



GlobalHealth

GlobalHealth 2019 Formulary

(List of
Covered Drugs)

For Generations
Generations
Select (HMO)



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

This formulary was updated
on 11/01/2019. For more
recent information or other
questions, please contact
GlobalHealth Customer Care at
1-866-494-3927 or,
for TTY users, 711
24 hours a day, seven days a week
www.GlobalHealth.com/medicare

HPMS Approved Formulary File
Submission ID: 00019291
Version 16

GlobalHealth is an HMO plan with
a Medicare contract. Enrollment in
GlobalHealth depends on contract
renewal.

GlobalHealth
2019 Formulary
(List of Covered Drugs)

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

HPMS Approved Formulary File Submission ID 00019291, Version Number 16.

This formulary was updated on 11/01/2019. For more recent information or other questions, please contact us, GlobalHealth Customer Care at 1-866-494-3927 (toll-free) or, for TTY users, 711, 24 hours a day, seven days a week or visit www.GlobalHealth.com/medicare.

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth is dependent on contract renewal.

The formulary may change at any time, you will receive notice when necessary.

H3706_COMPFORMULARY_SELECT_2019_C

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 GlobalHealth, Inc. When it refers to “plan” or “our plan,” it means Generations Select (HMO).

This document includes a list of the drugs (formulary) for our plan which is current as of 11/01/2019. For an updated formulary, please contact us. Our contact information, along with the date we last updated the 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, 2019, and from time to time during the year.

What is the Generations Select (HMO) Formulary?

A formulary is a list of covered drugs selected by our plan 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. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan 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 (drug list) change?

Generally, if you are taking a drug on our 2019 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2019 coverage year except when a new, less expensive generic drug becomes available, when new information about the safety or effectiveness of a drug is released, or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.) Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. Below are changes to the drug list that will also affect members currently taking a drug:

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that 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 the brand name drug for you. The notice we provide you will also include information on the steps you may take to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Generations Select (HMO) Formulary?”

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and 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 generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier. Or 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, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

The enclosed formulary is current as of 11/01/2019. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 7. 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 Agents. If you know what your drug is used for, look for the category name in the list that begins on page 7. 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 75. 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?

Our plan 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 cost less than brand name drugs.

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:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from GlobalHealth before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, our plan provides 30 tablets per prescription for Januvia. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan 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, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan 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 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted on line 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 our plan 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 Generations Select (HMO) formulary?" on page 5 for information about how to request an exception.

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 Customer Care and ask if your drug is covered. For more information, 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 learn that our plan does not cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask GlobalHealth 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 Generations Select (HMO) Formulary?

You can ask our plan 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 cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan 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, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

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 your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to 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 if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. 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, we will allow you to refill your prescription until we have provided you with 31-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If 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 (unless you have a prescription for fewer days) while you pursue a formulary exception.

If you are a current member in our plan, we will also cover a temporary transition supply if you have a change in your medications because of a level-of-care change. This may include unplanned changes in treatment settings, such as being discharged from an acute care (hospital) setting or being admitted to, or discharged from, a long-term care facility. For each drug that is not in our formulary, or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (up to a 31-day supply if you are a resident of a long-term care facility) when you go to a network pharmacy.

For more information

For more detailed information about your Generations Select (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about our plan, 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 <http://www.medicare.gov>.

Generations Select (HMO) Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 75.

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

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

- LA – Limited Access drugs are designated with the abbreviation LA. This prescription may be available only at certain pharmacies. For more information consult your Provider & Pharmacy Directory or call Customer Care, at 1-866-494-3927 (toll-free) 24 hours a day, seven days a week. TTY users should call 711.
- PA - Prior Authorization drugs are designated with the abbreviation PA;
- QL - Quantity Limit drugs are designated with the abbreviation QL and the limit is designated for each drug;
- ST - Step Therapy drugs are designated with the abbreviation ST;
- NM – Drugs that are not available by mail-order are designated with the abbreviation NM;
- B/D – Drugs that require coverage determination for Medicare Part B or Part D are designated with the abbreviation B/D;
- GC - We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage

Drug Name	Drug Tier	Requirements/Limits
------------------	------------------	----------------------------

