\$35/30)
HUMALOG KWIKPEN KWIK100 UNIT/ML SOLN	3	\$35 (\$35/30)
HUMALOG KWIKPEN KWIK200 UNIT/ML SOLN	3	\$35 (\$35/30)
HUMALOG MIX 50/50 (50-50) 100 UNIT/ML SUSPENSION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
HUMALOG MIX 50/50 KWIKPEN KWIK(50-50) 100 UNIT/ML SUSP	3	\$35 (\$35/30)
HUMALOG MIX 75/25 (75-25) 100 UNIT/ML SUSPENSION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
HUMALOG MIX 75/25 KWIKPEN KWIK(75-25) 100 UNIT/ML SUSP	3	\$35 (\$35/30)
HUMULIN R U-500 KWIKPEN KWIKUNIT/ML SOLN	3	\$35 (\$35/30)
INSULIN LISPRO (1 UNIT DIAL) 100 /ML SOLN PEN	3	\$35 (\$35/30)
INSULIN LISPRO 100 UNIT/ML SOLUTION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
INSULIN LISPRO JUNIOR KWIKPEN KWIK100 UNIT/ML SOLN	3	\$35 (\$35/30)
INSULIN LISPRO PROT & LISPRO (75-25) 100 UNIT/ML SUSP PEN	3	\$35 (\$35/30)
LANTUS 100 UNIT/ML SOLUTION	3	QL (120 PER 30 DAYS), \$35 (\$35/30)
LANTUS SOLOSTAR 100 UNIT/ML SOLN PEN	3	QL (120 PER 30 DAYS), \$35 (\$35/30)
NOVOLOG 100 UNIT/ML SOLUTION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
NOVOLOG 70/30 FLEXPEN RELION FLEX(70-30) 100 UNIT/ML SUSP	3	\$35 (\$35/30)
NOVOLOG FLEXPEN FLEX100 UNIT/ML SOLN	3	\$35 (\$35/30)
NOVOLOG FLEXPEN RELION FLEX100 UNIT/ML SOLN	3	\$35 (\$35/30)
NOVOLOG MIX 70/30 (70-30) 100 UNIT/ML SUSPENSION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
NOVOLOG MIX 70/30 FLEXPEN FLEX(70-30) 100 UNIT/ML SUSP	3	\$35 (\$35/30)
NOVOLOG MIX 70/30 RELION (70- 30) 100 UNIT/ML SUSPENSION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
NOVOLOG PENFILL 100 UNIT/ML SOLN CART	3	\$35 (\$35/30)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
NOVOLOG RELION 100 UNIT/ML SOLUTION	3	\$35 (\$35/30), (Route to BVSD with an AWD note.)
TOUJEO MAX SOLOSTAR 300 UNIT/ML SOLN PEN	3	QL (30 PER 30 DAYS), \$35 (\$35/30)
TOUJEO SOLOSTAR 300 UNIT/ML SOLN PEN	3	QL (45 PER 30 DAYS), \$35 (\$35/30)

BLOOD PRODUCTS AND MODIFIERS

ANTICOAGULANTS

<i>dabigatran etexilate mesylate (75 mg cap, 110 mg cap, 150 mg cap)</i>	4	QL (60 PER 30 DAYS)
ELIQUIS (1.5 MG PACK) 3 X 0.5 TAB SOL	3	QL (448 PER 28 DAYS)
ELIQUIS (2 MG PACK) 4 X 0.5 TAB SOL	3	QL (448 PER 28 DAYS)
ELIQUIS 0.15 MG CAP SPRINK	3	QL (70 PER 28 DAYS)
ELIQUIS 0.5 MG TAB SOL	3	QL (448 PER 28 DAYS)
ELIQUIS 2.5 MG TAB	3	QL (60 PER 30 DAYS)
ELIQUIS 5 MG TAB	3	QL (74 PER 30 DAYS)
ELIQUIS DVT/PE STARTER PACK 5 MG TAB THPK	3	QL (74 PER 180 OVER TIME)
<i>enoxaparin sodium (30 mg/0.3ml soln, 40 mg/0.4ml soln, 60 mg/0.6ml soln, 80 mg/0.8ml soln, 100 mg/ml soln, 120 mg/0.8ml soln, 150 mg/ml soln)</i>	3	
<i>fondaparinux sodium (5 mg/0.4ml, 7.5 mg/0.6ml, 10 mg/0.8ml)</i>	5	QL (30 PER 30 DAYS)
<i>fondaparinux sodium 2.5 mg/0.5ml solution</i>	4	QL (30 PER 30 DAYS)
<i>heparin sodium (porcine) (5000 unit/ml, 10000 unit/ml, 20000 unit/ml)</i>	3	(ESRD)
<i>heparin sodium (porcine) +rfid 1000 unit/ml solution</i>	3	
<i>heparin sodium (porcine) 1000 unit/ml solution</i>	3	(ESRD), (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>heparin sodium (porcine) pf 1000 unit/ml solution</i>	3	(ESRD), (Route to BVSD with an AWD note.)
<i>jantoven (1 mg tab, 2 mg tab, 2.5 mg tab, 3 mg tab, 4 mg tab, 5 mg tab, 6 mg tab, 7.5 mg tab, 10 mg tab)</i>	1	
<i>warfarin sodium (1 mg tab, 2 mg tab, 2.5 mg tab, 3 mg tab, 4 mg tab, 5 mg tab, 6 mg tab, 7.5 mg tab, 10 mg tab)</i>	1	
XARELTO (10 MG TAB, 20 MG TAB)	3	QL (30 PER 30 DAYS)
XARELTO 1 MG/ML RECON SUSP	3	QL (600 PER 30 DAYS)
XARELTO 15 MG TAB	3	QL (42 PER 30 DAYS)
XARELTO 2.5 MG TAB	3	QL (60 PER 30 DAYS)
XARELTO STARTER PACK 15 & 20 MG TAB THPK	3	QL (102 PER 365 OVER TIME)
BLOOD PRODUCTS AND MODIFIERS, OTHER		
<i>anagrelide hcl (0.5 mg cap, 1 mg cap)</i>	2	(Excluded from Auto Extension)
ARANESP (ALBUMIN FREE) (100 MCG/0.5ML SOLN PRSYR, 100 MCG/ML SOLUTION, 150 MCG/0.3ML SOLN PRSYR, 200 MCG/0.4ML SOLN PRSYR, 300 MCG/0.6ML SOLN PRSYR, 500 MCG/ML SOLN PRSYR)	5	BVD, (ESRD), (ESRD benefits and rules apply. If not ESRD, Route to BVSD with an AWD note.)
ARANESP (ALBUMIN FREE) (25 MCG/0.42ML SOLN PRSYR, 25 MCG/ML SOLUTION, 40 MCG/0.4ML SOLN PRSYR, 40 MCG/ML SOLUTION, 60 MCG/0.3ML SOLN PRSYR, 60 MCG/ML SOLUTION)	3	BVD, (ESRD), (ESRD benefits and rules apply. If not ESRD, Route to BVSD with an AWD note.)
ARANESP (ALBUMIN FREE) 10 MCG/0.4ML SOLN PRSYR	3	BVD, (ESRD), (ESRD benefits and rules apply. If not ESRD, Route to BVSD with an AWD note.)
ARANESP (ALBUMIN FREE) 200 MCG/ML SOLUTION	5	BVD
ARMLUPEG 6 MG/0.6ML SOLN PRSYR	5	PA, (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>eltrombopag olamine (12.5 mg packet, 25 mg packet)</i>	5	PA, QL (180 PER 30 DAYS)
<i>eltrombopag olamine (12.5 mg tab, 25 mg tab, 50 mg tab)</i>	5	PA, QL (30 PER 30 DAYS)
<i>eltrombopag olamine 75 mg tab</i>	5	PA, QL (60 PER 30 DAYS)
EPOGEN (2000 UNIT/ML SOLUTION, 3000 UNIT/ML SOLUTION, 4000 UNIT/ML SOLUTION, 10000 UNIT/ML SOLUTION, 20000 UNIT/ML SOLUTION)	4	BVD, (ESRD), (ESRD benefits and rules apply. If not ESRD, Route to BVSD with an AWD note.)
FULPHILA 6 MG/0.6ML SOLN PRSYR	5	BVD, (Route to BVSD with an AWD note.)
FYLNETRA 6 MG/0.6ML SOLN PRSYR	5	PA, (Route to BVSD with an AWD note.)
GRANIX (300 MCG/0.5ML SOLN PRSYR, 300 MCG/ML SOLUTION, 480 MCG/0.8ML SOLN PRSYR)	5	BVD, (Route to BVSD with an AWD note.)
LEUKINE 250 MCG RECON SOLN	5	PA, (Route to BVSD with an AWD note.)
MULPLETA 3 MG TAB	5	PA, QL (7 PER 30 OVER TIME)
NEULASTA 6 MG/0.6ML SOLN PRSYR	5	PA, (Route to BVSD with an AWD note.)
NEUPOGEN (300 MCG/0.5ML SOLN PRSYR, 300 MCG/ML SOLUTION, 480 MCG/0.8ML SOLN PRSYR, 480 MCG/1.6ML SOLUTION)	5	PA, (Route to BVSD with an AWD note.)
NIVESTYM (300 MCG/0.5ML SOLN PRSYR, 300 MCG/ML SOLUTION, 480 MCG/0.8ML SOLN PRSYR, 480 MCG/1.6ML SOLUTION)	5	BVD, (Route to BVSD with an AWD note.)
NYVEPRIA 6 MG/0.6ML SOLN PRSYR	5	PA, (Route to BVSD with an AWD note.)
RELEUKO (300 MCG/0.5ML SOLN PRSYR, 480 MCG/0.8ML SOLN PRSYR)	5	PA, (Route to BVSD with an AWD note.)
RETACRIT (10000 UNIT/ML SOLUTION, 20000 UNIT/ML SOLUTION)	3	BVD, (ESRD), (ESRD benefits and rules apply. If not ESRD, Route to BVSD with an AWD note.)