ANALGESICS

GOUT

<i>allopurinol tab</i>	2	
<i>colchicine w/ probenecid</i>	3	
COLCRYS	3	QL (120 tabs / 30 days)
<i>febuxostat</i>	3	ST
MITIGARE	3	QL (60 caps / 30 days)
<i>probenecid</i>	3	
ULORIC	3	ST

NSAIDS

<i>celecoxib CAPS 50mg</i>	3	QL (240 caps / 30 days)
<i>celecoxib CAPS 100mg</i>	3	QL (120 caps / 30 days)
<i>celecoxib CAPS 200mg</i>	3	QL (60 caps / 30 days)
<i>celecoxib CAPS 400mg</i>	3	QL (30 caps / 30 days)
<i>diclofenac potassium</i>	3	QL (120 tabs / 30 days)
<i>diclofenac sodium TB24; TBEC</i>	2	
<i>diclofenac w/ misoprostol</i>	4	
<i>diflunisal TABS</i>	3	
<i>etodolac</i>	3	
<i>etodolac er</i>	4	
<i>flurbiprofen TABS</i>	3	
<i>ibu tab 600mg</i>	1	GC
<i>ibu tab 800mg</i>	1	GC
<i>ibuprofen SUSP</i>	3	
<i>ibuprofen TABS 400mg, 600mg, 800mg</i>	1	GC
<i>meloxicam TABS</i>	1	GC
<i>nabumetone TABS</i>	2	
<i>naproxen TABS</i>	1	GC
<i>naproxen dr</i>	2	
<i>naproxen sodium TABS 275mg, 550mg</i>	4	
<i>oxaprozin</i>	4	
<i>piroxicam CAPS</i>	3	
<i>sulindac TABS</i>	2	

OPIOID ANALGESICS

<i>acetaminophen w/ codeine 300-15mg</i>	2	QL (400 tabs / 30 days)
<i>acetaminophen w/ codeine 300-30mg</i>	2	QL (360 tabs / 30 days)
<i>acetaminophen w/ codeine 300-60mg</i>	2	QL (180 tabs / 30 days)
<i>acetaminophen w/ codeine soln</i>	2	QL (2700 mL / 30 days)
<i>butorphanol tartrate SOLN 1mg/ml, 2mg/ml</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>nalbuphine hcl</i> SOLN	4	
<i>tramadol hcl tab 50 mg</i>	2	QL (240 tabs / 30 days)
<i>tramadol-acetaminophen</i>	3	QL (240 tabs / 30 days)
OPIOID ANALGESICS, CII		
<i>endocet 2.5-325mg</i>	3	QL (360 tabs / 30 days)
<i>endocet 5-325mg</i>	3	QL (360 tabs / 30 days)
<i>endocet 7.5-325mg</i>	3	QL (240 tabs / 30 days)
<i>endocet 10-325mg</i>	3	QL (180 tabs / 30 days)
<i>fentanyl citrate</i> LPOP	5	QL (120 lozenges / 30 days), PA
<i>fentanyl citrate</i> TABS 200mcg, 400mcg, 600mcg, 800mcg	5	QL (120 tabs / 30 days), PA
<i>fentanyl patch 12 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 25 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 50 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 75 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 100 mcg/hr</i>	4	QL (10 patches / 30 days), PA
FENTORA	5	QL (120 tabs / 30 days), PA
<i>hydroco/apap tab 5-325mg</i>	2	QL (240 tabs / 30 days)
<i>hydroco/apap tab 7.5-325</i>	2	QL (180 tabs / 30 days)
<i>hydroco/apap tab 10-325mg</i>	2	QL (180 tabs / 30 days)
<i>hydrocodone-acetaminophen 7.5-325 mg/15ml</i>	4	QL (2700 mL / 30 days)
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	3	QL (150 tabs / 30 days)
<i>hydromorphone hcl</i> LIQD	4	QL (600 mL / 30 days)
<i>hydromorphone hcl</i> SOLN 10mg/ml, 50mg/5ml, 500mg/50ml	4	B/D
<i>hydromorphone hcl</i> TABS	3	QL (180 tabs / 30 days)
HYSINGLA ER	3	QL (30 tabs / 30 days), PA
<i>lorcet hd tab 10-325mg</i>	2	QL (180 tabs / 30 days)
<i>lorcet plus tab 7.5-325</i>	2	QL (180 tabs / 30 days)
<i>lorcet tab 5-325mg</i>	2	QL (240 tabs / 30 days)
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml	3	QL (450 mL / 30 days), PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>methadone hcl 5mg</i>	3	QL (90 tabs / 30 days), PA
<i>methadone hcl 10mg</i>	3	QL (90 tabs / 30 days), PA
<i>methadone hcl intensol</i>	3	QL (90 mL / 30 days), PA
<i>morphine ext-rel tab 15mg, 30mg, 60mg, 100mg</i>	3	QL (90 tabs / 30 days), PA
<i>morphine ext-rel tab 200mg</i>	3	QL (60 tabs / 30 days), PA
<i>morphine sul inj 1mg/ml</i>	4	B/D
<i>morphine sul inj 10mg/ml</i>	4	B/D
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml, 150mg/30ml	4	B/D
<i>morphine sulfate SOLN 4mg/ml, 8mg/ml, 10mg/ml</i>	4	B/D
<i>morphine sulfate TABS 15mg</i>	3	QL (180 tabs / 30 days)
<i>morphine sulfate TABS 30mg</i>	3	QL (90 tabs / 30 days)
<i>morphine sulfate oral soln 10mg/5ml</i>	3	QL (900 mL / 30 days)
<i>morphine sulfate oral soln 20mg/5ml</i>	3	QL (750 mL / 30 days)
<i>morphine sulfate oral soln 100mg/5ml</i>	3	QL (180 mL / 30 days)
NUCYNTA ER 50mg, 100mg, 200mg, 250mg	3	QL (60 tabs / 30 days), PA
NUCYNTA ER 150mg	3	QL (90 tabs / 30 days), PA
<i>oxycodone hcl CAPS</i>	4	QL (180 caps / 30 days)
<i>oxycodone hcl CONC</i>	4	QL (180 mL / 30 days)
<i>oxycodone hcl SOLN</i>	4	QL (900 mL / 30 days)
<i>oxycodone hcl TABS</i>	3	QL (180 tabs / 30 days)
<i>oxycodone w/ acetaminophen 2.5-325mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen 5-325mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen 7.5-325mg</i>	3	QL (240 tabs / 30 days)
<i>oxycodone w/ acetaminophen 10-325mg</i>	3	QL (180 tabs / 30 days)