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RETACRIT (2000 UNIT/ML SOLUTION, 3000 UNIT/ML SOLUTION, 4000 UNIT/ML SOLUTION, 40000 UNIT/ML SOLUTION)	3	BVD, (ESRD), (ESRD benefits and rules apply. If not ESRD, Route to BVSD with an AWD note.)
STIMUFEND 6 MG/0.6ML SOLN PRSYR	5	PA, (Route to BVSD with an AWD note.)
UDENYCA (6 MG/0.6ML SOLN A-INJ, 6 MG/0.6ML SOLN PRSYR)	5	BVD, (Route to BVSD with an AWD note.)
ZARXIO (300 MCG/0.5ML SOLN PRSYR, 480 MCG/0.8ML SOLN PRSYR)	5	PA, (Route to BVSD with an AWD note.)
ZIEXTENZO 6 MG/0.6ML SOLN PRSYR	5	PA, (Route to BVSD with an AWD note.)
HEMOSTASIS AGENTS		
<i>tranexamic acid 650 mg tab</i>	3	QL (30 PER 30 DAYS)
PLATELET MODIFYING AGENTS		
<i>aspirin-dipyridamole er 25-200 mg cap 12h</i>	3	QL (60 PER 30 DAYS), (Excluded from Auto Extension)
CABLIVI 11 MG KIT	5	PA, QL (31 PER 30 DAYS), (Excluded from Auto Extension)
<i>cilostazol (50 mg tab, 100 mg tab)</i>	2	(Excluded from Auto Extension)
<i>clopidogrel bisulfate 75 mg tab</i>	1	QL (30 PER 30 DAYS), (Excluded from Auto Extension)
<i>prasugrel hcl (5 mg tab, 10 mg tab)</i>	2	QL (30 PER 30 DAYS), (Excluded from Auto Extension)
TAVALISSE (100 MG TAB, 150 MG TAB)	5	PA, QL (60 PER 30 DAYS), (Excluded from Auto Extension)
<i>ticagrelor 60 mg tab</i>	3	QL (60 PER 30 DAYS)
<i>ticagrelor 90 mg tab</i>	3	QL (60 PER 30 DAYS), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
<i>droxidopa (100 mg cap, 200 mg cap, 300 mg cap)</i>	4	PA, QL (180 PER 30 DAYS)
<i>midodrine hcl (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	3	
ALPHA-ADRENERGIC BLOCKING AGENTS		
<i>phenoxybenzamine hcl 10 mg cap</i>	5	PA, QL (3600 PER 30 DAYS)
<i>terazosin hcl 10 mg cap</i>	1	QL (60 PER 30 DAYS)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil (4 mg tab, 8 mg tab, 16 mg tab, 32 mg tab)</i>	1	
<i>irbesartan (75 mg tab, 150 mg tab, 300 mg tab)</i>	1	
<i>losartan potassium (25 mg tab, 50 mg tab, 100 mg tab)</i>	1	
<i>olmesartan medoxomil (5 mg tab, 20 mg tab, 40 mg tab)</i>	1	
<i>telmisartan (20 mg tab, 40 mg tab, 80 mg tab)</i>	1	
<i>valsartan (40 mg tab, 80 mg tab, 160 mg tab, 320 mg tab)</i>	1	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
<i>benazepril hcl (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab)</i>	1	
<i>captopril (12.5 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)</i>	1	
<i>enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	1	
<i>fosinopril sodium (10 mg tab, 20 mg tab, 40 mg tab)</i>	1	
<i>lisinopril (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)</i>	1	
<i>moexipril hcl (7.5 mg tab, 15 mg tab)</i>	1	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
PERINDOPRIL ERBUMINE (PERINDOPRIL ERBUMINE 2 MG TAB, PERINDOPRIL ERBUMINE 8 MG TAB, PERINDOPRIL ERBUMINE 4 MG TAB)	1	
<i>quinapril hcl (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab)</i>	1	
<i>ramipril (1.25 mg cap, 2.5 mg cap, 5 mg cap, 10 mg cap)</i>	1	
<i>trandolapril (1 mg tab, 2 mg tab, 4 mg tab)</i>	1	
ANTIARRHYTHMICS		
<i>amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)</i>	1	
<i>digoxin (125 mcg tab, 250 mcg tab)</i>	2	
<i>digoxin (digoxin 0.05 mg/ml solution, digoxin 0.05 mg/ml solution)</i>	2	
<i>digoxin 62.5 mcg tab</i>	3	
<i>dofetilide (125 mcg cap, 250 mcg cap, 500 mcg cap)</i>	3	
<i>flecainide acetate (50 mg tab, 100 mg tab, 150 mg tab)</i>	2	
<i>mexiletine hcl (150 mg cap, 200 mg cap, 250 mg cap)</i>	3	
<i>pacerone (100 mg tab, 200 mg tab)</i>	3	
<i>propafenone hcl (150 mg tab, 225 mg tab, 300 mg tab)</i>	2	
<i>propafenone hcl er (er 225 mg cap er, er 325 mg cap er, er 425 mg cap er)</i>	3	
QUINIDINE SULFATE (200 MG TAB, 300 MG TAB)	2	NM (Non-Mail Order)
<i>sotalol hcl (120 mg tab, 160 mg tab, 240 mg tab)</i>	4	
<i>sotalol hcl (af) (80 mg tab, 120 mg tab, 160 mg tab)</i>	4	
<i>sotalol hcl 80 mg tab</i>	4	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl (200 mg cap, 400 mg cap)</i>	2	
<i>atenolol (25 mg tab, 50 mg tab, 100 mg tab)</i>	2	
<i>betaxolol hcl (10 mg tab, 20 mg tab)</i>	2	
<i>bisoprolol fumarate (bisoprolol fumarate 2.5 mg tab, bisoprolol fumarate 5 mg tab, bisoprolol fumarate 10 mg tab)</i>	2	
<i>carvedilol (3.125 mg tab, 6.25 mg tab, 12.5 mg tab, 25 mg tab)</i>	1	
<i>carvedilol phosphate er (er 10 mg cap er, er 20 mg cap er, er 40 mg cap er, er 80 mg cap er)</i>	3	
<i>labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)</i>	1	
<i>metoprolol succinate er (er 25 mg tab er, er 50 mg tab er, er 100 mg tab er, er 200 mg tab er)</i>	1	
<i>metoprolol tartrate (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)</i>	1	
<i>nadolol (20 mg tab, 40 mg tab, 80 mg tab)</i>	3	
<i>nebivolol hcl (2.5 mg tab, 5 mg tab, 20 mg tab)</i>	2	QL (90 PER 30 DAYS)
<i>nebivolol hcl 10 mg tab</i>	2	QL (120 PER 30 DAYS)
<i>pindolol (5 mg tab, 10 mg tab)</i>	2	
<i>propranolol hcl (10 mg tab, 20 mg tab, 40 mg tab, 60 mg tab, 80 mg tab)</i>	1	
PROPRANOLOL HCL (PROPRANOLOL HCL 40 MG/5ML SOLUTION, PROPRANOLOL HCL 20 MG/5ML SOLUTION)	2	
<i>propranolol hcl er (er 60 mg cap er, er 80 mg cap er, er 120 mg cap er, er 160 mg cap er)</i>	2	
<i>timolol maleate (timolol maleate 20 mg tab, timolol maleate 5 mg tab, timolol maleate 10 mg tab, timolol maleate 20 mg tab, timolol maleate 5 mg tab)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
CALCIUM CHANNEL BLOCKING AGENTS		
<i>amlodipine besylate (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	1	
<i>cartia xt (120 mg cap er, 180 mg cap er, 240 mg cap er, 300 mg cap er)</i>	3	
<i>dilt-xr (120 mg cap er, 180 mg cap er, 240 mg cap er)</i>	2	
<i>diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)</i>	2	
<i>diltiazem hcl er (er 60 mg cap er 12h, er 90 mg cap er 12h, er 120 mg cap er 12h, er 120 mg cap er 24h, er 120 mg tab er 24h, er 180 mg cap er 24h, er 180 mg tab er 24h, er 240 mg cap er 24h, er 240 mg tab er 24h, er 300 mg tab er 24h, er 360 mg tab er 24h, er 420 mg tab er 24h)</i>	2	
<i>diltiazem hcl er beads (er 120 mg cap er, er 180 mg cap er, er 240 mg cap er, er 300 mg cap er, er 360 mg cap er, er 420 mg cap er)</i>	2	
<i>diltiazem hcl er coated beads (er 120 mg cap er, er 180 mg cap er, er 240 mg cap er, er 300 mg cap er, er 360 mg cap er)</i>	2	
<i>felodipine er (er 2.5 mg tab er, er 5 mg tab er, er 10 mg tab er)</i>	2	
<i>isradipine (2.5 mg cap, 5 mg cap)</i>	2	
<i>matzim la (180 mg tab er, 240 mg tab er, 300 mg tab er, 360 mg tab er, 420 mg tab er)</i>	3	
<i>nicardipine hcl (20 mg cap, 30 mg cap)</i>	2	
<i>nifedipine (10 mg cap, 20 mg cap)</i>	1	
<i>nifedipine er (er 30 mg tab er, er 60 mg tab er, er 90 mg tab er)</i>	1	
<i>nifedipine er osmotic release (er 30 mg tab er, er 60 mg tab er, er 90 mg tab er)</i>	1	
<i>nimodipine 30 mg cap</i>	2	
NIMODIPINE 60 MG/20ML SOLUTION	5	QL (1800 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>nisoldipine er (nisoldipine er 17 mg tab er 24h, nisoldipine er 8.5 mg tab er 24h, nisoldipine er 17 mg tab er 24h, nisoldipine er 34 mg tab er 24h, nisoldipine er 8.5 mg tab er 24h, nisoldipine er 34 mg tab er 24h)</i>	2	
NYMALIZE 6 MG/ML SOLUTION	5	QL (1800 PER 30 DAYS)
<i>tiadylt er (er 120 mg cap er, er 180 mg cap er, er 240 mg cap er, er 300 mg cap er, er 360 mg cap er, er 420 mg cap er)</i>	3	
<i>verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)</i>	1	
<i>verapamil hcl er (er 120 mg cap er 24h, er 120 mg tab er, er 180 mg cap er 24h, er 180 mg tab er, er 240 mg cap er 24h, er 240 mg tab er)</i>	2	
CARDIOVASCULAR AGENTS, OTHER		
<i>acetazolamide (125 mg tab, 250 mg tab)</i>	2	
<i>acetazolamide er 500 mg cap 12h</i>	2	
AMILORIDE-HYDROCHLOROTHIAZIDE 5-50 MG TAB	2	
<i>amlodipine besy-benazepril hcl (2.5-10 mg cap, 5-10 mg cap, 5-20 mg cap, 5-40 mg cap, 10-20 mg cap, 10-40 mg cap)</i>	1	
<i>amlodipine besylate-valsartan (5-160 mg tab, 5-320 mg tab, 10-160 mg tab, 10-320 mg tab)</i>	1	
<i>amlodipine-atorvastatin (2.5-10 mg tab, 2.5-20 mg tab, 2.5-40 mg tab, 5-10 mg tab, 5-20 mg tab, 5-40 mg tab, 5-80 mg tab, 10-10 mg tab, 10-20 mg tab, 10-40 mg tab, 10-80 mg tab)</i>	1	ST, QL (30 PER 30 DAYS)
<i>amlodipine-olmesartan (5-20 mg tab, 5-40 mg tab, 10-20 mg tab, 10-40 mg tab)</i>	1	
<i>atenolol-chlorthalidone (50-25 mg tab, 100-25 mg tab)</i>	2	
<i>benazepril-hydrochlorothiazide (5-6.25 mg tab, 10-12.5 mg tab, 20-12.5 mg tab, 20-25 mg tab)</i>	1	
<i>bisoprolol-hydrochlorothiazide (2.5-6.25 mg tab, 5-6.25 mg tab, 10-6.25 mg tab)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>candesartan cilexetil-hctz (16-12.5 mg tab, 32-12.5 mg tab, 32-25 mg tab)</i>	1	
EDARBYCLOR (40-12.5 MG TAB, 40-25 MG TAB)	4	ST
<i>enalapril-hydrochlorothiazide (5-12.5 mg tab, 10-25 mg tab)</i>	1	
ENTRESTO (6-6 MG CAP SPRINK, 15-16 MG CAP SPRINK)	3	QL (240 PER 30 DAYS)
FILSPARI (200 MG TAB, 400 MG TAB)	5	PA, QL (30 PER 30 DAYS)
<i>fosinopril sodium-hctz (10-12.5 mg tab, 20-12.5 mg tab)</i>	1	
<i>irbesartan-hydrochlorothiazide (150-12.5 mg tab, 300-12.5 mg tab)</i>	1	
<i>ivabradine hcl (5 mg tab, 7.5 mg tab)</i>	4	QL (60 PER 30 DAYS)
<i>lisinopril-hydrochlorothiazide (10-12.5 mg tab, 20-12.5 mg tab, 20-25 mg tab)</i>	1	
<i>losartan potassium-hctz (50-12.5 mg tab, 100-12.5 mg tab, 100-25 mg tab)</i>	1	
<i>metoprolol-hydrochlorothiazide (50-25 mg tab, 100-25 mg tab, 100-50 mg tab)</i>	3	
metirosine 250 mg cap	5	PA
<i>olmesartan medoxomil-hctz (20-12.5 mg tab, 40-12.5 mg tab, 40-25 mg tab)</i>	1	
<i>olmesartan-amlodipine-hctz (20-5-12.5 mg tab, 40-10-12.5 mg tab, 40-10-25 mg tab, 40-5-12.5 mg tab, 40-5-25 mg tab)</i>	1	
<i>pentoxifylline er 400 mg tab</i>	2	(Excluded from Auto Extension)
<i>ranolazine er (er 500 mg tab er, er 1000 mg tab er)</i>	3	QL (120 PER 30 DAYS)
<i>sacubitril-valsartan (49-51 mg tab, 97-103 mg tab)</i>	3	QL (60 PER 30 DAYS)
<i>sacubitril-valsartan 24-26 mg tab</i>	3	QL (180 PER 30 DAYS)
<i>spironolactone-hctz 25-25 mg tab</i>	2	
TELMISARTAN-AMLODIPINE (40-10 MG TAB, 40-5 MG TAB, 80-10 MG TAB, 80-5 MG TAB)	1	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>telmisartan-hctz (40-12.5 mg tab, 80-12.5 mg tab, 80-25 mg tab)</i>	1	
TRANDOLAPRIL-VERAPAMIL HCL ER (ER 1-240 MG TAB ER, ER 2-180 MG TAB ER, ER 2-240 MG TAB ER, ER 4-240 MG TAB ER)	1	
<i>triamterene-hctz (37.5-25 mg cap, 37.5-25 mg tab, 75-50 mg tab)</i>	1	
<i>valsartan-hydrochlorothiazide (80-12.5 mg tab, 160-12.5 mg tab, 160-25 mg tab, 320-12.5 mg tab, 320-25 mg tab)</i>	1	
VERQUVO (2.5 MG TAB, 5 MG TAB, 10 MG TAB)	3	PA, QL (30 PER 30 DAYS)
DIURETICS		
<i>amiloride hcl 5 mg tab</i>	2	
<i>bumetanide (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1	
<i>chlorthalidone (25 mg tab, 50 mg tab)</i>	2	
<i>ethacrynic acid 25 mg tab</i>	4	PA, QL (480 PER 30 DAYS)
<i>furosemide (20 mg tab, 40 mg tab, 80 mg tab)</i>	1	
<i>furosemide 10 mg/ml solution</i>	2	(Route to BVSD with an AWD note.)
FUROSEMIDE 10 MG/ML SOLUTION	2	
FUROSEMIDE 8 MG/ML SOLUTION	2	
<i>hydrochlorothiazide (12.5 mg cap, 12.5 mg tab, 25 mg tab, 50 mg tab)</i>	1	
<i>indapamide (1.25 mg tab, 2.5 mg tab)</i>	1	
<i>metolazone (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	1	
<i>torsemide (5 mg tab, 10 mg tab, 20 mg tab, 100 mg tab)</i>	2	
<i>triamterene (50 mg cap, 100 mg cap)</i>	3	QL (90 PER 30 DAYS)
DYSLIPIDEMICS		
ALTOPREV (20 MG TAB ER 24H, 40 MG TAB ER 24H, 60 MG TAB ER 24H)	4	QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>atorvastatin calcium (10 mg tab, 20 mg tab, 40 mg tab, 80 mg tab)</i>	1	
<i>cholestyramine (4 gm packet, 4 gm/dose powder)</i>	3	
<i>cholestyramine light (4 gm packet, 4 gm/dose powder)</i>	3	QL (1195 PER 30 DAYS)
<i>colesevelam hcl 3.75 gm packet</i>	4	QL (180 PER 30 DAYS)
<i>colesevelam hcl 625 mg tab</i>	3	QL (180 PER 30 DAYS)
<i>colestipol hcl (5 gm granules, 5 gm packet)</i>	3	QL (900 PER 30 DAYS)
<i>colestipol hcl 1 gm tab</i>	3	QL (480 PER 30 DAYS)
<i>ezetimibe 10 mg tab</i>	1	QL (30 PER 30 DAYS)
<i>ezetimibe-simvastatin (10-10 mg tab, 10-20 mg tab, 10-40 mg tab, 10-80 mg tab)</i>	1	QL (30 PER 30 DAYS)
<i>fenofibrate (48 mg tab, 54 mg tab, 67 mg cap, 134 mg cap, 145 mg tab, 160 mg tab, 200 mg cap)</i>	1	QL (60 PER 30 DAYS)
<i>fenofibrate micronized (43 mg cap, 67 mg cap, 134 mg cap, 200 mg cap)</i>	1	QL (60 PER 30 DAYS)
<i>fenofibric acid (45 mg cap dr, 135 mg cap dr)</i>	3	QL (60 PER 30 DAYS)
<i>fluvastatin sodium (20 mg cap, 40 mg cap)</i>	1	
<i>gemfibrozil 600 mg tab</i>	2	QL (60 PER 30 DAYS)
<i>icosapent ethyl (0.5 gm cap, 1 gm cap)</i>	4	QL (120 PER 30 DAYS)
JUXTAPID (2 MG CAP, 5 MG CAP, 10 MG CAP, 20 MG CAP, 30 MG CAP)	5	PA, QL (90 PER 30 DAYS)
<i>lovastatin (10 mg tab, 20 mg tab, 40 mg tab)</i>	1	
NEXLETOL 180 MG TAB	3	PA, QL (30 PER 30 DAYS)
NEXLIZET 180-10 MG TAB	3	PA, QL (30 PER 30 DAYS)
<i>niacin er (antihyperlipidemic) (er 500 mg tab er, er 750 mg tab er, er 1000 mg tab er)</i>	2	QL (120 PER 30 DAYS)
<i>omega-3-acid ethyl esters 1 gm cap</i>	3	QL (120 PER 30 DAYS)
<i>pitavastatin calcium (1 mg tab, 2 mg tab, 4 mg tab)</i>	1	ST
<i>pravastatin sodium (10 mg tab, 20 mg tab, 40 mg tab, 80 mg tab)</i>	1	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>prevalite (4 gm packet, 4 gm/dose powder)</i>	3	QL (1195 PER 30 DAYS)
REPATHA 140 MG/ML SOLN PRSYR	3	PA, QL (3 PER 30 OVER TIME)
REPATHA SURECLICK 140 MG/ML SOLN A-INJ	3	PA, QL (3 PER 30 OVER TIME)
<i>rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab)</i>	1	
<i>simvastatin (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab, 80 mg tab)</i>	1	
TRYNGOLZA (50 MG/0.8ML SOLN A-INJ, 80 MG/0.8ML SOLN A-INJ)	5	PA

MINERALOCORTICOID RECEPTOR ANTAGONISTS

<i>eplerenone (25 mg tab, 50 mg tab)</i>	3	
KERENDIA (10 MG TAB, 20 MG TAB, 40 MG TAB)	4	PA, QL (30 PER 30 DAYS)
<i>spironolactone (25 mg tab, 50 mg tab, 100 mg tab)</i>	2	

VASODILATORS

<i>hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)</i>	1	
<i>isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)</i>	2	
<i>isosorbide mononitrate (10 mg tab, 20 mg tab)</i>	2	
<i>isosorbide mononitrate er (er 30 mg tab er, er 60 mg tab er, er 120 mg tab er)</i>	2	
<i>metirosine 250 mg cap</i>	5	PA
<i>minoxidil (2.5 mg tab, 10 mg tab)</i>	2	
<i>nitro-bid 2 % ointment</i>	4	
<i>nitroglycerin (0.1 mg/hr patch 24hr, 0.2 mg/hr patch 24hr, 0.3 mg sl tab, 0.4 mg sl tab, 0.4 mg/hr patch 24hr, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)</i>	2	
<i>nitroglycerin 0.4 % ointment</i>	4	QL (30 PER 30 OVER TIME)
<i>nitroglycerin 0.4 mg/spray solution</i>	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
NITROLINGUAL 0.4 MG/SPRAY SOLUTION	3	
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS		
<i>amphetamine-dextroamphetamine (er 5 mg cap er, er 10 mg cap er, er 15 mg cap er, er 20 mg cap er, er 25 mg cap er, er 30 mg cap er)</i>	3	QL (60 PER 30 DAYS)
<i>amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab, 10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)</i>	3	QL (60 PER 30 DAYS)
<i>atomoxetine hcl (10 mg cap, 18 mg cap, 25 mg cap, 40 mg cap, 60 mg cap, 80 mg cap, 100 mg cap)</i>	3	QL (30 PER 30 DAYS)
ATOMOXETINE HCL 4 MG/ML SOLUTION	3	QL (750 PER 30 DAYS)
<i>clonidine hcl er 0.1 mg tab 12h</i>	1	QL (120 PER 30 DAYS)
<i>dexmethylphenidate hcl er (er 5 mg cap er, er 10 mg cap er, er 15 mg cap er, er 20 mg cap er, er 25 mg cap er, er 30 mg cap er, er 35 mg cap er, er 40 mg cap er)</i>	3	QL (60 PER 30 DAYS)
<i>dextroamphetamine sulfate (5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)</i>	3	QL (60 PER 30 DAYS)
<i>dextroamphetamine sulfate er (er 10 mg cap er, er 15 mg cap er)</i>	3	QL (120 PER 30 DAYS)
<i>dextroamphetamine sulfate er 5 mg cap 24h</i>	3	QL (60 PER 30 DAYS)
<i>guanfacine hcl er (er 1 mg tab er, er 2 mg tab er, er 3 mg tab er, er 4 mg tab er)</i>	2	
<i>lisdexamfetamine dimesylate (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap, 50 mg cap, 60 mg cap, 70 mg cap)</i>	3	ST, QL (30 PER 30 DAYS)
<i>methylphenidate (10 mg/9hr patch, 15 mg/9hr patch, 20 mg/9hr patch, 30 mg/9hr patch)</i>	4	ST, QL (30 PER 30 DAYS)
<i>methylphenidate hcl (2.5 mg chew tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	3	QL (90 PER 30 DAYS)
<i>methylphenidate hcl (5 mg chew tab, 10 mg chew tab)</i>	3	QL (180 PER 30 DAYS)
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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>methylphenidate hcl 10 mg/5ml solution</i>	3	QL (900 PER 30 DAYS)
<i>methylphenidate hcl 5 mg/5ml solution</i>	3	QL (1800 PER 30 DAYS)
<i>methylphenidate hcl er (cd) (er 20 mg cap er, er 50 mg cap er, er 60 mg cap er)</i>	3	QL (30 PER 30 DAYS)
<i>methylphenidate hcl er (cd) (er 30 mg cap er, er 40 mg cap er)</i>	3	QL (60 PER 30 DAYS)
<i>methylphenidate hcl er (cd) 10 mg cap</i>	3	QL (180 PER 30 DAYS)
<i>methylphenidate hcl er (la) (er 10 mg cap er, er 20 mg cap er, er 30 mg cap er, er 40 mg cap er, er 60 mg cap er)</i>	3	QL (60 PER 30 DAYS)
<i>methylphenidate hcl er (methylphenidate hcl er 18 mg tab er, methylphenidate hcl er 27 mg tab er, methylphenidate hcl er 36 mg tab er, methylphenidate hcl er 54 mg tab er, methylphenidate hcl er 18 mg tab er 24h)</i>	3	QL (60 PER 30 DAYS)
<i>methylphenidate hcl er (osm) (er 18 mg tab er, er 27 mg tab er, er 36 mg tab er, er 54 mg tab er)</i>	3	QL (60 PER 30 DAYS)
<i>methylphenidate hcl er 10 mg tab</i>	3	QL (120 PER 30 DAYS)
<i>methylphenidate hcl er 20 mg tab</i>	3	QL (90 PER 30 DAYS)
<i>methylphenidate hcl er(diffus) (27 mg tab er, 36 mg tab er, 54 mg tab er)</i>	3	QL (60 PER 30 DAYS)
WEGOVY (0.25 MG/0.5ML SOLN A-INJ, 0.5 MG/0.5ML SOLN A-INJ, 1 MG/0.5ML SOLN A-INJ)	3	PA, QL (2 PER 28 OVER TIME)
WEGOVY (1.5 MG TAB, 4 MG TAB, 9 MG TAB, 25 MG TAB)	3	PA, QL (30 PER 30 DAYS)
WEGOVY (1.7 MG/0.75ML SOLN A-INJ, 2.4 MG/0.75ML SOLN A-INJ)	3	PA, QL (3 PER 28 OVER TIME)
CENTRAL NERVOUS SYSTEM, OTHER		
AUSTEDO (6 MG TAB, 9 MG TAB, 12 MG TAB)	5	PA, QL (120 PER 30 DAYS)
AUSTEDO XR (18 MG TAB ER 24H, 30 MG TAB ER 24H, 36 MG TAB ER 24H, 42 MG TAB ER 24H, 48 MG TAB ER 24H)	5	PA, QL (30 PER 30 DAYS)

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AUSTEDO XR (6 MG TAB ER 24H, 12 MG TAB ER 24H)	5	PA, QL (90 PER 30 DAYS)
AUSTEDO XR 24 MG TAB ER 24H	5	PA, QL (60 PER 30 DAYS)
AUSTEDO XR PATIENT TITRATION 12 & 18 & 24 & 30 MG TBER THPK	5	PA, QL (28 PER 180 OVER TIME)
AUSTEDO XR PATIENT TITRATION 6 & 12 & 24 MG TBER THPK	5	PA, QL (42 PER 180 OVER TIME)
<i>pyridostigmine bromide (pyridostigmine bromide 30 mg tab, pyridostigmine bromide 60 mg tab, pyridostigmine bromide 60 mg/5ml solution)</i>	3	
<i>pyridostigmine bromide er 180 mg tab</i>	3	
<i>riluzole 50 mg tab</i>	3	
<i>tetrabenazine 12.5 mg tab</i>	4	PA, QL (240 PER 30 DAYS)
<i>tetrabenazine 25 mg tab</i>	5	PA, QL (120 PER 30 DAYS)

MULTIPLE SCLEROSIS AGENTS

<i>dalfampridine er 10 mg tab 12h</i>	3	QL (60 PER 30 DAYS)
<i>dimethyl fumarate (120 mg cap dr, 240 mg cap dr)</i>	3	QL (60 PER 30 DAYS)
<i>dimethyl fumarate starter pack 120 & 240 mg cpdr thpk</i>	3	QL (60 PER 30 DAYS)
<i>fingolimod hcl 0.5 mg cap</i>	3	QL (30 PER 30 DAYS)
<i>glatiramer acetate 20 mg/ml soln prsyr</i>	5	QL (30 PER 30 DAYS)
<i>glatiramer acetate 40 mg/ml soln prsyr</i>	5	QL (12 PER 28 OVER TIME)
<i>glatopa 20 mg/ml soln prsyr</i>	5	QL (30 PER 30 DAYS)
<i>glatopa 40 mg/ml soln prsyr</i>	5	QL (12 PER 28 OVER TIME)
<i>teriflunomide (7 mg tab, 14 mg tab)</i>	3	QL (30 PER 30 DAYS)

DENTAL AND ORAL AGENTS

<i>chlorhexidine gluconate 0.12 % solution</i>	2	
<i>kourzeq 0.1 % paste</i>	2	
<i>lidocaine viscous hcl 2 % solution</i>	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>periogard 0.12 % solution</i>	2	
<i>pilocarpine hcl (5 mg tab, 7.5 mg tab)</i>	3	
<i>triamcinolone acetonide 0.1 % paste</i>	2	

DERMATOLOGICAL AGENTS

ACNE AND ROSACEA AGENTS

<i>acutane (10 mg cap, 20 mg cap, 40 mg cap)</i>	3	
<i>acitretin (10 mg cap, 25 mg cap)</i>	4	QL (60 PER 30 DAYS)
<i>acitretin 17.5 mg cap</i>	4	
<i>adapalene (0.1 % cream, 0.3 % gel)</i>	3	ST
ALTRENO 0.05 % LOTION	4	PA, QL (45 PER 30 OVER TIME)
<i>amnesteam (10 mg cap, 20 mg cap, 40 mg cap)</i>	3	
<i>amnesteam 30 mg cap</i>	3	
<i>azelaic acid 15 % gel</i>	3	QL (50 PER 30 OVER TIME)
AZELEX 20 % CREAM	4	ST
<i>benzoyl peroxide-erythromycin 5-3 % gel</i>	3	
<i>claravis (10 mg cap, 20 mg cap, 40 mg cap)</i>	3	
<i>claravis 30 mg cap</i>	3	
<i>clindamycin phos-benzoyl perox (1.2-2.5 % gel, 1.2-5 % gel)</i>	2	
<i>clindamycin phos-benzoyl perox 1-5 % gel</i>	3	
FINACEA 15 % FOAM	4	
<i>isotretinoin (10 mg cap, 20 mg cap, 40 mg cap)</i>	3	
<i>isotretinoin 30 mg cap</i>	3	
<i>tazarotene 0.1 % cream</i>	3	
<i>tretinoin (0.01 % gel, 0.025 % cream, 0.025 % gel, 0.05 % cream, 0.1 % cream)</i>	3	
<i>tretinoin 0.05 % gel</i>	3	ST

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>tretinoin microsphere (tretinoin microsphere 0.04 % gel, tretinoin microsphere 0.04 % gel, tretinoin microsphere 0.1 % gel, tretinoin microsphere 0.1 % gel)</i>	4	ST
TRETINOIN MICROSPHERE PUMP (PUMP 0.04 % GEL, PUMP 0.1 % GEL)	4	ST
<i>zenatane (10 mg cap, 20 mg cap, 40 mg cap)</i>	3	
<i>zenatane 30 mg cap</i>	3	

DERMATITIS AND PRURITUS AGENTS

ADBRY (150 MG/ML SOLN PRSYR, 300 MG/2ML SOLN A-INJ)	5	PA, QL (6 PER 28 OVER TIME)
<i>alclometasone dipropionate (alclometasone dipropionate 0.05 % cream, alclometasone dipropionate 0.05 % ointment, alclometasone dipropionate 0.05 % cream, alclometasone dipropionate 0.05 % ointment)</i>	3	
<i>ammonium lactate 12 % cream</i>	2	
<i>betamethasone dipropionate (0.05 % cream, 0.05 % lotion, 0.05 % ointment)</i>	3	
<i>betamethasone dipropionate aug (0.05 % cream, 0.05 % lotion, 0.05 % ointment)</i>	3	
<i>betamethasone valerate (betamethasone valerate 0.1 % cream, betamethasone valerate 0.1 % lotion, betamethasone valerate 0.1 % ointment, betamethasone valerate 0.12 % foam, betamethasone valerate 0.1 % lotion)</i>	3	
<i>clobetasol prop emollient base 0.05 % cream</i>	3	
<i>clobetasol propionate (0.05 % cream, 0.05 % foam, 0.05 % gel, 0.05 % lotion, 0.05 % ointment, 0.05 % shampoo, 0.05 % solution)</i>	3	
<i>clobetasol propionate 0.05 % liquid</i>	3	QL (125 PER 14 OVER TIME)
<i>clobetasol propionate e clobtasol propionat0.05 % cram</i>	3	
<i>desonide (0.05 % cream, 0.05 % lotion, 0.05 % ointment)</i>	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>desoximetasone (0.25 % cream, 0.25 % ointment)</i>	4	
EUCRISA 2 % OINTMENT	3	QL (60 PER 30 DAYS)
<i>fluocinolone acetonide 0.01 % solution</i>	3	
<i>fluocinolone acetonide 0.025 % ointment</i>	3	
<i>fluocinolone acetonide scalp 0.01 % oil</i>	3	
<i>fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment, 0.05 % solution, 0.1 % cream)</i>	3	
<i>fluocinonide emulsified base 0.05 % cream</i>	3	
<i>fluticasone propionate (0.005 % ointment, 0.05 % cream)</i>	2	
<i>halobetasol propionate (0.05 % cream, 0.05 % ointment)</i>	3	
<i>hydrocortisone (hydrocortisone 1 % cream, hydrocortisone 1 % ointment, hydrocortisone 2.5 % cream, hydrocortisone 2.5 % ointment, hydrocortisone 2.5 % lotion, hydrocortisone 2.5 % lotion)</i>	2	
<i>hydrocortisone (perianal) (hydrocortisone (perianal) 1 % cream, hydrocortisone (perianal) 2.5 % cream)</i>	2	
<i>mometasone furoate (0.1 % cream, 0.1 % ointment, 0.1 % solution)</i>	2	
<i>pimecrolimus 1 % cream</i>	4	ST
<i>procto-med hc 2.5 % cream</i>	2	
<i>proctosol hc 2.5 % cream</i>	2	
<i>proctozone-hc 2.5 % cream</i>	2	
<i>tacrolimus (0.03 %, 0.1 %)</i>	3	QL (100 PER 30 OVER TIME)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>triamcinolone acetonide (triamcinolone acetonide 0.025 % cream, triamcinolone acetonide 0.025 % lotion, triamcinolone acetonide 0.025 % ointment, triamcinolone acetonide 0.1 % cream, triamcinolone acetonide 0.1 % lotion, triamcinolone acetonide 0.1 % ointment, triamcinolone acetonide 0.5 % cream, triamcinolone acetonide 0.5 % ointment, triamcinolone acetonide 0.025 % lotion)</i>	2	
<i>triderm 0.5 % cream</i>	2	
DERMATOLOGICAL AGENTS, OTHER		
<i>calcipotriene (calcipotriene 0.005 % ointment, calcipotriene 0.005 % solution, calcipotriene 0.005 % cream, calcipotriene 0.005 % solution)</i>	3	
<i>calcipotriene-betameth diprop 0.005-0.064 % ointment</i>	4	
<i>calcipotriene-betameth diprop 0.005-0.064 % suspension</i>	3	
CALCITRIOL 3 MCG/GM OINTMENT	3	
ENSTILAR 0.005-0.064 % FOAM	5	
<i>fluorouracil (fluorouracil 5 % cream, fluorouracil 2 % solution, fluorouracil 5 % solution)</i>	3	
HYDROCORTISONE ACE-PRAMOXINE 1-1 % CREAM	3	
<i>imiquimod 5 % cream</i>	3	
METHOXSALEN RAPID 10 MG CAP	5	
PODOFILOX 0.5 % SOLUTION	2	
SANTYL 250 UNIT/GM OINTMENT	4	
<i>silver sulfadiazine 1 % cream</i>	2	
<i>ssd 1 % cream</i>	2	
VALCHLOR 0.016 % GEL	5	PA, QL (120 PER 30 DAYS)
VTAMA 1 % CREAM	4	ST, QL (60 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
TOPICAL ANTI-INFECTIVES		
<i>ciclopirox (0.77 % gel, 1 % shampoo)</i>	3	
<i>ciclopirox 8 % solution</i>	3	NM (Non-Mail Order)
<i>ciclopirox olamine (0.77 % cream, 0.77 % suspension)</i>	3	
CLEOCIN 100 MG SUPPOS	4	
<i>clindamycin phos (once-daily) 1 % gel</i>	3	
<i>clindamycin phos (twice-daily) 1 % gel</i>	3	
<i>clindamycin phosphate (1 % lotion, 1 % swab, 2 % cream)</i>	3	
<i>clindamycin phosphate 1 % solution</i>	3	
<i>dapsone 5 % gel</i>	3	ST
ERY 2 % PAD	2	
<i>erythromycin (erythromycin 2 % gel, erythromycin 2 % gel, erythromycin 2 % solution)</i>	2	
<i>gentamicin sulfate (0.1 % cream, 0.1 % ointment)</i>	3	
<i>ivermectin 1 % cream</i>	3	ST, QL (45 PER 30 OVER TIME)
<i>metronidazole (0.75 % cream, 0.75 % gel, 0.75 % lotion)</i>	3	
<i>metronidazole 1 % gel</i>	3	QL (60 PER 30 DAYS)
<i>mupirocin 2 % ointment</i>	3	
<i>mupirocin calcium 2 % cream</i>	3	
<i>naftifine hcl 2 % cream</i>	3	
<i>permethrin 5 % cream</i>	3	
SPINOSAD 0.9 % SUSPENSION	4	
<i>sulfacetamide sodium (acne) 10 % lotion</i>	3	
VANDAZOLE 0.75 % GEL	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
ALTRIXA OB 15-0.4-0.6 MG TAB	3	
ATABEX EC AEX 29-1 MG DR	3	
AZENTRA 13-1 MG TAB	3	
AZESCO 13-1 MG TAB	3	
C-NATE DHA 28-1-200 MG CAP	3	
CITRANATAL 90 DHA -1 & 300 MG MISC	3	
CITRANATAL ASSURE 35-1 & 300 MG MISC	3	
CITRANATAL B-CALM 20-1 MG & 2 X 25 MG MISC	3	
CITRANATAL DHA 27-1 & 250 MG MISC	3	
CITRANATAL HARMONY 27-1-260 MG CAP	3	
CLINIMIX E/DEXTROSE (2.75/5) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX E/DEXTROSE (4.25/10) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX E/DEXTROSE (4.25/5) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX E/DEXTROSE (5/15) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX E/DEXTROSE (5/20) (/20) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX E/DEXTROSE (8/10) % SOLUTION	3	(Route to BVSD with an AWD note.)
CLINIMIX E/DEXTROSE (8/14) (/14) % SOLUTION	3	(Route to BVSD with an AWD note.)
CLINIMIX/DEXTROSE (4.25/10) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
CLINIMIX/DEXTROSE (4.25/5) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX/DEXTROSE (5/15) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX/DEXTROSE (5/20) (/20) % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
CLINIMIX/DEXTROSE (6/5) (/5) % SOLUTION	3	(Route to BVSD with an AWD note.)
CLINIMIX/DEXTROSE (8/10) % SOLUTION	3	(Route to BVSD with an AWD note.)
CLINIMIX/DEXTROSE (8/14) (/14) % SOLUTION	3	(Route to BVSD with an AWD note.)
<i>clinisol sf 15 % solution</i>	2	HI, (Route to BVSD with an AWD note.)
CO-NATAL FA TAB	3	
COMPLETE NATAL DHA 29-1-200 & 200 MG MISC	3	
COMPLETENATE 29-1 MG CHEW TAB	3	
DERMACINRX PNV PRENATOL 27-1 MG TAB	3	
DERMACINRX PRETRATE 1 MG TAB	3	
<i>dextrose (dextrose 10 % solution, dextrose 10 % solution)</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
DEXTROSE-NACL 5-0.9 % SOLUTION	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>dextrose-sodium chloride (dextrose-sodium chloride 5-0.225 % solution, dextrose-sodium chloride 10-0.2 % solution, dextrose-sodium chloride 10-0.45 % solution, dextrose-sodium chloride 2.5-0.45 % solution, dextrose-sodium chloride 5-0.45 % solution, dextrose-sodium chloride 2.5-0.45 % solution, dextrose-sodium chloride 5-0.2 % solution, dextrose-sodium chloride 5-0.45 % solution, dextrose-sodium chloride 5-0.9 % solution, dextrose-sodium chloride 5-0.9 % solution)</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
DUET DHA 400 25-1 & MG MISC	3	
DUET DHA BALANCED 25-1 & 267 MG MISC	3	
EMBRIVA 13-1 MG TAB	3	
FOLATEXCEL 20-1 MG TAB	3	
GESTYRA 13-1 MG TAB	3	
INATAL GT TAB	3	
ISOLYTE-P IN D5W INSOLUTION	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
ISOLYTE-S PH 7.4 SOLUTION	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>kcl in dextrose-nacl (kcl in dextrose-nacl 10-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 40-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 10-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 20-5-0.2 meq/l-%-% solution, kcl in dextrose-nacl 20-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 40-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 20-5-0.225 meq/l-%-% solution, kcl in dextrose-nacl 20-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 20-5-0.9 meq/l-%-% solution, kcl in dextrose-nacl 20-5-0.9 meq/l-%-% solution, kcl in dextrose-nacl 30-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 30-5-0.45 meq/l-%-% solution, kcl in dextrose-nacl 40-5-0.9 meq/l-%-% solution)</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
KCL-LACTATED RINGERS-D5W 20 MEQ/L SOLUTION	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>klor-con (klor-con 8 meq tab er, klor-con 20 meq packet, klor-con 8 meq tab er)</i>	3	
<i>klor-con 10 (klor-con 10 10 meq tab er, klor-con 10 10 meq tab er)</i>	3	
<i>klor-con m10 meq tab er</i>	3	
<i>klor-con m15 meq tab er</i>	4	
<i>klor-con m20 meq tab er</i>	3	
KOSHER PRENATAL PLUS IRON 30-1 MG TAB	3	
M-NATAL PLUS 27-1 MG TAB	3	
<i>magnesium sulfate (magnesium sulfate 50 % solution, magnesium sulfate 50 % solution)</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
MATERNACEL 20-1 MG TAB	3	
MATERVIA 0.5 MG CAP	3	
MATRIAPRO 29-1 MG CHEW TAB	3	
MATRONEX 27-1 MG TAB	3	
MULTI-MAC 15-0.75-1 MG TAB	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
MULTIPLE ELECTRO TYPE 1 PH 5.5 SOLUTION	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>multiple electro type 1 ph 7.4 solution</i>	3	
<i>nafrinse 2.2 (1 f) mg chew tab</i>	2	
NATACHEW NATA28-1 MG TAB	3	
NATAL PNV 6-0.5 MG TAB	3	
NATALCHEW 29-1 MG TAB	3	
NATALCORE 29-1 MG CHEW TAB	3	
NATALVIT TAB	3	
NEO-VITAL RX 1 MG TAB	3	
NEOMATERNA 20-1 MG TAB	3	
NEONATAL + DHA 29-1 & 200 MG MISC	3	
NEONATAL COMPLETE (27-1 MG TAB, 29-1 MG TAB)	3	
NEONATAL PLUS 27-1 MG TAB	3	
NESTABS DHA 32-1 MG MISC	3	
NESTABS NESS 32-1 MG	3	
NIVA-PLUS 27-1 MG TAB	3	
NOVYRA 27-1 MG TAB	3	
NUTRILIPID 20 % EMULSION	3	HI, (Route to BVSD with an AWD note.)
OB COMPLETE ONE 50-1-476 MG CAP	3	
OB COMPLETE PETITE 35-5-1-200 MG CAP	3	
OB COMPLETE PREMIER 30-20-1 MG TAB	3	
OB COMPLETE/DHA 30-10-1-200 MG CAP	3	
OBSTETRIX EC (WITH DOCUSATE) 29-1 MG TAB	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
ONE VITE WOMENS PLUS 27-1 MG TAB	3	
ONENATAL RX 1 MG TAB	3	
PLASMA-LYTE 148 SOLUTION	3	HI
PLASMA-LYTE 148 SOLUTION	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
PLASMA-LYTE A SOLUTION	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>plenamine 15 % solution</i>	2	HI, (Route to BVSD with an AWD note.)
PNV 27-CA/FE/FA 60-1 MG TAB	3	
PNV PRENATAL PLUS MULTIVIT+DHA 27-1 & 312 MG MISC	3	
PNV TABS 20-1 S MG	3	
PNV-DHA+DOCUSATE 27-1.25-300 MG CAP	3	
PNV-SELECT 27-0.6-0.4 MG TAB	3	
<i>potassium chloride (10 %, 20 meq/15ml (10%), 40 meq/15ml (20%))</i>	3	(Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>potassium chloride (potassium chloride 20 meq/100ml solution, potassium chloride 40 meq/100ml solution, potassium chloride 20 meq/100ml solution, potassium chloride 40 meq/100ml solution, potassium chloride 10 meq/100ml solution, potassium chloride 10 meq/100ml solution)</i>	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>potassium chloride 2 meq/ml solution</i>	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>potassium chloride 20 meq packet</i>	3	
<i>potassium chloride crys er (er 10 tab er, er 15 tab er, er 20 tab er)</i>	1	