ANESTHETICS

LOCAL ANESTHETICS

<i>lidocaine hcl (local anesth.)</i>	2	B/D
<i>lidocaine inj 0.5%</i>	2	B/D
<i>lidocaine inj 1%</i>	2	B/D
<i>lidocaine inj 1.5% preservative free (pf)</i>	2	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
-----------	-----------	---------------------

ANTI-INFECTIVES

ANTI-BACTERIALS - MISCELLANEOUS

<i>amikacin sulfate</i> SOLN	4	
<i>gentamicin in saline</i>	2	
<i>gentamicin sulfate</i> SOLN	3	
<i>neomycin sulfate</i> TABS	3	
<i>paromomycin sulfate</i> CAPS	4	
<i>streptomycin sulfate</i> SOLR	5	
SULFADIAZINE TABS	4	
<i>tobramycin</i> NEBU	5	NM, PA
<i>tobramycin inj 1.2 gm/30ml</i>	3	
<i>tobramycin inj 1.2gm</i>	5	
<i>tobramycin inj 10mg/ml</i>	3	
<i>tobramycin inj 40mg/ml</i>	3	
<i>tobramycin inj 80mg/2ml</i>	3	

ANTI-INFECTIVES - MISCELLANEOUS

<i>albendazole</i> TABS	5	
ALINIA	5	
<i>atovaquone</i> SUSP	5	
AZACTAM INJ	4	
<i>aztreonam</i>	4	
CAYSTON	5	NM, LA, PA
<i>clindamycin cap 75mg</i>	2	
<i>clindamycin cap 300mg</i>	2	
<i>clindamycin hcl cap 150 mg</i>	2	
<i>clindamycin phosphate in d5w</i>	4	
CLINDAMYCIN PHOSPHATE IN NACL	4	
<i>clindamycin phosphate inj</i>	3	
<i>clindamycin soln 75mg/5ml</i>	4	
<i>colistimethate sodium</i> SOLR	4	
<i>dapsone</i> TABS	3	
DAPTOMYCIN 350mg	5	
<i>daptomycin 350mg, 500mg</i>	5	
EMVERM	5	
<i>ertapenem sodium</i>	4	
<i>imipenem-cilastatin</i>	3	
<i>ivermectin</i> TABS	3	
<i>linezolid in sodium chloride</i>	4	
<i>linezolid inj</i>	4	
<i>linezolid susp</i>	5	

PA - Prior Authorization QL - Quantity Limits ST - Step Therapy NM - Not available at mail-order B/D - Covered under Medicare B or D LA - Limited Access GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>linezolid tab 600mg</i>	5	
<i>meropenem</i>	4	
<i>methenamine hippurate</i>	3	
<i>metronidazole TABS</i>	2	
<i>metronidazole in nacl</i>	2	
NEBUPENT	4	B/D
<i>nitrofurantoin macrocrystal 50mg, 100mg</i>	3	PA; PA applies if 70 years and older after a 90 day supply in a calendar year
<i>nitrofurantoin monohyd macro</i>	3	PA; PA applies if 70 years and older after a 90 day supply in a calendar year
PENTAM 300	4	
<i>pentamidine isethionate</i>	4	
<i>praziquantel TABS</i>	3	
SIVEXTRO	5	
<i>sulfamethoxazole-trimethop ds</i>	1	GC
<i>sulfamethoxazole-trimethoprim inj</i>	4	
<i>sulfamethoxazole-trimethoprim susp</i>	4	
<i>sulfamethoxazole-trimethoprim tab 400-80mg</i>	1	GC
SYNERCID	5	
<i>tigecycline</i>	5	
<i>trimethoprim TABS</i>	2	
<i>vancomycin hcl CAPS 125mg</i>	4	
<i>vancomycin hcl CAPS 250mg</i>	5	
<i>vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg</i>	4	
VANCOMYCIN IN NAACL	4	
ANTIFUNGALS		
ABELCET	5	B/D
AMBISOME	5	B/D
<i>amphotericin b SOLR</i>	3	B/D
<i>caspofungin acetate</i>	5	
<i>fluconazole SUSR</i>	3	
<i>fluconazole TABS</i>	2	
<i>fluconazole inj nacl 200</i>	3	
<i>fluconazole inj nacl 400</i>	3	
<i>flucytosine CAPS</i>	5	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>griseofulvin microsize</i> SUSP	3	
<i>griseofulvin microsize</i> TABS	4	
<i>griseofulvin ultramicrosize</i>	4	
<i>itraconazole</i> CAPS	4	PA
<i>ketoconazole</i> TABS	3	PA
MYCAMINE	5	
NOXAFIL SUSP	5	QL (630 mL / 30 days)
NOXAFIL TBEC	5	QL (93 tabs / 30 days)
<i>nystatin</i> TABS	3	
<i>posaconazole</i>	5	QL (93 tabs / 30 days)
<i>terbinafine hcl</i> TABS	2	QL (90 tabs / year)
<i>voriconazole</i> SOLR	4	
<i>voriconazole</i> SUSR; TABS	5	
ANTIMALARIALS		
<i>atovaquone-proguanil hcl</i>	4	
<i>chloroquine phosphate</i> TABS	4	
COARTEM	4	
<i>mefloquine hcl</i>	3	
<i>primaquine phosphate</i> 26.3mg	3	
PRIMAQUINE PHOSPHATE 26.3mg	3	
<i>quinine sulfate</i> CAPS	4	PA
ANTIRETROVIRAL AGENTS		
<i>abacavir sulfate</i> SOLN	4	
<i>abacavir sulfate</i> TABS	3	
APTIVUS	5	
<i>atazanavir sulfate</i>	5	
CRIXIVAN	4	
<i>didanosine</i>	4	
EDURANT	5	
<i>efavirenz</i> CAPS 50mg	4	
<i>efavirenz</i> CAPS 200mg	5	
<i>efavirenz</i> TABS	5	
EMTRIVA	3	
<i>fosamprenavir tab 700 mg</i>	5	
FUZEON	5	NM
INTELENCE 25mg	4	
INTELENCE 100mg, 200mg	5	
INVIRASE	5	
ISENTRESS CHEW 25mg	3	
ISENTRESS CHEW 100mg	5	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ISENTRESS PACK	3	
ISENTRESS TABS	5	
ISENTRESS HD	5	
<i>lamivudine</i>	3	
LEXIVA SUSP	4	
<i>nevirapine susp 50 mg/5ml</i>	4	
<i>nevirapine tab 100mg er</i>	4	
<i>nevirapine tab 200mg</i>	3	
<i>nevirapine tab 400mg er</i>	4	