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<i>potassium chloride er (potassium chloride er 8 meq cap er, potassium chloride er 8 meq tab er, potassium chloride er 10 meq cap er, potassium chloride er 15 meq tab er, potassium chloride er 10 meq tab er, potassium chloride er 20 meq tab er)</i>	1	
<i>potassium chloride in dextrose 20-5 meq/l-% solution</i>	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>potassium chloride in nacl (potassium chloride in nacl 20-0.9 meq/l-% solution, potassium chloride in nacl 20-0.9 meq/l-% solution, potassium chloride in nacl 20-0.45 meq/l-% solution, potassium chloride in nacl 40-0.9 meq/l-% solution, potassium chloride in nacl 20-0.45 meq/l-% solution, potassium chloride in nacl 40-0.9 meq/l-% solution)</i>	3	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
<i>potassium citrate er (er 5 (540 mg) tab er, er 10 (1080 mg) tab er, er 15 (1620 mg) tab er)</i>	3	
POTASSIUM CL IN DEXTROSE 5% 20 MEQ/L SOLUTION	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
PREGEN DHA 28-1-35 MG CAP	3	
PREGENNA 20-1 MG TAB	3	
PREMASOL 10 % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
PRENA 1 TRUE 30-.4 & 300 MG MISC	3	
PRENA1 1.4 MG CHEW TAB	3	
PRENA1 PEARL 30-1.4-200 MG CAP ER	3	
PRENACORE 29-1 MG CHEW TAB	3	
PRENAISSANCE 29-1.25-325 MG CAP	3	
PRENAISSANCE PLUS 28-1-250 MG CAP	3	
PRENATAL 19 (19 CHEW TAB, 19 29-1 MG CHEW TAB, 19 29-1 MG TAB)	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
PRENATAL 27-1 MG TAB	3	
PRENATAL PLUS 27-1 MG TAB	3	
PRENATAL PLUS VITAMIN/MINERAL 27-1 MG TAB	3	
PRENATAL VITAMIN PLUS LOW IRON 27-1 MG TAB	3	
PRENATE DHA 18-0.6-0.4-300 MG CAP	3	
PRENATE ELITE 20-0.6-0.4 MG TAB	3	
PRENATE ENHANCE 28-0.6-0.4-400 MG CAP	3	
PRENATE MINI 18-0.6-0.4-350 MG CAP	3	
PRENATE PIXIE 10-0.6-0.4-200 MG CAP	3	
PRENATE RESTORE 27-0.6-0.4-400 MG CAP	3	
PRENATRIX 27-1 MG TAB	3	
PRENATRYL 27-1 MG TAB	3	
PRENATVITE COMPLETE 1 MG TAB	3	
PRENATVITE PLUS 1 MG TAB	3	
PRENATVITE RX 0.8 MG TAB	3	
PRENOVA 0.8 MG TAB	3	
PRENYRA 13-1 MG TAB	3	
PRIMACARE 30-1-470 MG CAP	3	
PROSOL 20 % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
PROVIDA OB 20-20-1.25 MG CAP	3	
RELEVIA 27-1 MG TAB	3	
SE-NATAL 19 (19 29-1 MG CHEW TAB, 19 29-1 MG TAB)	3	
SELECT-OB (29-0.6-0.4 MG CHEW TAB, 29-1 MG CHEW TAB)	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
SELECT-OB+DHA 29-1 & 250 MG MISC	3	
<i>sodium chloride (0.45 %, 3 %, 5 %)</i>	2	HI, (Route to BVSD with an AWD note.)
<i>sodium chloride (pf) 0.9 % solution</i>	2	HI, (Route to BVSD with an AWD note.)
SODIUM CHLORIDE 0.9 % SOLUTION	2	BVD, (Route to BVSD with an AWD note.)
<i>sodium chloride 0.9 % solution</i>	2	BVD, HI, (Route to BVSD with an AWD note.)
SODIUM FLUORIDE (SODIUM FLUORIDE 0.55 (0.25 F) MG CHEW TAB, SODIUM FLUORIDE 0.55 (0.25 F) MG CHEW TAB, SODIUM FLUORIDE 1.1 (0.5 F) MG CHEW TAB, SODIUM FLUORIDE 2.2 (1 F) MG CHEW TAB, SODIUM FLUORIDE 1.1 (0.5 F) MG CHEW TAB, SODIUM FLUORIDE 1.1 (0.5 F) MG TAB, SODIUM FLUORIDE 2.2 (1 F) MG CHEW TAB, SODIUM FLUORIDE 2.2 (1 F) MG TAB)	2	
THRIVITE RX 29-1 MG TAB	3	
TPN ELECTROLYTES CONC	2	HI, (Part of Part C Home Infusion Bundle-Will pay 100% under Part B)
TRAVASOL 10 % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
TRICARE TAB	3	
TRINATAL RX 1 60-MG TAB	3	
TRINATE TAB	3	
TRISTART DHA 31-0.6-0.4-200 MG CAP	3	
TROPHAMINE 10 % SOLUTION	3	HI, (Route to BVSD with an AWD note.)
VINATE II 29-1 MG TAB	3	
VINATE ONE 60-1 MG TAB	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
VIRT-NATE DHA 28-1-200 MG CAP	3	
VITAFOL FE+ 90-0.6-0.4-200 MG CAP	3	
VITAFOL GUMMIES 3.33-0.333-34.8 MG CHEW TAB	3	
VITAFOL ULTRA 29-0.6-0.4-200 MG CAP	3	
VITAFOL-NANO 18-0.6-0.4 MG TAB	3	
VITAFOL-OB TAB	3	
VITAFOL-OB+DHA 65-1 & 250 MG MISC	3	
VITAFOL-ONE 29-1-200 MG CAP	3	
VITALARA 20-1 MG TAB	3	
VITAMEDMD ONE RX/QUATREFOLIC 30-0.6-0.4-200 MG CAP	3	
VITAMEDMD REDICHEW RX 1.4 MG TAB	3	
VITAPEARL 30-1.4-200 MG CAP ER	3	
VITATHELY WITH GINGER 27-1 MG TAB	3	
VITATRUE 30-1.4 & 300 MG MISC	3	
VIVA DHA 28-1-200 MG CAP	3	
WESNATAL DHA COMPLETE 29-1-200 & 200 MG MISC	3	
WESNATE DHA 28-1-200 MG CAP	3	
WESTAB PLUS WES27-1 MG	3	
WESTGEL DHA 31-0.6-0.4-200 MG CAP	3	
ZALVIT 13-1 MG TAB	3	
ZIPHEX 13-1 MG TAB	3	

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 You can find information on what the symbols and abbreviations on this table mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
ELECTROLYTE/MINERAL/METAL MODIFIERS		
CHEMET 100 MG CAP	4	
<i>deferasirox (90 mg packet, 180 mg packet, 360 mg packet)</i>	5	PA, QL (120 PER 30 DAYS)
<i>deferasirox 125 mg tab sol</i>	4	QL (720 PER 30 DAYS)
<i>deferasirox 180 mg tab</i>	5	QL (450 PER 30 DAYS)
<i>deferasirox 250 mg tab sol</i>	5	PA, QL (360 PER 30 DAYS)
<i>deferasirox 360 mg tab</i>	3	QL (120 PER 30 DAYS)
<i>deferasirox 500 mg tab sol</i>	5	PA, QL (180 PER 30 DAYS)
<i>deferasirox 90 mg tab</i>	4	QL (240 PER 30 DAYS)
<i>deferasirox granules (90 mg packet, 180 mg packet, 360 mg packet)</i>	5	PA, QL (120 PER 30 DAYS)
<i>deferiprone (500 mg tab, 1000 mg tab)</i>	5	
FERRIPROX 100 MG/ML SOLUTION	5	QL (2970 PER 30 DAYS)
<i>penicillamine 250 mg tab</i>	5	
<i>tolvaptan (15 mg tab thpk, 30 & 15 mg tab thpk, 45 & 15 mg tab thpk, 60 & 30 mg tab thpk, 90 & 30 mg tab thpk)</i>	5	PA, QL (60 PER 30 DAYS)
<i>tolvaptan (15 mg tab, 30 mg tab)</i>	5	PA, QL (120 PER 30 DAYS)
<i>tolvaptan (hyponatremia) (15 mg tab, 30 mg tab)</i>	5	PA, QL (120 PER 30 DAYS)
TRIENTINE HCL (TRIENTINE HCL 250 MG CAP, TRIENTINE HCL 500 MG CAP)	5	PA
PHOSPHATE BINDERS		
<i>calcium acetate (phos binder) (667 mg cap, 667 mg tab)</i>	3	(ESRD)
<i>calcium acetate 667 mg tab</i>	3	(ESRD)
<i>lanthanum carbonate (500 mg chew tab, 750 mg chew tab, 1000 mg chew tab)</i>	4	(ESRD)
<i>sevelamer carbonate 800 mg tab</i>	4	(ESRD), (ESRD benefits and rules apply.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>sevelamer hcl (400 mg tab, 800 mg tab)</i>	4	(ESRD)
VELPHORO 500 MG CHEW TAB	5	PA, QL (180 PER 30 DAYS), (ESRD)

POTASSIUM BINDERS

<i>kionex 15 gm/60ml suspension</i>	3	
LOKELMA 10 GM PACKET	3	QL (90 PER 30 DAYS)
LOKELMA 5 GM PACKET	3	QL (30 PER 30 DAYS)
<i>sodium polystyrene sulfonate 15 gm/60ml suspension</i>	3	
<i>sodium polystyrene sulfonate powder</i>	3	
SPS (SODIUM POLYSTYRENE SULF) (SPS (SODIUM POLYSTYRENE SULF) 30 GM/120ML SUSPENSION, SPS (SODIUM POLYSTYRENE SULF) 15 GM/60ML SUSPENSION)	3	
VELTASSA (8.4 GM PACKET, 16.8 GM PACKET, 25.2 GM PACKET)	4	PA, QL (30 PER 30 DAYS)
VELTASSA 1 GM PACKET	4	PA, QL (120 PER 30 DAYS)

GASTROINTESTINAL AGENTS

ANTI-CONSTIPATION AGENTS

<i>constulose 10 gm/15ml solution</i>	2	
<i>enulose 10 gm/15ml solution</i>	2	
<i>generlac 10 gm/15ml solution</i>	3	
<i>kristalose 10 gm packet</i>	2	
<i>lactulose (10 gm packet, 10 gm/15ml solution, 20 gm/30ml solution)</i>	2	
<i>lactulose 20 gm packet</i>	2	
<i>lactulose encephalopathy 10 gm/15ml solution</i>	2	
LINZESS (72 MCG CAP, 145 MCG CAP, 290 MCG CAP)	3	QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>lubiprostone (8 mcg cap, 24 mcg cap)</i>	2	QL (60 PER 30 DAYS)
MOVANTIK (12.5 MG TAB, 25 MG TAB)	3	QL (30 PER 30 DAYS)
<i>prucalopride succinate (1 mg tab, 2 mg tab)</i>	3	QL (30 PER 30 DAYS)
SYMPROIC 0.2 MG TAB	3	QL (30 PER 30 DAYS)

ANTI-DIARRHEAL AGENTS

<i>alosetron hcl (0.5 mg tab, 1 mg tab)</i>	4	QL (60 PER 30 DAYS)
<i>diphenoxylate-atropine 2.5-0.025 mg tab</i>	4	
DIPHENOXYLATE-ATROPINE 2.5-0.025 MG/5ML LIQUID	4	
<i>loperamide hcl 2 mg cap</i>	3	
XERMELO 250 MG TAB	5	PA, QL (90 PER 30 DAYS)

ANTISPASMODICS, GASTROINTESTINAL

<i>dicyclomine hcl (10 mg cap, 20 mg tab)</i>	2	
<i>dicyclomine hcl 10 mg/5ml solution</i>	2	
<i>glycopyrrolate (1 mg tab, 2 mg tab)</i>	2	
<i>glycopyrrolate 1 mg/5ml solution</i>	3	
<i>methscopolamine bromide 2.5 mg tab</i>	2	
<i>methscopolamine bromide 5 mg tab</i>	2	

GASTROINTESTINAL AGENTS, OTHER

<i>bis subcit-metronid-tetracyc 140-125-125 mg cap</i>	4	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
<i>bismuth/metronidaz/tetracyclin 140-125-125 mg cap</i>	4	QL (120 PER 30 DAYS), NM (Non-Mail Order), (Excluded from Auto Extension)
CHENODAL 250 MG TAB	5	
CLENPIQ 10-3.5-12 MG-GM - GM/175ML SOLUTION	3	
GATTEX 5 MG KIT	5	PA
GAVILYTE-C 240 GM RECON SOLN	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>gavilyte-g 236 gm recon soln</i>	2	
<i>gavilyte-n with flavor pack 420 gm recon soln</i>	2	
GENOTROPIN (5 MG CARTRIDGE, 12 MG CARTRIDGE)	5	PA, (Excluded from Auto Extension)
GENOTROPIN MINISQUICK (0.4 MG PRSYR, 0.6 MG PRSYR, 0.8 MG PRSYR, 1 MG PRSYR, 1.2 MG PRSYR, 1.4 MG PRSYR, 1.6 MG PRSYR, 1.8 MG PRSYR, 2 MG PRSYR)	5	PA, (Excluded from Auto Extension)
GENOTROPIN MINISQUICK 0.2 MG PRSYR	4	PA, (Excluded from Auto Extension)
<i>misoprostol (100 mcg tab, 200 mcg tab)</i>	2	
<i>na sulfate-k sulfate-mg sulf 17.5-3.13-1.6 gm/177ml solution</i>	3	
OMNITROPE (5 MG/1.5ML SOLN CART, 5.8 MG RECON SOLN, 10 MG/1.5ML SOLN CART)	5	PA, (Excluded from Auto Extension)
<i>peg 3350-kcl-na bicarb-nacl 420 gm recon soln</i>	2	
<i>peg-3350/electrolytes 236 gm recon soln</i>	2	
<i>peg-3350/electrolytes/ascorbat 100 gm recon soln</i>	3	
<i>peg-kcl-nacl-nasulf-na asc-c 100 gm recon soln</i>	3	
REZDIFFRA (60 MG TAB, 80 MG TAB, 100 MG TAB)	5	PA, QL (30 PER 30 DAYS)
<i>sucrafate 1 gm tab</i>	2	
<i>sucrafate 1 gm/10ml suspension</i>	3	
SUFLAVE 178.7 GM RECON SOLN	3	
SUPREP BOWEL PREP KIT SU17.5-3.13-1.6 GM/177ML SOLUTION	3	
SUTAB SU1479-225-188 MG	3	
<i>ursodiol (250 mg tab, 300 mg cap, 500 mg tab)</i>	3	
VOWST CAP	5	ST, QL (12 PER 180 OVER TIME), NM (Non-Mail Order), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
HISTAMINE-2 (H2) RECEPTOR ANTAGONISTS		
<i>cimetidine (200 mg tab, 300 mg tab, 400 mg tab, 800 mg tab)</i>	2	
<i>famotidine 20 mg tab</i>	2	
<i>famotidine 40 mg tab</i>	2	
<i>famotidine 40 mg/5ml recon susp</i>	3	
NIZATIDINE (NIZATIDINE 150 MG CAP, NIZATIDINE 300 MG CAP)	2	
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)</i>	2	
<i>lansoprazole (15 mg cap dr, 30 mg cap dr)</i>	2	
<i>omeprazole (10 mg cap dr, 20 mg cap dr, 40 mg cap dr)</i>	2	
<i>pantoprazole sodium (20 mg tab dr, 40 mg tab dr)</i>	2	
<i>rabeprazole sodium 20 mg tab dr</i>	3	QL (60 PER 30 DAYS)

GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT

AQNEURSA 1 GM PACKET	5	PA, QL (120 PER 30 DAYS)
ATTRUBY 356 MG TAB THPK	5	PA, QL (120 PER 30 DAYS)
<i>betaine powder</i>	5	
<i>carglumic acid 200 mg tab sol</i>	5	PA
CHOLBAM (50 MG CAP, 250 MG CAP)	5	PA, LA, QL (120 PER 30 DAYS)
CREON (3000-9500 CP DR PART, 6000-19000 CP DR PART, 12000-38000 CP DR PART, 24000-76000 CP DR PART, 36000-114000 CP DR PART)	3	
<i>cromolyn sodium 100 mg/5ml conc</i>	3	
CYSTAGON (50 MG CAP, 150 MG CAP)	4	PA

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>dichlorphenamide 50 mg tab</i>	5	PA, QL (120 PER 30 DAYS)
<i>L-glutamine 5 gm packet</i>	5	PA, QL (180 PER 30 DAYS)
MYALEPT 11.3 MG RECON SOLN	5	PA, QL (67.8 PER 30 DAYS)
<i>nitisinone (2 mg cap, 5 mg cap, 10 mg cap, 20 mg cap)</i>	5	PA, QL (600 PER 30 DAYS)
ORFADIN 4 MG/ML SUSPENSION	5	PA, QL (1500 PER 30 DAYS)
PALYNZIQ (2.5 MG/0.5ML SOLN PRSYR, 10 MG/0.5ML SOLN PRSYR, 20 MG/ML SOLN PRSYR)	5	PA, QL (60 PER 30 DAYS), (Excluded from Auto Extension)
PROLASTIN-C 1000 MG/20ML SOLUTION	5	PA, (Route to BVSD with an AWD note.)
PYRUKYND (5 MG TAB, 20 MG TAB, 50 MG TAB)	5	PA, QL (56 PER 28 DAYS), (Excluded from Auto Extension)
PYRUKYND TAPER PACK (PACK 5 MG TAB THPK, PACK 7 20 MG & 7 5 MG TAB THPK, PACK 7 50 MG & 7 20 MG TAB THPK)	5	PA, QL (56 PER 28 DAYS), (Excluded from Auto Extension)
REVCovi 2.4 MG/1.5ML SOLUTION	5	PA
<i>sapropterin dihydrochloride (100 mg packet, 100 mg tab, 500 mg packet)</i>	5	PA
<i>sodium phenylbutyrate 3 gm/tsp powder</i>	5	
ZENPEP (3000-10000 CP DR PART, 5000-24000 CP DR PART, 10000-32000 CP DR PART, 15000-47000 CP DR PART, 20000-63000 CP DR PART, 25000-79000 CP DR PART, 40000-126000 CP DR PART, 60000-189600 CP DR PART)	3	