NORVIR PACK	4	
NORVIR SOLN	4	
PIFELTRO	5	
PREZISTA SUSP	5	QL (400 mL / 30 days)
PREZISTA TABS 75mg	3	QL (480 tabs / 30 days)
PREZISTA TABS 150mg	5	QL (240 tabs / 30 days)
PREZISTA TABS 600mg	5	QL (60 tabs / 30 days)
PREZISTA TABS 800mg	5	QL (30 tabs / 30 days)
RESCRIPTOR	4	
REYATAZ PACK	5	
<i>ritonavir</i>	3	
SELZENTRY SOLN	5	
SELZENTRY TABS 25mg	4	
SELZENTRY TABS 75mg, 150mg, 300mg	5	
<i>stavudine</i>	3	
<i>tenofovir disoproxil fumarate</i>	5	
TIVICAY 10mg	3	
TIVICAY 25mg, 50mg	5	
TROGARZO	5	NM, LA
TYBOST	4	
VIDEX EC 125mg	4	
VIDEX PEDIATRIC	4	
VIRACEPT	5	
VIRAMUNE SUSP	4	
VIREAD POWD	5	
VIREAD TABS 150mg, 200mg, 250mg	5	
<i>zidovudine cap 100mg</i>	4	
<i>zidovudine syp 50mg/5ml</i>	4	
<i>zidovudine tab 300mg</i>	3	
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>abacavir sulfate-lamivudine-zidovudine</i>	5	
ATRIPLA	5	
BIKTARVY	5	
CIMDUO	5	
COMPLERA	5	
DELSTRIGO	5	
DESCOVY	5	
DOVATO	5	
EVOTAZ	5	
GENVOYA	5	
JULUCA	5	
KALETRA TAB 100-25MG	4	
KALETRA TAB 200-50MG	5	
<i>lamivudine-zidovudine</i>	4	
<i>lopinavir-ritonavir</i>	4	
ODEFSEY	5	
PREZCOBIX	5	
STRIBILD	5	
SYMFI	5	
SYMFI LO	5	
SYMTUZA	5	
TRIUMEQ	5	
TRUVADA TAB 100-150	5	QL (60 tabs / 30 days)
TRUVADA TAB 133-200	5	QL (30 tabs / 30 days)
TRUVADA TAB 167-250	5	QL (30 tabs / 30 days)
TRUVADA TAB 200-300	5	QL (30 tabs / 30 days)
ANTITUBERCULAR AGENTS		
<i>cycloserine</i> CAPS	5	
<i>ethambutol hcl</i> TABS	3	
<i>isoniazid</i> TABS	1	GC
<i>isoniazid syp 50mg/5ml</i>	4	
PASER D/R	4	
PRIFTIN	4	
<i>pyrazinamide</i> TABS	4	
<i>rifabutin</i>	4	
<i>rifampin</i> CAPS	3	
<i>rifampin</i> SOLR	4	
RIFATER	4	
SIRTURO	5	LA, PA
TRECTOR	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ANTIVIRALS		
<i>acyclovir</i> CAPS; TABS	2	
<i>acyclovir</i> SUSP	4	
<i>acyclovir sodium</i>	4	B/D
<i>adefovir dipivoxil</i>	5	
BARACLUDE SOLN	5	
<i>entecavir</i>	5	
EPCLUSA	5	NM, PA
EPIVIR HBV SOLN	4	
<i>famciclovir</i>	3	
<i>ganciclovir sodium</i>	3	B/D
HARVONI	5	NM, PA
<i>lamivudine (hbv)</i>	4	
MAVYRET	5	NM, PA
<i>oseltamivir phosphate</i> CAPS 30mg	3	QL (168 caps / year)
<i>oseltamivir phosphate</i> CAPS 45mg, 75mg	3	QL (84 caps / year)
<i>oseltamivir phosphate</i> SUSR	3	QL (1080 mL / year)
PEGASYS	5	NM, PA
PEGASYS PROCLICK	5	NM, PA
REBETOL SOLN	5	NM
RELENZA DISKHALER	3	QL (6 inhalers / year)
<i>ribasphere cap 200mg</i>	3	NM
<i>ribasphere tab 200mg</i>	4	NM
<i>ribasphere tab 600mg</i>	5	NM
<i>ribavirin 200mg</i> CAPS	3	NM
<i>ribavirin 200mg</i> TABS	4	NM
<i>rimantadine hydrochloride</i>	3	
<i>valacyclovir hcl</i> TABS	3	
<i>valganciclovir hcl</i>	5	
VEMLIDY	5	
VOSEVI	5	NM, PA
ZEPATIER	5	NM, PA
CEPHALOSPORINS		
<i>cefaclor</i> CAPS	3	
<i>cefaclor</i> SUSR	4	
CEFACLOR MONOHYDRATE ER	4	
<i>cefadroxil</i> CAPS	2	
<i>cefadroxil</i> SUSR	3	
<i>cefadroxil</i> TABS	4	