GENITOURINARY AGENTS

GENITOURINARY AGENTS, OTHER

<i>alfuzosin hcl er 10 mg tab 24h</i>	2	QL (30 PER 30 DAYS)
<i>bethanechol chloride (5 mg tab, 10 mg tab, 25 mg tab, 50 mg tab)</i>	2	
<i>darifenacin hydrobromide er (er 7.5 mg tab er, er 15 mg tab er)</i>	3	QL (30 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>dutasteride 0.5 mg cap</i>	2	QL (30 PER 30 DAYS)
<i>dutasteride-tamsulosin hcl 0.5-0.4 mg cap</i>	3	QL (30 PER 30 DAYS)
ELMIRON 100 MG CAP	4	
<i>fesoterodine fumarate er (er 4 mg tab er, er 8 mg tab er)</i>	4	QL (30 PER 30 DAYS)
<i>finasteride 5 mg tab</i>	1	QL (30 PER 30 DAYS)
<i>flavoxate hcl 100 mg tab</i>	2	
INTRAROSA 6.5 MG INSERT	4	QL (30 PER 30 DAYS)
<i>mirabegron er (er 25 mg tab er, er 50 mg tab er)</i>	3	QL (30 PER 30 DAYS)
<i>mirabegron er 8 mg/ml sr</i>	3	QL (300 PER 30 DAYS)
<i>oxybutynin chloride 5 mg tab</i>	2	QL (120 PER 30 DAYS)
<i>oxybutynin chloride 5 mg/5ml solution</i>	2	QL (473 PER 23 DAYS)
<i>oxybutynin chloride er (er 5 mg tab er, er 10 mg tab er, er 15 mg tab er)</i>	2	QL (60 PER 30 DAYS)
PHEXX 1.8-1-0.4 % GEL	4	
<i>silodosin (4 mg cap, 8 mg cap)</i>	2	QL (30 PER 30 DAYS)
<i>solifenacin succinate (5 mg tab, 10 mg tab)</i>	2	QL (30 PER 30 DAYS)
<i>tadalafil 5 mg tab</i>	3	PA, QL (30 PER 30 DAYS)
<i>tamsulosin hcl 0.4 mg cap</i>	1	QL (60 PER 30 DAYS)
<i>tolterodine tartrate (1 mg tab, 2 mg tab)</i>	2	QL (60 PER 30 DAYS)
<i>tolterodine tartrate er (er 2 mg cap er, er 4 mg cap er)</i>	3	QL (30 PER 30 DAYS)
<i>trospium chloride 20 mg tab</i>	2	QL (60 PER 30 DAYS)
<i>trospium chloride er 60 mg cap 24h</i>	3	QL (30 PER 30 DAYS)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)

<i>budesonide 3 mg cp dr part</i>	3	
<i>budesonide er 9 mg tab 24h</i>	5	ST, QL (30 PER 30 DAYS)
<i>dexamethasone (0.5 mg tab, 0.75 mg tab, 1 mg tab, 1.5 mg tab, 2 mg tab, 4 mg tab, 6 mg tab)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
DEXAMETHASONE 0.5 MG/5ML SOLUTION	2	
<i>fludrocortisone acetate 0.1 mg tab</i>	2	
HEMADY 20 MG TAB	4	PA, QL (60 PER 30 DAYS)
<i>hydrocortisone (5 mg tab, 10 mg tab, 20 mg tab)</i>	2	
<i>hydrocortisone 100 mg/60ml enema</i>	3	
<i>methylprednisolone (4 mg tab, 8 mg tab, 16 mg tab, 32 mg tab)</i>	2	
<i>methylprednisolone 4 mg tab thpk</i>	2	
<i>prednisolone 15 mg/5ml solution</i>	3	
<i>prednisolone sodium phosphate (prednisolone sodium phosphate 5 mg/5ml solution, prednisolone sodium phosphate 10 mg/5ml solution, prednisolone sodium phosphate 25 mg/5ml solution, prednisolone sodium phosphate 10 mg tab disp, prednisolone sodium phosphate 15 mg tab disp, prednisolone sodium phosphate 25 mg/5ml solution, prednisolone sodium phosphate 30 mg tab disp, prednisolone sodium phosphate 6.7 (5 base) mg/5ml solution)</i>	3	
<i>prednisolone sodium phosphate 20 mg/5ml solution</i>	3	
PREDNISONE (1 MG TAB DR, 2 MG TAB DR, 5 MG TAB DR)	4	
<i>prednisone (1 mg tab, 2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab, 50 mg tab)</i>	1	
PREDNISONE 5 MG/5ML SOLUTION	2	
PREDNISONE INTENSOL 5 MG/ML CONC	2	
TARPEYO 4 MG CAP DR	5	PA, LA, QL (120 PER 30 DAYS), (Excluded from Auto Extension)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)

<i>desmopressin ace spray refrig 0.01 % solution</i>	3	
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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>desmopressin acetate (0.1 mg tab, 0.2 mg tab)</i>	3	
INCRELEX 40 MG/4ML SOLUTION	5	PA, (Excluded from Auto Extension)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)

ANDROGENS

<i>danazol (50 mg cap, 100 mg cap, 200 mg cap)</i>	4	
<i>testosterone (testosterone 12.5 mg/act (1%) gel, testosterone 25 mg/2.5gm (1%) gel, testosterone 50 mg/5gm (1%) gel, testosterone 12.5 mg/act (1%) gel, testosterone 50 mg/5gm (1%) gel)</i>	3	PA, QL (300 PER 30 DAYS)
<i>testosterone (testosterone 20.25 mg/1.25gm (1.62%) gel, testosterone 20.25 mg/act (1.62%) gel, testosterone 40.5 mg/2.5gm (1.62%) gel, testosterone 20.25 mg/1.25gm (1.62%) gel)</i>	3	PA, QL (150 PER 30 DAYS)
<i>testosterone cypionate (100 mg/ml, 200 mg/ml)</i>	3	PA
TESTOSTERONE ENANTHATE 200 MG/ML SOLUTION	3	PA, QL (10 PER 28 OVER TIME)

ESTROGENS

<i>abigale 1-0.5 mg tab</i>	3	
<i>abigale lo 0.5-0.1 mg tab</i>	3	
<i>amabelz 0.5-0.1 mg tab</i>	3	
<i>apri 0.15-30 mg-mcg tab</i>	2	
ARANELLE 0.5/1/0.5-35 MG-MCG TAB	2	
<i>aviane 0.1-20 mg-mcg tab</i>	2	
<i>azurette 0.15-0.02/0.01 mg (21/5) tab</i>	2	
<i>balziva 0.4-35 mg-mcg tab</i>	2	
<i>blisovi fe 1.5/30 1.5-30 mg-mcg tab</i>	2	
<i>briellyn 0.4-35 mg-mcg tab</i>	2	
<i>cryselle 0.3-30 mg-mcg tab</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>cryselle-28 0.3-30 mg-mcg tab</i>	2	
DEPO-ESTRADIOL 5 MG/ML OIL	4	
<i>desogestrel-ethinyl estradiol 0.15-0.02/0.01 mg (21/5) tab</i>	2	
<i>dolishale 90-20 mcg tab</i>	2	
<i>dotti (0.0375 mg/24hr patch tw, 0.05 mg/24hr patch tw, 0.075 mg/24hr patch tw, 0.1 mg/24hr patch tw)</i>	3	
<i>dotti 0.025 mg/24hr patch tw</i>	3	
<i>drospiren-eth estrad-levomefol 3-0.02-0.451 mg tab</i>	2	
<i>drospirenone-ethinyl estradiol (3-0.02 mg tab, 3-0.03 mg tab)</i>	2	
<i>eluryng 0.12-0.015 mg/24hr ring</i>	3	QL (1 PER 28 OVER TIME), (Only covered for Endometrial Hyperplasia, CPT 58999)
<i>enilloring 0.12-0.015 mg/24hr</i>	3	QL (1 PER 28 OVER TIME), (Only covered for Endometrial Hyperplasia, CPT 58999)
<i>estarylla 0.25-35 mg-mcg tab</i>	2	
<i>estradiol (0.025 mg/24hr patch tw, 0.025 mg/24hr patch wk)</i>	3	
<i>estradiol (0.0375 mg/24hr patch tw, 0.0375 mg/24hr patch wk, 0.05 mg/24hr patch tw, 0.05 mg/24hr patch wk, 0.06 mg/24hr patch wk, 0.075 mg/24hr patch tw, 0.075 mg/24hr patch wk, 0.1 mg/24hr patch tw, 0.1 mg/24hr patch wk, 0.5 mg tab, 1 mg tab, 2 mg tab)</i>	3	
<i>estradiol 0.01 % cream</i>	3	QL (127.5 PER 30 OVER TIME)
<i>estradiol 10 mcg tab</i>	3	QL (30 PER 30 DAYS)
<i>estradiol-norethindrone acet (0.5-0.1 mg tab, 1-0.5 mg tab)</i>	3	
<i>estrogens conjugated (0.3 mg tab, 0.45 mg tab, 0.625 mg tab, 0.9 mg tab, 1.25 mg tab)</i>	3	QL (30 PER 30 DAYS)
<i>ethynodiol diac-eth estradiol (1-35 tab, 1-50 tab)</i>	2	

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<i>etonogestrel-ethinyl estradiol 0.12-0.015 mg/24hr ring</i>	2	QL (1 PER 28 OVER TIME), (Only covered for Endometrial Hyperplasia, CPT 58999)
<i>feirza 1.5/30 1.5-30 mg-mcg tab</i>	2	
<i>feirza 1/20 1-20 mg-mcg tab</i>	2	
FEMRING (0.05 MG/24HR RING, 0.1 MG/24HR RING)	4	ST, QL (1 PER 90 OVER TIME)
<i>fyavolv (0.5-2.5 tab, 1-5 tab)</i>	3	
<i>hailey 24 fe 1-20 mg-mcg() tab</i>	2	
<i>hailey fe 1/20 1-20 mg-mcg tab</i>	2	
<i>iclevia 0.15-0.03 mg tab</i>	2	QL (91 PER 91 DAYS)
<i>introvale 0.15-0.03 mg tab</i>	2	QL (91 PER 91 DAYS)
<i>jaimiess 0.15-0.03 & 0.01 mg tab</i>	2	
<i>jasmiel 3-0.02 mg tab</i>	2	
<i>jinteli 1-5 mg-mcg tab</i>	3	
<i>junel 1.5/30 1.5-30 mg-mcg tab</i>	2	
<i>junel 1/20 1-20 mg-mcg tab</i>	2	
<i>junel fe 1.5/30 1.5-30 mg-mcg tab</i>	2	
<i>junel fe 1/20 1-20 mg-mcg tab</i>	2	
<i>junel fe 24 1-20 mg-mcg() tab</i>	2	
<i>kariva 0.15-0.02/0.01 mg (21/5) tab</i>	2	
<i>kelnor 1/35 1-35 mg-mcg tab</i>	2	
<i>lessina 0.1-20 mg-mcg tab</i>	2	
<i>levonest 50-30/75-40/ 125-30 mcg tab</i>	2	
<i>levonorg-eth estrad triphasic 50-30/75-40/ 125-30 mcg tab</i>	2	
<i>levonorgest-eth estrad 91-day 0.15-0.03 & 0.01 mg tab</i>	2	
<i>levonorgest-eth estrad 91-day 0.15-0.03 mg tab</i>	2	QL (91 PER 91 DAYS)
<i>levonorgestrel-ethinyl estrad 90-20 mcg tab</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>levora 0.15/30 (28) 0.15-30 mg-mcg tab</i>	2	
LO LOESTRIN FE ESTRIN 1 MG-10 MCG / 10 MCG TAB	4	
<i>loestrin 1.5/30 (21) 1.5-30 mg-mcg tab</i>	4	
<i>loestrin 1/20 (21) 1-20 mg-mcg tab</i>	4	
<i>loestrin fe 1.5/30 1.5-30 mg-mcg tab</i>	4	
<i>loestrin fe 1/20 1-20 mg-mcg tab</i>	4	
<i>loryna 3-0.02 mg tab</i>	2	
<i>luizza 1.5/30 1.5-30 mg-mcg tab</i>	2	
<i>luizza 1/20 1-20 mg-mcg tab</i>	2	
<i>lyllana (0.0375 mg/24hr patch tw, 0.05 mg/24hr patch tw, 0.075 mg/24hr patch tw, 0.1 mg/24hr patch tw)</i>	3	
<i>lyllana 0.025 mg/24hr patch tw</i>	3	
<i>marlissa 0.15-30 mg-mcg tab</i>	2	
<i>merzee 1-20 mg-mcg(24) cap</i>	2	
<i>microgestin 1.5/30 1.5-30 mg-mcg tab</i>	2	
<i>microgestin 1/20 1-20 mg-mcg tab</i>	2	
<i>microgestin fe 1.5/30 1.5-30 mg-mcg tab</i>	2	
<i>microgestin fe 1/20 1-20 mg-mcg tab</i>	2	
<i>mili 0.25-35 mg-mcg tab</i>	2	
<i>mimvey 1-0.5 mg tab</i>	3	
MYFEMBREE 40-1-0.5 MG TAB	5	PA, QL (30 PER 30 DAYS)
<i>necon 0.5/35 (28) 0.5-35 mg-mcg tab</i>	2	
<i>norelgestromin-eth estradiol 150-35 mcg/24hr patch wk</i>	2	QL (4 PER 28 OVER TIME)
<i>norethin ace-eth estrad-fe 1-20 mg-mcg tab</i>	2	
<i>norethindron-ethinyl estrad-fe 1-20/1-30/1-35 mg-mcg tab</i>	2	
<i>norethindrone acet-ethinyl est 1-20 mg-mcg tab</i>	2	
<i>norethindrone-eth estradiol (0.5-2.5 tab, 1-5 tab)</i>	3	

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You can find information on what the symbols and abbreviations on this table mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>norgestim-eth estrad triphasic (0.18/0.215/0.25 mg-25 mcg tab, 0.18/0.215/0.25 mg-35 mcg tab)</i>	2	
<i>norgestimate-eth estradiol 0.25-35 mg-mcg tab</i>	2	
<i>nortrel 0.5/35 (28) 0.5-35 mg-mcg tab</i>	2	
<i>nortrel 1/35 (21) 1-35 mg-mcg tab</i>	2	
<i>nortrel 1/35 (28) 1-35 mg-mcg tab</i>	2	
<i>nortrel 7/7/7 0.5/0.75/1-35 mg-mcg tab</i>	2	
<i>nylia 1/35 1-35 mg-mcg tab</i>	2	
<i>nylia 7/7/7 0.5/0.75/1-35 mg-mcg tab</i>	2	
ORILISSA 150 MG TAB	5	PA, QL (30 PER 30 DAYS), (Excluded from Auto Extension)
ORILISSA 200 MG TAB	5	PA, QL (60 PER 30 DAYS), (Excluded from Auto Extension)
<i>portia-28 0.15-30 mg-mcg tab</i>	2	
PREMARIN 0.625 MG/GM CREAM	3	ST, QL (60 PER 30 DAYS)
PREMPHASE 0.625-5 MG TAB	3	
PREMPRO (0.3-1.5 MG TAB, 0.45-1.5 MG TAB, 0.625-2.5 MG TAB, 0.625-5 MG TAB)	3	
<i>reclipsen 0.15-30 mg-mcg tab</i>	2	
SAFYRAL 3-0.03-0.451 MG TAB	4	
<i>sprintec 28 0.25-35 mg-mcg tab</i>	2	
<i>sronyx 0.1-20 mg-mcg tab</i>	2	
<i>tarina 24 fe 1-20 mg-mcg() tab</i>	2	
<i>tilia fe 1-20/1-30/1-35 mg-mcg tab</i>	2	
<i>tri-estarylla 0.18/0.215/0.25 mg-35 mcg tab</i>	2	
<i>tri-legest fe 1-20/1-30/1-35 mg-mcg tab</i>	2	
<i>tri-lo-estarylla 0.18/0.215/0.25 mg-25 mcg tab</i>	2	
<i>tri-lo-sprintec 0.18/0.215/0.25 mg-25 mcg tab</i>	2	
<i>tri-sprintec 0.18/0.215/0.25 mg-35 mcg tab</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>tri-vylibra lo 0.18/0.215/0.25 mg-25 mcg tab</i>	2	
<i>turqoz 0.3-30 mg-mcg tab</i>	2	
<i>tydemy 3-0.03-0.451 mg tab</i>	4	
<i>valtya 1/35 1-35 mg-mcg tab</i>	2	
VALTYA 1/50 1-50 MG-MCG TAB	2	
VELIVET 0.1/0.125/0.15 -0.025 MG TAB	2	
<i>vestura 3-0.02 mg tab</i>	2	
<i>vienva 0.1-20 mg-mcg tab</i>	2	
<i>viorele 0.15-0.02/0.01 mg (21/5) tab</i>	2	
<i>vylibra 0.25-35 mg-mcg tab</i>	2	
<i>xarah fe 1-20/1-30/1-35 mg-mcg tab</i>	2	
<i>xulane 150-35 mcg/24hr patch wk</i>	2	QL (4 PER 28 OVER TIME)
<i>yuvaferm 10 mcg tab</i>	3	QL (30 PER 30 DAYS)
<i>zovia 1/35 (28) 1-35 mg-mcg tab</i>	2	

PROGESTINS

<i>camila 0.35 mg tab</i>	2	
CRINONE 4 % GEL	4	PA
DEPO-SUBQ PROVERA 104 MG/0.65ML SUSP PRSYR	3	QL (1 PER 90 OVER TIME)
<i>errin 0.35 mg tab</i>	2	
<i>gallifrey 5 mg tab</i>	2	
<i>heather 0.35 mg tab</i>	2	
LILETTA (52 MG) 20.1 MCG/DAY IUD	3	QL (1 PER 365 OVER TIME), BvD, (Only covered for Endometrial Hyperplasia, CPT 58999)
<i>lyleq 0.35 mg tab</i>	2	
<i>medroxyprogesterone acetate (150 mg/ml susp prsy, 150 mg/ml suspension)</i>	2	QL (1 PER 90 OVER TIME)
<i>medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>megestrol acetate (megestrol acetate 625 mg/5ml suspension, megestrol acetate 625 mg/5ml suspension)</i>	4	
<i>meleya 0.35 mg tab</i>	2	
NEXPLANON 68 MG IMPLANT	3	QL (1 PER 365 OVER TIME)
<i>norethindrone 0.35 mg tab</i>	2	
<i>norethindrone acetate 5 mg tab</i>	2	
ORIAHNN 300-1-0.5 & 300 MG CAP THPK	5	PA, QL (60 PER 30 DAYS)
<i>orquidea 0.35 mg tab</i>	2	
<i>progesterone (100 mg cap, 200 mg cap)</i>	3	

SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS

DUAVEE 0.45-20 MG TAB	3	QL (30 PER 30 DAYS)
OSPHENA 60 MG TAB	4	QL (30 PER 30 DAYS)
<i>raloxifene hcl 60 mg tab</i>	2	QL (30 PER 30 DAYS)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)

<i>levothyroxine sodium (25 mcg tab, 50 mcg tab, 75 mcg tab, 88 mcg tab, 100 mcg tab, 112 mcg tab, 125 mcg tab, 137 mcg tab, 150 mcg tab, 175 mcg tab, 200 mcg tab, 300 mcg tab)</i>	1	
<i>levoxyl (25 mcg tab, 50 mcg tab, 75 mcg tab, 88 mcg tab, 100 mcg tab, 112 mcg tab, 125 mcg tab, 137 mcg tab, 150 mcg tab, 175 mcg tab, 200 mcg tab)</i>	3	
<i>liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)</i>	2	
SYNTHROID (25 MCG TAB, 50 MCG TAB, 75 MCG TAB, 88 MCG TAB, 100 MCG TAB, 112 MCG TAB, 125 MCG TAB, 137 MCG TAB, 150 MCG TAB, 175 MCG TAB, 200 MCG TAB, 300 MCG TAB)	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
TIROSINT-SOL (13 MCG/ML SOLUTION, 25 MCG/ML SOLUTION, 37.5 MCG/ML SOLUTION, 44 MCG/ML SOLUTION, 50 MCG/ML SOLUTION, 62.5 MCG/ML SOLUTION, 75 MCG/ML SOLUTION, 88 MCG/ML SOLUTION, 100 MCG/ML SOLUTION, 112 MCG/ML SOLUTION, 125 MCG/ML SOLUTION, 137 MCG/ML SOLUTION, 150 MCG/ML SOLUTION, 175 MCG/ML SOLUTION, 200 MCG/ML SOLUTION)	3	

HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)

<i>cabergoline 0.5 mg tab</i>	2	
LUPRON DEPOT-PED (1-MONTH) 7.5 MG KIT	5	BVD, (Route to BVSD with an AWD note.)
LUPRON DEPOT-PED (3-MONTH) 11.25 MG (PED) KIT	5	BVD, (Route to BVSD with an AWD note.)
<i>octreotide acetate (50 mcg/ml, 100 mcg/ml, 200 mcg/ml)</i>	4	PA, (Route to BVSD with an AWD note.)
<i>octreotide acetate (500 mcg/ml, 1000 mcg/ml)</i>	5	PA, (Route to BVSD with an AWD note.)
SIGNIFOR (0.3 MG/ML SOLUTION, 0.6 MG/ML SOLUTION, 0.9 MG/ML SOLUTION)	5	PA, QL (60 PER 30 DAYS)
SOMAVERT (15 MG RECON SOLN, 20 MG RECON SOLN)	5	PA, QL (60 PER 30 DAYS)
SOMAVERT (25 MG RECON SOLN, 30 MG RECON SOLN)	5	PA, QL (30 PER 30 DAYS)
SOMAVERT 10 MG RECON SOLN	5	PA, QL (90 PER 30 DAYS)
SYNAREL 2 MG/ML SOLUTION	4	PA

HORMONAL AGENTS, SUPPRESSANT (THYROID)

ANTITHYROID AGENTS

<i>methimazole (5 mg tab, 10 mg tab)</i>	1	
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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>propylthiouracil 50 mg tab</i>	2	
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
HAEGARDA (2000 RECON SOLN, 3000 RECON SOLN)	5	PA, QL (16 PER 28 OVER TIME), (Excluded from Auto Extension)
<i>icatibant acetate 30 mg/3ml soln prsyr</i>	5	PA, QL (18 PER 30 OVER TIME), (Excluded from Auto Extension)
IMMUNOGLOBULINS		
<i>aliskiren fumarate (150 mg tab, 300 mg tab)</i>	2	ST, QL (30 PER 30 DAYS)
BIVIGAM (5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION)	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>clonidine (0.1 mg/24hr patch wk, 0.2 mg/24hr patch wk, 0.3 mg/24hr patch wk)</i>	3	
<i>clonidine hcl (0.1 mg tab, 0.2 mg tab, 0.3 mg tab)</i>	1	
<i>doxazosin mesylate (1 mg tab, 2 mg tab, 4 mg tab, 8 mg tab)</i>	2	QL (60 PER 30 DAYS)
GAMMAGARD (1 GM/10ML SOLUTION, 2.5 GM/25ML SOLUTION, 20 GM/200ML SOLUTION, 30 GM/300ML SOLUTION)	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
GAMMAGARD S/D LESS IGA (5 GM RECON SOLN, 10 GM RECON SOLN)	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
GAMMAKED 1 GM/10ML SOLUTION	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
GAMMAPLEX (5 GM/100ML SOLUTION, 5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 10 GM/200ML SOLUTION, 20 GM/200ML SOLUTION, 20 GM/400ML SOLUTION)	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
GAMUNEX-C 1 GM/10ML SOLUTION	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
OCTAGAM (1 GM/20ML SOLUTION, 2.5 GM/50ML SOLUTION, 5 GM/100ML SOLUTION, 10 GM/200ML SOLUTION, 25 GM/500ML SOLUTION)	4	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
OCTAGAM (2 GM/20ML SOLUTION, 10 GM/100ML SOLUTION)	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
OCTAGAM 30 GM/300ML SOLUTION	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>prazosin hcl (1 mg cap, 2 mg cap, 5 mg cap)</i>	2	
PRIVIGEN (5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 20 GM/200ML SOLUTION, 40 GM/400ML SOLUTION)	5	PA, (Route to BVSD with an AWD note.), (Excluded from Auto Extension)
<i>terazosin hcl (1 mg cap, 2 mg cap, 5 mg cap)</i>	1	QL (60 PER 30 DAYS)
IMMUNOLOGICAL AGENTS, OTHER		
AMJEVITA (40 MG/0.4ML SOLN A-INJ, 40 MG/0.4ML SOLN PRSYR)	5	PA, QL (3.2 PER 28 OVER TIME)
AMJEVITA 20 MG/0.2ML SOLN PRSYR	5	PA, QL (0.8 PER 28 OVER TIME)
AMJEVITA 80 MG/0.8ML SOLN A-INJ	5	PA, QL (2.4 PER 28 OVER TIME)
ARCALYST 220 MG RECON SOLN	5	PA, (Route to BVSD with an AWD note.)
AURANOFIN 3 MG CAP	5	
AVTOZMA 162 MG/0.9ML SOLN A-INJ	5	PA, QL (3.6 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
AVTOZMA 162 MG/0.9ML SOLN PRSYR	5	PA, QL (3.6 PER 28 DAYS), (Route to BVSD with an AWD note.)
BENLYSTA (200 MG/ML SOLN A-INJ, 200 MG/ML SOLN PRSYR)	5	PA, (Route to BVSD with an AWD note.)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
COSENTYX (300 MG DOSE) 150 /ML SOLN PRSYR	5	PA, QL (8 PER 28 OVER TIME)
COSENTYX 150 MG/ML SOLN PRSYR	5	PA, QL (8 PER 28 OVER TIME)
COSENTYX 75 MG/0.5ML SOLN PRSYR	5	PA, QL (2 PER 28 DAYS)
COSENTYX SENSOREADY (300 MG) 150 MG/ML SOLN A-INJ	5	PA, QL (8 PER 28 OVER TIME)
COSENTYX SENSOREADY PEN 150 MG/ML SOLN A-INJ	5	PA, QL (8 PER 28 OVER TIME)
COSENTYX UNOREADY 300 MG/2ML SOLN A-INJ	5	PA, QL (8 PER 28 OVER TIME)
DUPIXENT (200 MG/1.14ML SOLN A-INJ, 200 MG/1.14ML SOLN PRSYR)	5	PA, QL (3.42 PER 28 OVER TIME), (Excluded from Auto Extension)
DUPIXENT 300 MG/2ML SOLN A-INJ	5	PA, QL (8 PER 28 OVER TIME), (Excluded from Auto Extension)
DUPIXENT 300 MG/2ML SOLN PRSYR	5	PA, QL (8 PER 28 OVER TIME), (Excluded from Auto Extension)
ENBREL (25 MG/0.5ML SOLN PRSYR, 25 MG/0.5ML SOLUTION)	5	PA, QL (4 PER 28 OVER TIME)
ENBREL 50 MG/ML SOLN PRSYR	5	PA, QL (8 PER 28 OVER TIME)
ENBREL SURECLICK 50 MG/ML SOLN A-INJ	5	PA, QL (8 PER 28 OVER TIME)
ENSPRYNG 120 MG/ML SOLN PRSYR	5	PA, QL (5 PER 84 OVER TIME)
ENTYVIO PEN 108 MG/0.68ML SOLN A-INJ	5	PA, QL (1.36 PER 28 OVER TIME)
FASENRA 10 MG/0.5ML SOLN PRSYR	5	PA, QL (0.5 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
FASENRA 30 MG/ML SOLN PRSYR	5	PA, QL (2 PER 56 OVER TIME), (Route to BVSD with an AWD note.)
FASENRA PEN 30 MG/ML SOLN A-INJ	5	PA, QL (2 PER 56 OVER TIME)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
HADLIMA (40 MG/0.4ML SOLN PRSYR, 40 MG/0.8ML SOLN PRSYR)	5	PA, QL (8 PER 28 OVER TIME)
HADLIMA PUSHTOUCH (40 MG/0.4ML SOLN A-INJ, 40 MG/0.8ML SOLN A-INJ)	5	PA, QL (8 PER 28 OVER TIME)
KINERET 100 MG/0.67ML SOLN PRSYR	5	PA, QL (120 PER 30 DAYS)
OMVOH (100 MG/ML SOLN A-INJ, 100 MG/ML SOLN PRSYR, 200 MG/2ML SOLN A-INJ, 200 MG/2ML SOLN PRSYR)	5	PA, QL (2 PER 28 OVER TIME)
OMVOH (300 MG DOSE) (MG 100 MG/ML 200 MG/2ML SOLN A-INJ, MG 100 MG/ML 200 MG/2ML SOLN PRSYR)	5	PA, QL (3 PER 28 OVER TIME)
OTEZLA (20 MG TAB, 30 MG TAB)	5	PA, QL (60 PER 30 DAYS)
OTEZLA (4 X 10 51 X20 MG TAB THPK, 10 20 30 MG TAB THPK)	5	PA, QL (55 PER 180 OVER TIME)
OTEZLA XR 75 MG TAB ER 24H	5	PA, QL (30 PER 30 DAYS)
OTEZLA/OTEZLA XR INITIATION PK 10&20&30&(ER)75 MG TAB TH	5	PA, QL (41 PER 180 OVER TIME)
PYZCHIVA (45 MG/0.5ML SOLN A-INJ, 45 MG/0.5ML SOLN PRSYR, 45 MG/0.5ML SOLUTION)	3	PA, QL (3 PER 84 OVER TIME)
PYZCHIVA (90 MG/ML SOLN A-INJ, 90 MG/ML SOLN PRSYR)	5	PA, QL (3 PER 84 OVER TIME)
RINVOQ (15 MG TAB ER 24H, 30 MG TAB ER 24H)	5	PA, QL (30 PER 30 DAYS)
RINVOQ 45 MG TAB ER 24H	5	PA, QL (84 PER 180 OVER TIME)
RINVOQ LQ 1 MG/ML SOLUTION	5	PA, QL (360 PER 30 DAYS)
SELARSDI 45 MG/0.5ML SOLN PRSYR	3	PA, QL (3 PER 84 OVER TIME)
SELARSDI 45 MG/0.5ML SOLUTION	3	PA, QL (3 PER 84 OVER TIME)
SELARSDI 90 MG/ML SOLN PRSYR	5	PA, QL (3 PER 84 OVER TIME)
TAVNEOS 10 MG CAP	5	PA, LA, QL (180 PER 30 DAYS), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>tofacitinib citrate (5 mg tab, 10 mg tab)</i>	2	QL (60 PER 30 DAYS)
<i>tofacitinib citrate 1 mg/ml solution</i>	2	QL (300 PER 30 DAYS)
<i>tofacitinib citrate er (er 11 mg tab er, er 22 mg tab er)</i>	2	QL (30 PER 30 DAYS)
TYENNE (162 MG/0.9ML SOLN A-INJ, 162 MG/0.9ML SOLN PRSYR)	5	PA, QL (3.6 PER 28 OVER TIME)
USTEKINUMAB (45 MG/0.5ML SOLN PRSYR, 45 MG/0.5ML SOLUTION)	5	PA, QL (2 PER 84 OVER TIME)
USTEKINUMAB 90 MG/ML SOLN PRSYR	5	PA, QL (3 PER 84 OVER TIME)
VELSIPITY 2 MG TAB	5	PA, QL (30 PER 30 DAYS)
XOLAIR (150 MG RECON SOLN, 150 MG/ML SOLN A-INJ, 300 MG/2ML SOLN A-INJ, 300 MG/2ML SOLN PRSYR)	5	PA, QL (8 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
XOLAIR 150 MG/ML SOLN PRSYR	5	PA, QL (8 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
XOLAIR 75 MG/0.5ML SOLN A-INJ	5	PA, QL (4 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
XOLAIR 75 MG/0.5ML SOLN PRSYR	5	PA, QL (4 PER 28 OVER TIME), (Route to BVSD with an AWD note.)
ZYMFENTRA (1 PEN) 120 MG/ML AUT-IJ KIT	5	PA, QL (2 PER 28 OVER TIME)
ZYMFENTRA (2 PEN) 120 MG/ML AUT-IJ KIT	5	PA, QL (2 PER 28 OVER TIME)
ZYMFENTRA (2 SYRINGE) RINGE) 120 MG/ML PREF KT	5	PA, QL (2 PER 28 OVER TIME)

IMMUNOSUPPRESSANTS

<i>azathioprine (50 mg tab, 75 mg tab, 100 mg tab)</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>cyclosporine 100 mg cap</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>cyclosporine 25 mg cap</i>	2	BVD, (Part B Home Infusion Benefit when billed with G0068, G0069 or G0070)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>cyclosporine modified (100 mg cap, 100 mg/ml solution)</i>	3	BVD, (Route to BVSD with an AWD note.)
<i>cyclosporine modified 25 mg cap</i>	3	BVD, (Part B Home Infusion Benefit when billed with G0068, G0069 or G0070)
<i>cyclosporine modified 50 mg cap</i>	3	BVD, (Route to BVSD with an AWD note.)
ENBREL MINI 50 MG/ML SOLN CART	5	PA, QL (8 PER 28 OVER TIME)
ENVARUSUS XR (0.75 MG TAB ER 24H, 1 MG TAB ER 24H, 4 MG TAB ER 24H)	4	ST, BVD, (Route to BVSD with an AWD note.)
<i>everolimus (0.5 mg tab, 0.75 mg tab, 1 mg tab)</i>	5	QL (120 PER 30 DAYS), BVD, (Route to BVSD with an AWD note.)
<i>everolimus 0.25 mg tab</i>	4	QL (120 PER 30 DAYS), BVD, (Route to BVSD with an AWD note.)
<i>engraf 100 mg cap</i>	3	BVD, (Route to BVSD with an AWD note.)
<i>engraf 25 mg cap</i>	3	BVD, (Part B Home Infusion Benefit when billed with G0068, G0069 or G0070)
<i>leflunomide (10 mg tab, 20 mg tab)</i>	3	
LUPKYNIS 7.9 MG CAP	5	PA, QL (180 PER 30 DAYS)
<i>mycophenolate mofetil (200 mg/ml recon susp, 250 mg cap, 500 mg tab)</i>	3	BVD, (Route to BVSD with an AWD note.)
<i>mycophenolate sodium (180 mg tab dr, 360 mg tab dr)</i>	3	BVD, (Route to BVSD with an AWD note.)
<i>mycophenolic acid (180 mg tab dr, 360 mg tab dr)</i>	3	BVD, (Route to BVSD with an AWD note.)
PROGRAF (0.2 MG PACKET, 1 MG PACKET)	4	BVD, (Route to BVSD with an AWD note.)
RASUVO 10 MG/0.2ML SOLN A-INJ	3	ST, QL (0.8 PER 28 OVER TIME)
RASUVO 12.5 MG/0.25ML SOLN A-INJ	3	ST, QL (1 PER 28 OVER TIME)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
RASUVO 15 MG/0.3ML SOLN A-INJ	3	ST, QL (1.2 PER 28 OVER TIME)
RASUVO 17.5 MG/0.35ML SOLN A-INJ	3	ST, QL (1.4 PER 28 OVER TIME)
RASUVO 20 MG/0.4ML SOLN A-INJ	3	ST, QL (1.6 PER 28 OVER TIME)
RASUVO 22.5 MG/0.45ML SOLN A-INJ	3	ST, QL (1.8 PER 28 OVER TIME)
RASUVO 25 MG/0.5ML SOLN A-INJ	3	ST, QL (2 PER 28 OVER TIME)
RASUVO 30 MG/0.6ML SOLN A-INJ	3	ST, QL (2.4 PER 28 OVER TIME)
RASUVO 7.5 MG/0.15ML SOLN A-INJ	3	ST, QL (0.6 PER 28 OVER TIME)
<i>sirolimus (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	4	BVD, (Route to BVSD with an AWD note.)
<i>sirolimus 1 mg/ml solution</i>	4	BVD, (Route to BVSD with an AWD note.)
<i>tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>tacrolimus er (er 1 mg cap er, er 5 mg cap er)</i>	4	ST, BVD, (Route to BVSD with an AWD note.)
<i>tacrolimus er 0.5 mg cap 24h</i>	4	BVD, (Route to BVSD with an AWD note.)