CEFAZOLIN IN DEXTROSE 2GM/100ML-4%	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>cefazolin inj</i>	3	
<i>cefazolin sodium</i> SOLR 1gm, 20gm	3	
CEFAZOLIN SODIUM 1 GM/50ML	3	
<i>cefdinir</i> CAPS	3	
<i>cefdinir</i> SUSR	4	
<i>cefepime hcl</i>	4	
<i>cefixime cap 400mg</i>	3	
<i>cefixime susr</i>	4	
<i>cefotaxime sodium</i> 1gm, 500mg	4	
<i>cefoxitin sodium</i>	4	
<i>cefpodoxime proxetil</i> SUSR	4	
<i>cefpodoxime proxetil</i> TABS	3	
<i>cefprozil</i>	3	
<i>ceftazidime</i> SOLR	3	
CEFTAZIDIME/DEXTROSE	4	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	3	
<i>cefuroxime axetil</i>	3	
<i>cefuroxime sodium</i>	4	
<i>cephalexin</i> CAPS 250mg, 500mg	1	GC
<i>cephalexin</i> SUSR	3	
SUPRAX CHEW	4	
SUPRAX SUSR 500mg/5ml	3	
<i>tazicef</i> SOLR	3	
TEFLARO	5	
ERYTHROMYCINS/MACROLIDES		
<i>azithromycin</i> PACK; SOLR; SUSR	3	
<i>azithromycin</i> TABS	1	GC
<i>clarithromycin</i> TABS	3	
<i>clarithromycin er</i>	3	
<i>clarithromycin for susp</i>	4	
DIFICID	5	
<i>e.e.s 400</i>	4	
<i>ery-tab</i>	4	
ERYTHROCIN LACTOBIONATE	4	
<i>erythrocin stearate</i>	4	
<i>erythromycin base</i>	4	
<i>erythromycin cap 250mg ec</i>	4	
<i>erythromycin ethylsuccinate</i> TABS	4	
<i>erythromycin tab ec</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
FLUOROQUINOLONES		
<i>ciprofloxacin</i> SUSR	4	
<i>ciprofloxacin hcl tab</i> 100mg	4	
<i>ciprofloxacin hcl tab</i> 250mg, 500mg, 750mg	1	GC
<i>ciprofloxacin in d5w</i>	3	
<i>levofloxacin</i> TABS	1	GC
<i>levofloxacin in d5w</i>	3	
<i>levofloxacin inj</i> 25mg/ml	4	
<i>levofloxacin oral soln</i> 25 mg/ml	4	
MOXIFLOXACIN HCL SOLN	4	
<i>moxifloxacin hcl</i> TABS	4	
<i>moxifloxacin hcl in sodium chloride</i>	4	
PENICILLINS		
<i>amoxicillin</i> CAPS; SUSR; TABS	1	GC
<i>amoxicillin</i> CHEW	2	
<i>amoxicillin & pot clavulanate</i> CHEW; TB12	4	
<i>amoxicillin & pot clavulanate</i> SUSR	3	
<i>amoxicillin & pot clavulanate</i> TABS	2	
<i>ampicillin & sulbactam sodium</i>	4	
<i>ampicillin cap</i> 500mg	2	
<i>ampicillin inj</i>	4	
<i>ampicillin sodium</i>	4	
AUGMENTIN SUS 125/5ML	4	
BICILLIN L-A	4	
<i>dicloxacillin sodium</i>	3	
<i>nafcillin sodium</i> 1gm, 2gm	4	
<i>nafcillin sodium</i> 10gm	5	
NAFCILLIN SODIUM FOR INJ 10GM	4	
<i>oxacillin sodium</i> 1gm, 2gm	4	
<i>oxacillin sodium</i> 10gm	5	
PENICILLIN G POT IN DEXTROSE 2MU	4	
PENICILLIN G POT IN DEXTROSE 3MU	4	
PENICILLIN G PROCAINE	4	
<i>penicillin g sodium</i>	4	
<i>penicillin v potassium</i> SOLR	2	
<i>penicillin v potassium</i> TABS	1	GC
<i>penicillin gk inj</i> 5mu	4	
<i>penicillin gk inj</i> 20mu	4	
<i>pfizerpen-g inj</i> 5mu	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>pfizerpen-g inj 20mu</i>	4	
<i>piper/tazoba inj 2-0.25gm</i>	4	
<i>piper/tazoba inj 3-0.375gm</i>	4	
<i>piper/tazoba inj 4-0.5gm</i>	4	
<i>piper/tazoba inj 12-1.5gm</i>	4	
<i>piper/tazoba inj 36-4.5gm</i>	4	