VACCINES

ABRYSVO 120 MCG/0.5ML RECON SOLN	3	QL (1 PER 999 OVER TIME), \$0 (PREVENTIVE)
ACTHIB RECONSOLN	3	
ADACEL (5-2-15.5 LF-MCG/0.5 SUSP PRSYR, 5-2-15.5 LF-MCG/0.5 SUSPENSION)	3	\$0 (PREVENTIVE), (Route to BVSD with an AWD note.)
AREXVY 120 MCG/0.5ML RECON SUSP	3	QL (1 PER 999 OVER TIME), \$0 (PREVENTIVE)
BCG VACCINE 50 MG RECON SOLN	3	\$0 (PREVENTIVE)
BEXSERO SUSPPRSYR	3	\$0 (PREVENTIVE)
BOOSTRIX 5-2.5-18.5 LF-MCG/0.5 SUSP PRSYR	3	\$0 (PREVENTIVE), (Route to BVSD with an AWD note.)
DAPTACEL 23-15-5SUSPENSION	3	\$0 (PREVENTIVE)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
ENGRIX-B (10 MCG/0.5ML SUSP PRSYR, 20 MCG/ML SUSP PRSYR, 20 MCG/ML SUSPENSION)	3	BVD, \$0 (PREVENTIVE), (Route to BVSD with an AWD note.)
GARDASIL 9 (9 SUSPENSION, 9 0.5 ML SUSP PRSYR)	3	\$0 (PREVENTIVE)
HAVRIX (720 U/0.5ML SUSP PRSYR, 720 U/0.5ML SUSPENSION, 1440 U/ML SUSP PRSYR)	3	\$0 (PREVENTIVE)
HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	3	BVD, \$0 (PREVENTIVE), (Route to BVSD with an AWD note.)
HIBERIX 10 MCG RECON SOLN	3	
IMOVAX RABIES 2.5 UNIT/ML RECON SUSP	3	\$0 (PREVENTIVE)
INFANRIX 25-58-10SUSPENSION	3	\$0 (PREVENTIVE)
IPOL SUSPENSION	3	\$0 (PREVENTIVE)
IXIARO SUSPENSION	3	\$0 (PREVENTIVE)
JYNNEOS 0.5 ML SUSPENSION	3	\$0 (PREVENTIVE)
KINRIX 0.5 ML SUSP PRSYR	3	\$0 (PREVENTIVE)
M-M-R II RECONSOLN	3	\$0 (PREVENTIVE)
MENQUADFI (0.5 ML SOLUTION, SOLUTION)	3	\$0 (PREVENTIVE)
MENVEO RECONSOLN	3	\$0 (PREVENTIVE)
MENVEO SOLUTION	3	\$0 (PREVENTIVE)
MRESVIA 50 MCG/0.5ML SUSP PRSYR	3	QL (1 PER 999 OVER TIME), \$0 (PREVENTIVE)
PEDIARIX SUSPPRSYR	3	
PEDVAXHIB 7.5 MCG/0.5ML SUSPENSION	3	
PENBRAYA RECONSUSP	3	\$0 (PREVENTIVE)
PENMENVY RECONSUSP	3	\$0 (Preventive)
PENTACEL RECONSUSP	3	
PRIORIX RECONSUSP	3	\$0 (PREVENTIVE)
PROQUAD RECONSUSP	3	\$0 (PREVENTIVE)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
QUADRACEL 0.5 ML SUSP PRSYR	3	\$0 (PREVENTIVE)
QUADRACEL SUSPENSION	3	
RABAVERT RECONSUSP	3	\$0 (PREVENTIVE)
RECOMBIVAX HB (5 MCG/0.5ML SUSP PRSYR, 5 MCG/0.5ML SUSPENSION, 10 MCG/ML SUSP PRSYR, 10 MCG/ML SUSPENSION, 40 MCG/ML SUSPENSION)	3	BVD, \$0 (PREVENTIVE), (Route to BVSD with an AWD note.)
ROTARIX SUSPENSION	3	\$0 (PREVENTIVE)
ROTATEQ SOLUTION	3	\$0 (PREVENTIVE)
SHINGRIX 50 MCG/0.5ML RECON SUSP	3	\$0 (PREVENTIVE)
SHINGRIX 50 MCG/0.5ML SUSP PRSYR	3	\$0 (Preventive)
TENIVAC 5-2 LF/0.5ML SUSPENSION	3	\$0 (PREVENTIVE), (Route to BVSD with an AWD note.)
TICOVAC (1.2 MCG/0.25ML SUSP PRSYR, 2.4 MCG/0.5ML SUSP PRSYR)	3	\$0 (PREVENTIVE)
TRUMENBA SUSPPRSYR	3	\$0 (PREVENTIVE)
TWINRIX 720-20 ELU-MCG/ML SUSP PRSYR	3	BVD, \$0 (PREVENTIVE), (Route to BVSD with an AWD note.)
TYPHIM VI 25 MCG/0.5ML SOLN PRSYR	3	\$0 (PREVENTIVE)
VAQTA (25 UNIT/0.5ML SUSP PRSYR, 25 UNIT/0.5ML SUSPENSION, 50 UNIT/ML SUSP PRSYR, 50 UNIT/ML SUSPENSION)	3	\$0 (PREVENTIVE)
VARIVAX 1350 PFU/0.5ML RECON SUSP	3	\$0 (Preventive)
VAXCHORA RECONSUSP	3	PA, \$0 (PREVENTIVE)
VIMKUNYA 40 MCG/0.8ML SUSP PRSYR	3	PA, \$0 (PREVENTIVE)
VIVOTIF CAPDR	3	PA, QL (4 PER 999 OVER TIME), \$0 (Preventive)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
YF-VAX RECONSUSP	3	\$0 (PREVENTIVE)
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES AND/OR PRODRUGS		
<i>balsalazide disodium 750 mg cap</i>	3	
DIPENTUM 250 MG CAP	4	
<i>mesalamine 1.2 gm tab dr</i>	3	QL (120 PER 30 DAYS)
<i>mesalamine 4 gm enema</i>	3	
<i>mesalamine er 0.375 gm cap 24h</i>	3	QL (120 PER 30 DAYS)
ROWASA 4 GM KIT	4	
<i>sulfasalazine (500 mg tab, 500 mg tab dr)</i>	4	NM (Non-Mail Order)
METABOLIC BONE DISEASE AGENTS		
<i>alendronate sodium (35 mg tab, 70 mg tab)</i>	1	
<i>alendronate sodium 10 mg tab</i>	1	
BILDYOS 60 MG/ML SOLN PRSYR	4	BVD, (Route to BVSD with an AWD note.)
BILPREVDA 120 MG/1.7ML SOLUTION	5	BVD, (Route to BVSD with an AWD note.)
<i>calcitonin (salmon) 200 unit/act solution</i>	2	(ESRD)
<i>calcitriol (0.25 mcg cap, 0.5 mcg cap)</i>	4	(ESRD)
<i>calcitriol 1 mcg/ml solution</i>	4	(ESRD)
<i>cinacalcet hcl (30 mg tab, 60 mg tab, 90 mg tab)</i>	4	QL (120 PER 30 DAYS), (ESRD), (ESRD benefits and rules apply.)
<i>doxercalciferol (doxercalciferol 0.5 mcg cap, doxercalciferol 1 mcg cap, doxercalciferol 2.5 mcg cap, doxercalciferol 0.5 mcg cap, doxercalciferol 1 mcg cap, doxercalciferol 2.5 mcg cap)</i>	2	(ESRD)
EVENITY 105 MG/1.17ML SOLN PRSYR	5	PA, QL (2.4 PER 30 OVER TIME), (Route to BVSD with an AWD note.), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>ibandronate sodium 150 mg tab</i>	2	QL (1 PER 28 OVER TIME)
JUBBONTI 60 MG/ML SOLN PRSYR	4	BVD, (Route to BVSD with an AWD note.)
<i>paricalcitol (1 mcg cap, 2 mcg cap, 4 mcg cap)</i>	3	(ESRD), (ESRD benefits and rules apply. If not ESRD, Route to BVSD with an AWD note.)
<i>risedronate sodium 150 mg tab</i>	2	QL (1 PER 28 OVER TIME)
<i>risedronate sodium 30 mg tab</i>	3	QL (30 PER 30 DAYS)
<i>risedronate sodium 35 mg tab</i>	2	QL (4 PER 28 OVER TIME)
<i>risedronate sodium 35 mg tab</i>	3	QL (4 PER 28 OVER TIME)
<i>risedronate sodium 5 mg tab</i>	2	QL (30 PER 30 DAYS)
<i>teriparatide 560 mcg/2.24ml soln pen</i>	5	PA, (Excluded from Auto Extension)
TERIPARATIDE 560 MCG/2.24ML SOLN PEN	5	PA, (Excluded from Auto Extension)
TYMLOS 3120 MCG/1.56ML SOLN PEN	5	PA, QL (1.56 PER 30 OVER TIME), (Excluded from Auto Extension)
WYOST 120 MG/1.7ML SOLUTION	5	BVD, (Route to BVSD with an AWD note.)

MISCELLANEOUS THERAPEUTIC AGENTS

ALCOH-GLOVE CONTOURED WIPE PAD	2	
AQ INSULIN SYRINGE (29G 1/2" 1 ML MISC, 30G 5/16" 0.5 ML MISC)	2	QL (200 PER 30 DAYS)
AQ INSULIN SYRINGE 31G X 5/16" 1 ML MISC	2	QL (200 PER 30 DAYS)
AQINJECT PEN NEEDLE (PEN 31G 5 MISC, PEN 32G 4 MISC)	2	QL (200 PER 30 DAYS)
AUTOKEEPER SAFETY PEN NEEDLE (PEN 5 MISC, PEN 8 MISC)	2	
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML MISC	2	QL (200 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML MISC	2	QL (200 PER 30 DAYS)
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML MISC	2	QL (200 PER 30 DAYS)
DROPSAFE SAFETY SYRINGE/NEEDLE (29G 1/2" 1 ML MISC, 31G 15/64" 0.3 ML MISC, 31G 15/64" 0.5 ML MISC, 31G 15/64" 1 ML MISC, 31G 5/16" 0.5 ML MISC)	2	QL (200 PER 30 DAYS)
DROPSAFE SAFETY SYRINGE/NEEDLE (5/16" 0.3 ML MISC, 5/16" 1 ML MISC)	2	QL (200 PER 30 DAYS)
EMBECTA INSULIN SYRINGE (1/2" 0.5 ML MISC, 1/2" 1 ML MISC)	2	QL (200 PER 30 DAYS)
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" ML MISC	2	QL (200 PER 30 DAYS)
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML MISC	2	QL (200 PER 30 DAYS)
ESSENTRA WIPES 9X9" 70 % SHEET	2	
INSULIN SYRINGE-NEEDLE U-100 (27G 1/2" 0.5 ML MISC, 28G 1/2" 0.5 ML MISC)	2	QL (200 PER 30 DAYS)
INSULIN SYRINGE-NEEDLE U-100 (28G 1/2" 1 ML MISC, 29G 1/2" 0.5 ML MISC, 29G 1/2" 1 ML MISC, 30G 1/2" 1 ML MISC, 30G 5/16" 0.5 ML MISC, 31G 5/16" 0.5 ML MISC)	2	QL (200 PER 30 DAYS)
INSULIN SYRINGE-NEEDLE U-100 3G X 5/6" ML MISC	2	QL (200 PER 30 DAYS)
MAGELLAN INSULIN SAFETY SYR (29G 1/2" 0.3 ML MISC, 29G 1/2" 0.5 ML MISC, 29G 1/2" 1 ML MISC, 30G 5/16" 0.3 ML MISC, 30G 5/16" 0.5 ML MISC)	2	QL (200 PER 30 DAYS)
MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 1 ML MISC	2	QL (200 PER 30 DAYS)
MARATHON MEDICAL PENTIPS (29G 12MM MISC, 31G 5 MM MISC, 31G 8 MM MISC, 32G 4 MM MISC)	2	QL (200 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
MONOJECT INSULIN SYRINGE (28G 1/2" 1 ML MISC, 29G 1/2" 0.3 ML MISC, 29G 1/2" 0.5 ML MISC, 29G 1/2" 1 ML MISC, 30G 5/16" 0.3 ML MISC, 30G 5/16" 0.5 ML MISC)	2	QL (200 PER 30 DAYS)
MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML MISC	2	QL (200 PER 30 DAYS)
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML MISC	2	QL (200 PER 30 DAYS)
MONOJECT ULTRA COMFORT SYRINGE (28G 1/2" 1 ML MISC, 30G 5/16" 0.3 ML MISC, 30G 5/16" 0.5 ML MISC)	2	QL (200 PER 30 DAYS)
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML MISC	2	QL (200 PER 30 DAYS)
PEN NEEDLES (PEN 30G 5 MISC, PEN 31G 5 MISC, PEN 31G 8 MISC, PEN 32G 4 MISC)	2	QL (200 PER 30 DAYS)
PENTIPS (29G 12MM MISC, 31G 5 MM MISC, 31G 8 MM MISC, 32G 4 MM MISC)	2	QL (200 PER 30 DAYS)
PRO COMFORT PEN NEEDLES (PEN 4 MISC, PEN 5 MISC)	2	QL (200 PER 30 DAYS)
SURE COMFORT PEN NEEDLES (PEN 31G 6 MISC, PEN 32G 4 MISC)	2	QL (200 PER 30 DAYS)
TOPFINE INSULIN PEN NEEDLE 32GX4MMMISC	2	
ULTICARE INSULIN SAFETY SYR (1/2" 0.5 ML MISC, 1/2" 1 ML MISC)	2	QL (200 PER 30 DAYS)
VERISAFE SAFETY INSULIN SYR 29G X 1/2" 1 ML MISC	2	

OPHTHALMIC AGENTS

OPHTHALMIC AGENTS, OTHER

<i>atropine sulfate (atropine sulfate 1 % solution, atropine sulfate 1 % solution)</i>	3	
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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>azelastine hcl 0.05 % solution</i>	3	
<i>bepotastine besilate 1.5 % solution</i>	3	QL (15 PER 30 OVER TIME)
COMBIGAN 0.2-0.5 % SOLUTION	3	QL (10 PER 30 OVER TIME)
<i>cyclosporine (pf) 0.05 % emulsion</i>	3	QL (60 PER 30 DAYS)
<i>dorzolamide hcl-timolol mal (2, 22.3-6.8 mg/ml)</i>	3	
<i>dorzolamide hcl-timolol mal pf 2-0.5 % solution</i>	3	
ROCKLATAN 0.02-0.005 % SOLUTION	4	ST, QL (5 PER 30 OVER TIME)
TYRVAYA 0.03 MG/ACT SOLUTION	3	QL (8.4 PER 30 OVER TIME)
XIIDRA 5 % SOLUTION	3	QL (60 PER 30 DAYS)

OPHTHALMIC ANTI-INFECTIVES

<i>ak-poly-bac 500-10000 unit/gm ointment</i>	2	
<i>bacitra-neomycin-polymyxin-hc (bacitra-neomycin-polymyxin-hc 1 % ointment, bacitra-neomycin-polymyxin-hc 1 % ointment)</i>	2	
BACITRACIN-POLYMYXIN B 500-10000 UNIT/GM OINTMENT	2	
BESIVANCE 0.6 % SUSPENSION	4	QL (15 PER 30 OVER TIME)
CILOXAN 0.3 % OINTMENT	4	QL (17.5 PER 30 OVER TIME)
<i>ciprofloxacin hcl 0.3 % solution</i>	2	
<i>erythromycin 5 mg/gm ointment</i>	2	
<i>gatifloxacin 0.5 % solution</i>	2	QL (15 PER 30 OVER TIME)
<i>gentamicin sulfate 0.3 % solution</i>	2	
LEVOFLOXACIN 0.5 % SOLUTION	2	
<i>moxifloxacin hcl 0.5 % solution</i>	2	QL (15 PER 30 OVER TIME)
<i>neomycin-bacitracin zn-polymyx (neomycin-bacitracin zn-polymyx 3.5-400-10000 ointment, neomycin-bacitracin zn-polymyx 5-400-10000 ointment, neomycin-bacitracin zn-polymyx 5-400-10000 ointment)</i>	2	
<i>neomycin-polymyxin-dexameth (0.1 % suspension, 3.5-10000-0.1 ointment, 3.5-10000-0.1 suspension)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
NEOMYCIN-POLYMYXIN-GRAMICIDIN 1.75-10000-.025SOLUTION	2	
NEOMYCIN-POLYMYXIN-HC 3.5-10000-1SUSPENSION	3	
<i>ofloxacin 0.3 % solution</i>	2	
<i>polymyxin b-trimethoprim 10000-0.1 unit/ml-% solution</i>	2	
<i>sulfacetamide sodium (sulfacetamide sodium 10 % solution, sulfacetamide sodium 10 % solution)</i>	2	
SULFACETAMIDE-PREDNISOLONE 10-0.23 % SOLUTION	2	
TOBRADEX 0.3-0.1 % OINTMENT	4	
<i>tobramycin 0.3 % solution</i>	2	
<i>tobramycin-dexamethasone 0.3-0.1 % suspension</i>	3	
TOBREX 0.3 % OINTMENT	4	
TRIFLURIDINE 1 % SOLUTION	3	
XDEMY 0.25 % SOLUTION	5	PA
ZIRGAN 0.15 % GEL	4	
ZYLET 0.5-0.3 % SUSPENSION	4	

OPHTHALMIC ANTI-INFLAMMATORIES

<i>bromfenac sodium (once-daily) 0.09 % solution</i>	3	
CROMOLYN SODIUM 4 % SOLUTION	3	
DEXAMETHASONE SODIUM PHOSPHATE 0.1 % SOLUTION	3	
<i>diclofenac sodium 0.1 % solution</i>	2	
FLAREX 0.1 % SUSPENSION	4	
<i>fluorometholone 0.1 % suspension</i>	3	
FLURBIPROFEN SODIUM 0.03 % SOLUTION	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
FML FORTE 0.25 % SUSPENSION	4	
ILEVRO 0.3 % SUSPENSION	4	QL (15 PER 30 OVER TIME)
<i>ketorolac tromethamine (ketorolac tromethamine 0.4 % solution, ketorolac tromethamine 0.5 % solution)</i>	2	
LOTEMAX 0.5 % OINTMENT	4	QL (15 PER 30 OVER TIME)
LOTEMAX SM 0.38 % GEL	4	QL (15 PER 30 OVER TIME)
<i>loteprednol etabonate (0.5 % gel, 0.5 % suspension)</i>	3	QL (15 PER 30 OVER TIME)
<i>loteprednol etabonate 0.2 % suspension</i>	4	QL (15 PER 30 OVER TIME)
MAXIDEX 0.1 % SUSPENSION	4	
<i>prednisolone acetate 1 % suspension</i>	3	QL (30 PER 30 DAYS)
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	2	

OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS

BETAXOLOL HCL 0.5 % SOLUTION	2	
BETOPTIC-S 0.25 % SUSPENSION	4	
CARTEOLOL HCL 1 % SOLUTION	2	
LEVOBUNOLOL HCL 0.5 % SOLUTION	2	
<i>timolol maleate (0.25 % gel soln, 0.5 % gel soln)</i>	3	
<i>timolol maleate (0.25 %, 0.5 %)</i>	2	
<i>timolol maleate ocudose 0.5 % solution</i>	2	
<i>timolol maleate pf (0.25 %, 0.5 %)</i>	2	

OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER

ALPHAGAN P ALHAGAN 0.1 % SOLUTION	3	QL (15 PER 30 OVER TIME)
APRACLONIDINE HCL 0.5 % SOLUTION	2	
<i>brimonidine tartrate 0.2 % solution</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>brinzolamide 1 % suspension</i>	3	QL (15 PER 30 OVER TIME)
<i>dorzolamide hcl 2 % solution</i>	2	
IOPIDINE 1 % SOLUTION	4	
<i>methazolamide (25 mg tab, 50 mg tab)</i>	3	
<i>pilocarpine hcl (1 %, 2 %, 4 %)</i>	3	
RHOPRESSA 0.02 % SOLUTION	4	ST, QL (60 PER 30 DAYS)
SIMBRINZA 1-0.2 % SUSPENSION	3	QL (16 PER 30 OVER TIME)

OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS

<i>bimatoprost 0.01 % solution</i>	3	QL (5 PER 30 DAYS)
<i>bimatoprost 0.03 % solution</i>	3	QL (7.5 PER 30 OVER TIME)
<i>latanoprost 0.005 % solution</i>	2	
VYZULTA 0.024 % SOLUTION	4	ST

OTIC AGENTS

<i>acetic acid 2 % solution</i>	2	
<i>ciprofloxacin hcl 0.2 % solution</i>	3	NM (Non-Mail Order)
<i>ciprofloxacin-dexamethasone 0.3-0.1 % suspension</i>	3	
<i>ciprofloxacin-hydrocortisone 0.2-1 % suspension</i>	3	
<i>fluocinolone acetonide 0.01 % oil</i>	3	
<i>hydrocortisone-acetic acid 1-2 % solution</i>	3	
<i>neomycin-polymyxin-hc (1 % solution, 3.5-10000-1 solution, 3.5-10000-1 suspension)</i>	3	
<i>ofloxacin 0.3 % solution</i>	3	

RESPIRATORY TRACT/PULMONARY AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

ARNUITY ELLIPTA (50 MCG/ACT AER POW BA, 100 MCG/ACT AER POW BA, 200 MCG/ACT AER POW BA)	3	QL (30 PER 30 DAYS)
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DRUG NAME	TIER	REQUIREMENTS/LIMITS
ASMANEX (120 METERED DOSES) 220 MCG/ACT AER POW BA	3	QL (1 PER 30 DAYS)
ASMANEX (30 METERED DOSES) (110 MCG/ACT AER POW BA, 220 MCG/ACT AER POW BA)	3	QL (1 PER 30 DAYS)
ASMANEX (60 METERED DOSES) 220 MCG/ACT AER POW BA	3	QL (1 PER 30 DAYS)
ASMANEX HFA (100 MCG/ACT AEROSOL, 200 MCG/ACT AEROSOL)	3	QL (13 PER 30 DAYS)
ASMANEX HFA 50 MCG/ACT AEROSOL	3	QL (13 PER 30 DAYS)
<i>budesonide (0.25 mg/2ml suspension, 0.5 mg/2ml suspension, 1 mg/2ml suspension)</i>	3	QL (240 PER 30 DAYS), BvD, (Route to BVSD with an AWD note.)
<i>flunisolide 25 mcg/act (0.025%) solution</i>	3	QL (50 PER 30 OVER TIME)
<i>fluticasone propionate 50 mcg/act suspension</i>	2	QL (16 PER 30 OVER TIME)
FLUTICASONE PROPIONATE DISKUS (50 MCG/ACT AER POW BA, 100 MCG/ACT AER POW BA)	3	QL (60 PER 30 DAYS)
FLUTICASONE PROPIONATE DISKUS 250 MCG/ACT AER POW BA	3	QL (240 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA 110 MCG/ACT AEROSOL	3	QL (12 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA 220 MCG/ACT AEROSOL	3	QL (24 PER 30 DAYS)
<i>fluticasone propionate hfa 44 mcg/act aerosol</i>	3	QL (10.6 PER 30 DAYS)
<i>mometasone furoate 50 mcg/act suspension</i>	3	QL (34 PER 30 OVER TIME)
ANTIHISTAMINES		
<i>azelastine hcl (0.1 %, 137 mcg/spray)</i>	2	QL (60 PER 30 DAYS)
<i>azelastine-fluticasone 137-50 mcg/act suspension</i>	4	ST, QL (23 PER 30 OVER TIME)
<i>cetirizine hcl (1 mg/ml, 5 mg/5ml)</i>	2	QL (300 PER 30 DAYS)
<i>cyproheptadine hcl 2 mg/5ml syrup</i>	2	QL (4500 PER 30 DAYS)

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mean by going to page vii

DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>cyproheptadine hcl 4 mg tab</i>	3	QL (450 PER 30 DAYS)
<i>desloratadine 5 mg tab</i>	2	QL (30 PER 30 DAYS)
<i>levocetirizine dihydrochloride 2.5 mg/5ml solution</i>	2	
<i>levocetirizine dihydrochloride 5 mg tab</i>	2	QL (30 PER 30 DAYS)
<i>olopatadine hcl 0.6 % solution</i>	3	ST, QL (30.5 PER 30 OVER TIME)

ANTILEUKOTRIENES

<i>montelukast sodium (4 mg chew tab, 5 mg chew tab, 10 mg tab)</i>	1	QL (60 PER 30 DAYS)
<i>montelukast sodium 4 mg packet</i>	1	QL (30 PER 30 DAYS)
<i>roflumilast (250 mcg tab, 500 mcg tab)</i>	3	QL (30 PER 30 DAYS)
<i>zafirlukast (10 mg tab, 20 mg tab)</i>	3	QL (60 PER 30 DAYS)

BRONCHODILATORS

<i>albuterol sulfate (0.63 mg/3ml soln, 1.25 mg/3ml soln, (2.5 mg/3ml) 0.083% soln, 2.5 mg/0.5ml soln, (5 mg/ml) 0.5% soln)</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab, 8 mg/20ml syrup)</i>	2	
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln</i>	2	QL (36 PER 30 OVER TIME)
<i>arformoterol tartrate 15 mcg/2ml nebu soln</i>	3	QL (120 PER 30 DAYS), BVD, (Route to BVSD with an AWD note.)
AUVI-Q (0.15 MG/0.15ML SOLN A-INJ, 0.3 MG/0.3ML SOLN A-INJ)	3	
AUVI-Q 0.1 MG/0.1ML SOLN A-INJ	3	
<i>cromolyn sodium 20 mg/2ml nebu soln</i>	3	BVD, (Route to BVSD with an AWD note.)
EPINEPHRINE (0.15 MG/0.15ML SOLN A-INJ, 0.3 MG/0.3ML SOLN A-INJ)	3	QL (2 PER 30 OVER TIME)
<i>epinephrine (0.15 mg/0.3ml soln, 0.3 mg/0.3ml soln)</i>	3	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>formoterol fumarate 20 mcg/2ml nebu soln</i>	4	QL (120 PER 30 DAYS), BVD, (Route to BVSD with an AWD note.)
<i>ipratropium bromide 0.02 % solution</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>ipratropium bromide 0.03 % solution</i>	2	
<i>ipratropium bromide 0.06 % solution</i>	2	
<i>ipratropium bromide hfa 17 mcg/act aero soln</i>	4	
<i>levalbuterol hcl (0.31 mg/3ml soln, 0.63 mg/3ml soln, 1.25 mg/0.5ml soln, 1.25 mg/3ml soln)</i>	2	BVD, (Route to BVSD with an AWD note.)
LEVALBUTEROL TARTRATE 45 MCG/ACT AEROSOL	2	
SEREVENT DISKUS 50 MCG/ACT AER POW BA	3	QL (60 PER 30 DAYS)
SPIRIVA HANDIHALER 18 MCG CAP	3	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT 1.25 MCG/ACT AERO SOLN	3	QL (4 PER 30 DAYS)
SPIRIVA RESPIMAT 2.5 MCG/ACT AERO SOLN	3	QL (4 PER 30 DAYS)
STRIVERDI RESPIMAT 2.5 MCG/ACT AERO SOLN	3	QL (4 PER 30 DAYS)
<i>terbutaline sulfate (2.5 mg tab, 5 mg tab)</i>	2	
UMECLIDINIUM ELLIPTA 62.5 MCG/INH AER POW BA	3	ST, QL (30 PER 30 DAYS)
VENTOLIN HFA 108 (90 BASE) MCG/ACT AERO SOLN	3	QL (36 PER 30 DAYS)
CYSTIC FIBROSIS AGENTS		
BRONCHITOL 40 MG CAP	5	PA, QL (600 PER 30 DAYS)
BRONCHITOL TOLERANCE TEST 40 MG CAP	5	PA, QL (600 PER 30 DAYS)
KALYDECO (5.8 MG PACKET, 13.4 MG PACKET, 25 MG PACKET, 50 MG PACKET, 75 MG PACKET, 150 MG TAB)	5	PA, QL (60 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
PULMOZYME 2.5 MG/2.5ML SOLUTION	5	QL (150 PER 30 DAYS), BVD, (Route to BVSD with an AWD note.)
TRIKAFTA (50-25-37.5 75 MG TAB THPK, 100-50-75 150 MG TAB THPK)	5	PA, QL (90 PER 30 DAYS)
TRIKAFTA (80-40-60 59.5 MG THER PACK, 100-50-75 75 MG THER PACK)	5	PA, QL (60 PER 30 DAYS)

PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE

<i>theophylline er (theophylline er 400 mg tab er 24h, theophylline er 600 mg tab er 24h, theophylline er 100 mg tab er 12h, theophylline er 300 mg tab er 12h, theophylline er 200 mg tab er 12h)</i>	3	
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PULMONARY ANTIHYPERTENSIVES

ADEMPAS (0.5 MG TAB, 1 MG TAB, 1.5 MG TAB, 2 MG TAB, 2.5 MG TAB)	5	PA, QL (90 PER 30 DAYS), (Excluded from Auto Extension)
<i>ambrisentan (5 mg tab, 10 mg tab)</i>	5	PA, LA, QL (30 PER 30 DAYS), (Available from Walgreens Specialty), (Excluded from Auto Extension)
<i>bosentan (62.5 mg tab, 125 mg tab)</i>	5	PA, QL (60 PER 30 DAYS), (Excluded from Auto Extension)
<i>bosentan 32 mg tab sol</i>	5	PA, QL (120 PER 30 DAYS), (Excluded from Auto Extension)
<i>macitentan 10 mg tab</i>	5	PA, QL (30 PER 30 DAYS), (Excluded from Auto Extension)
<i>sildenafil citrate 10 mg/ml recon susp</i>	3	PA, QL (180 PER 30 DAYS), (Excluded from Auto Extension)
<i>sildenafil citrate 20 mg tab</i>	3	PA, QL (90 PER 30 DAYS), (Excluded from Auto Extension)
<i>tadalafil (pah) 20 mg tab</i>	3	PA, QL (60 PER 30 DAYS), (Excluded from Auto Extension)
TADLIQ 20 MG/5ML SUSPENSION	5	PA, QL (300 PER 30 DAYS), (Excluded from Auto Extension)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
UPTRAVI (200 MCG TAB, 400 MCG TAB, 600 MCG TAB, 800 MCG TAB, 1000 MCG TAB, 1200 MCG TAB, 1400 MCG TAB, 1600 MCG TAB)	5	PA, QL (60 PER 30 DAYS), (Excluded from Auto Extension)
UPTRAVI 200 & 800 MCG TAB THPK	5	PA, QL (200 PER 180 OVER TIME), (Excluded from Auto Extension)
WINREVAIR (2 X 45 MG KIT, 2 X 60 MG KIT, 45 MG KIT, 60 MG KIT)	5	PA, (Route to BVSD with an AWD note.)

PULMONARY FIBROSIS AGENTS

<i>nintedanib esylate (100 mg cap, 150 mg cap)</i>	5	PA, QL (60 PER 30 DAYS)
OFEV (100 MG CAP, 150 MG CAP)	5	PA, QL (60 PER 30 DAYS)
<i>pirfenidone (267 mg cap, 267 mg tab)</i>	5	PA, QL (270 PER 30 DAYS)
PIRFENIDONE 534 MG TAB	5	PA, QL (90 PER 30 DAYS)
<i>pirfenidone 801 mg tab</i>	5	PA, QL (90 PER 30 DAYS)

RESPIRATORY TRACT AGENTS, OTHER

<i>acetylcysteine 10 % solution</i>	2	BVD, (Route to BVSD with an AWD note.)
<i>acetylcysteine 20 % solution</i>	2	BVD, (Route to BVSD with an AWD note.)
ANORO ELLIPTA 62.5-25 MCG/ACT AER POW BA	3	QL (60 PER 30 DAYS)
BEVESPI AEROSPHERE 9-4.8 MCG/ACT AEROSOL	4	ST, QL (10.7 PER 30 DAYS)
BREO ELLIPTA (50-25 MCG/INH AER POW BA, 200-25 MCG/ACT AER POW BA)	3	QL (60 PER 30 DAYS)
BREO ELLIPTA 100-25 MCG/ACT AER POW BA	3	QL (60 PER 30 DAYS)
<i>breyna (80-4.5 mcg/act, 160-4.5 mcg/act)</i>	3	QL (20.4 PER 30 DAYS)
BREZTRI AEROSPHERE 160-18-4.8 MCG/ACT AEROSOL	3	QL (10.7 PER 30 OVER TIME)
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACT AEROSOL	3	QL (10.7 PER 30 DAYS)

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>budesonide-formoterol fumarate (80-4.5 mcg/act, 160-4.5 mcg/act)</i>	3	QL (20.4 PER 30 DAYS)
COMBIVENT RESPIMAT 20-100 MCG/ACT AERO SOLN	3	QL (8 PER 30 DAYS)
FLUTICASONE FUROATE-VILANTEROL 100-25 MCG/ACT AER POW BA	3	QL (60 PER 30 DAYS)
FLUTICASONE FUROATE-VILANTEROL 200-25 MCG/ACT AER POW BA	3	QL (60 PER 30 DAYS)
<i>fluticasone-salmeterol (100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act)</i>	3	QL (60 PER 30 DAYS)
FLUTICASONE-SALMETEROL (45-21 MCG/ACT AEROSOL, 115-21 MCG/ACT AEROSOL, 230-21 MCG/ACT AEROSOL)	4	QL (12 PER 30 DAYS)
FLUTICASONE-SALMETEROL (55-14 MCG/ACT AER POW BA, 113-14 MCG/ACT AER POW BA, 232-14 MCG/ACT AER POW BA)	3	QL (1 PER 30 DAYS)
<i>ipratropium-albuterol 0.5-2.5 (3) mg/3ml solution</i>	2	BVD, (Route to BVSD with an AWD note.)
STIOLTO RESPIMAT 2.5-2.5 MCG/ACT AERO SOLN	3	QL (4 PER 30 DAYS)
TRELEGY ELLIPTA 100-62.5-25 MCG/ACT AER POW BA	3	QL (60 PER 30 DAYS)
TRELEGY ELLIPTA 200-62.5-25 MCG/ACT AER POW BA	3	QL (60 PER 30 DAYS)
<i>wixela inhub (100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act)</i>	3	QL (60 PER 30 DAYS)

SKELETAL MUSCLE RELAXANTS

<i>baclofen (5 mg tab, 10 mg tab, 20 mg tab)</i>	2	
<i>carisoprodol 350 mg tab</i>	2	QL (120 PER 30 DAYS)
<i>cyclobenzaprine hcl (5 mg tab, 7.5 mg tab, 10 mg tab)</i>	2	

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DRUG NAME	TIER	REQUIREMENTS/LIMITS
<i>metaxalone 800 mg tab</i>	3	
<i>methocarbamol (500 mg tab, 750 mg tab)</i>	2	
<i>tizanidine hcl (2 mg tab, 4 mg tab)</i>	2	
<i>tizanidine hcl 2 mg cap</i>	2	ST, QL (540 PER 30 DAYS)
<i>tizanidine hcl 4 mg cap</i>	2	ST, QL (270 PER 30 DAYS)
<i>tizanidine hcl 6 mg cap</i>	2	ST, QL (180 PER 30 DAYS)

SLEEP DISORDER AGENTS

SLEEP PROMOTING AGENTS

BELSOMRA (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB)	4	ST, QL (30 PER 30 DAYS)
<i>eszopiclone (1 mg tab, 2 mg tab, 3 mg tab)</i>	2	QL (30 PER 30 DAYS)
<i>ramelteon 8 mg tab</i>	2	QL (30 PER 30 DAYS)
<i>temazepam 15 mg cap</i>	2	QL (60 PER 30 DAYS)
<i>temazepam 30 mg cap</i>	2	QL (30 PER 30 DAYS)
<i>triazolam (0.125 mg tab, 0.25 mg tab)</i>	3	QL (30 PER 30 DAYS)
<i>zaleplon (5 mg cap, 10 mg cap)</i>	2	QL (30 PER 30 DAYS)
<i>zolpidem tartrate (5 mg tab, 10 mg tab)</i>	2	QL (60 PER 30 DAYS)
<i>zolpidem tartrate er (er 6.25 mg tab er, er 12.5 mg tab er)</i>	2	QL (30 PER 30 DAYS)

WAKEFULNESS PROMOTING AGENTS

<i>armodafinil (50 mg tab, 150 mg tab, 200 mg tab, 250 mg tab)</i>	3	QL (90 PER 30 DAYS)
<i>modafinil (100 mg tab, 200 mg tab)</i>	3	QL (90 PER 30 DAYS)
SUNOSI (75 MG TAB, 150 MG TAB)	4	ST, QL (30 PER 30 DAYS)
WAKIX (4.45 MG TAB, 17.8 MG TAB)	5	PA, QL (60 PER 30 DAYS)

Uncategorized

Unclassified

CAREPOINT SAFETY1ST SYR/NEEDLE 25G X 1" 3 ML MISC	2	
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DRUG NAME	TIER	REQUIREMENTS/LIMITS
CAREPOINT SYRINGE LUER LOCK 25G X 1" 3 ML MISC	2	
EASYPPOINT NEEDLE/SYRINGE 25G X 1" 3 ML MISC	2	
MONOJECT ALLERGIST TRAY 27G X 1/2" 1 ML KIT	2	
MONOJECT MAGELLAN SYRINGE 25G X 1" 3 ML MISC	2	
MONOJECT SYRINGE 25G X 1" 3 ML MISC	2	
OMNIPOD 5 DEXG7G6 PODS GEN 5 MISC	3	PA, QL (15 PER 30 OVER TIME)
OMNIPOD 5 G7 PODS (GEN 5) MISC	3	PA, QL (15 PER 30 OVER TIME)
OMNIPOD 5 LIBRE PODS MISC	3	PA, QL (15 PER 30 OVER TIME)
OMNIPOD CLASSIC PODS (GEN 3) MISC	3	
OMNIPOD DASH PODS (GEN 4) MISC	3	PA, QL (15 PER 30 OVER TIME)
SOL-CARE SAFETY SYRINGE ALLERG 27G X 1/2" 1 ML KIT	2	
VERISAFE SAFE STERILE SYRINGE 25G X 1" 3 ML MISC	2	

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buprenorphine hcl	14	CAPLYTA	55	celecoxib	11
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ZYLET.....135

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ZYMFENTRA (2 PEN).....125

ZYMFENTRA (2 SYRINGE)125



P.O. Box 30196
Salt Lake City, UT 84130-0196
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selecthealth.org/medicare

This formulary was updated on 01/01/202.

For more recent information or other questions, please contact Select Health Member Services at **855-442-9900** (TTY users should call **711**), during the following dates and times:

October 1 to March 31:

Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.

April 1 to September 30:

Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday.

Outside these hours of operation, please leave a message. Your call will be returned within one business day, or visit **selecthealth.org/medicare**.

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