TETRACYCLINES

<i>doxy 100</i>	4	
<i>doxycycline (monohydrate) CAPS 50mg, 100mg</i>	2	
<i>doxycycline (monohydrate) TABS</i>	3	
<i>doxycycline hyclate CAPS</i>	3	
<i>doxycycline hyclate SOLR</i>	4	
<i>doxycycline hyclate TABS 20mg, 100mg</i>	3	
<i>minocycline hcl CAPS</i>	3	
<i>mondoxyne nl cap 100mg</i>	2	
<i>morgidox cap 1x50mg</i>	3	
<i>tetracycline hcl CAPS</i>	4	

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

<i>BENDEKA</i>	5	B/D, NM
<i>cyclophosphamide CAPS</i>	4	B/D
<i>cyclophosphamide SOLR</i>	5	B/D
<i>dacarbazine 100mg</i>	3	B/D
<i>EMCYT</i>	4	
<i>GLEOSTINE</i>	4	
<i>IFEX INJ 3GM</i>	4	B/D
<i>ifosfamide inj 1gm/20ml</i>	4	B/D
<i>IFOSFAMIDE INJ 3GM</i>	4	B/D
<i>ifosfamide inj 3gm/60ml</i>	4	B/D
<i>LEUKERAN</i>	5	

ANTHRACYCLINES

<i>adriamycin SOLN</i>	4	B/D
<i>doxorubicin hcl</i>	4	B/D
<i>doxorubicin hcl liposomal</i>	5	B/D
<i>epirubicin hcl</i>	4	B/D

ANTIBIOTICS

<i>bleomycin sulfate</i>	3	B/D
<i>mitomycin SOLR</i>	5	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ANTIMETABOLITES		
<i>adrucil</i>	3	B/D
ALIMTA	5	B/D
<i>azacitidine</i>	5	B/D
<i>cytarabine</i> 20mg/ml	3	B/D
<i>fluorouracil</i> SOLN	3	B/D
<i>gemcitabine inj soln</i>	4	B/D
<i>gemcitabine inj solr</i>	4	B/D
<i>mercaptopurine</i> TABS	4	
<i>methotrexate sodium inj</i>	2	B/D
PURIXAN	5	NM
TABLOID	4	
ANTIMITOTIC, TAXOIDS		
ABRAXANE	5	B/D
<i>docetaxel</i> CONC 20mg/ml, 80mg/4ml, 160mg/8ml	5	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml, 200mg/10ml	5	B/D
<i>docetaxel</i> SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
DOCETAXEL SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
<i>paclitaxel</i>	4	B/D
TAXOTERE 80mg/4ml	5	B/D
ANTIMITOTIC, VINCA ALKALOIDS		
<i>vinblastine sulfate</i>	3	B/D
<i>vincristine sulfate</i>	2	B/D
<i>vinorelbine tartrate</i>	3	B/D
BIOLOGIC RESPONSE MODIFIERS		
AVASTIN	5	LA, PA
BORTEZOMIB	5	PA
DAURISMO	5	NM, LA, PA
ERIVEDGE	5	NM, LA, PA
FARYDAK	5	NM, LA, PA
HERCEPTIN	5	PA
HERCEPTIN HYLECTA	5	PA
IBRANCE	5	NM, LA, PA
IDHIFA	5	NM, LA, PA
KADCYLA	5	B/D
KEYTRUDA SOLN	5	NM, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
KEYTRUDA SOLR	5	PA
KISQALI	5	NM, PA
KISQALI FEMARA 200 DOSE	5	NM, PA
KISQALI FEMARA 400 DOSE	5	NM, PA
KISQALI FEMARA 600 DOSE	5	NM, PA
LYNPARZA	5	NM, LA, PA
MYLOTARG	5	NM, LA, PA
NINLARO	5	NM, PA
ODOMZO	5	NM, LA, PA
RITUXAN	5	LA, PA
RITUXAN HYCELA	5	NM, LA, PA
RUBRACA	5	NM, LA, PA
TALZENNA	5	NM, LA, PA
TECENTRIQ	5	NM, LA, PA
TIBSOVO	5	NM, LA, PA
VELCADE	5	PA
VENCLEXTA 10mg, 50mg	4	NM, LA, PA
VENCLEXTA 100mg	5	NM, LA, PA
VENCLEXTA STARTING PACK	5	NM, LA, PA
VERZENIO	5	NM, LA, PA
ZEJULA	5	NM, LA, PA
ZOLINZA	5	NM, PA
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate</i>	5	NM, PA
<i>anastrozole TABS</i>	2	
<i>bicalutamide</i>	3	
DEPO-PROVERA INJ 400/ML	4	B/D
ERLEADA	5	NM, LA, PA
<i>exemestane</i>	4	
FASLODEX	5	B/D
<i>flutamide</i>	3	
<i>fulvestrant</i>	5	B/D
<i>letrozole TABS</i>	2	
<i>leuprolide inj 1mg/0.2</i>	3	NM, PA
LUPRON DEPOT (1-MONTH) 3.75mg	5	NM, PA
LUPRON DEPOT INJ 11.25MG (3-MONTH)	5	NM, PA
LYSODREN	3	
<i>megestrol ac sus 40mg/ml</i>	4	
<i>megestrol ac tab 20mg</i>	3	
<i>megestrol ac tab 40mg</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>megestrol sus 625mg/5ml</i>	4	PA
<i>nilutamide</i>	5	
NUBEQA	5	NM, LA, PA
SOLTAMOX	5	
<i>tamoxifen citrate TABS</i>	1	GC
<i>toremifene citrate</i>	5	
TRELSTAR DEP INJ 3.75MG	5	NM, PA
TRELSTAR LA INJ 11.25MG	5	NM, PA
XTANDI	5	NM, LA, PA
ZYTIGA 500mg	5	NM, LA, PA

IMMUNOMODULATORS

POMALYST CAP 1MG	5	NM, LA, PA
POMALYST CAP 2MG	5	NM, LA, PA
POMALYST CAP 3MG	5	NM, LA, PA
POMALYST CAP 4MG	5	NM, LA, PA
REVLIMID	5	QL (28 caps / 28 days), NM, LA, PA
THALOMID 50mg, 100mg	5	QL (30 caps / 30 days), NM, PA
THALOMID 150mg, 200mg	5	QL (60 caps / 30 days), NM, PA

KINASE INHIBITORS

AFINITOR	5	QL (30 tabs / 30 days), NM, PA
AFINITOR DISPERZ 2mg	5	QL (150 tabs / 30 days), NM, PA
AFINITOR DISPERZ 3mg	5	QL (90 tabs / 30 days), NM, PA
AFINITOR DISPERZ 5mg	5	QL (60 tabs / 30 days), NM, PA
ALECENSA	5	NM, LA, PA
ALUNBRIG	5	NM, LA, PA
BALVERSA	5	NM, LA, PA
BOSULIF	5	NM, PA
BRAFTOVI	5	NM, LA, PA
CABOMETYX	5	QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE	5	NM, LA, PA
CAPRELSA	5	NM, LA, PA
COMETRIQ	5	NM, LA, PA
COPIKTRA	5	NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
COTELLIC	5	NM, LA, PA
<i>erlotinib hcl</i> 25mg	5	QL (90 tabs / 30 days), NM, PA
<i>erlotinib hcl</i> 100mg, 150mg	5	QL (30 tabs / 30 days), NM, PA
GILOTRIF TAB 20MG	5	NM, LA, PA
GILOTRIF TAB 30MG	5	NM, LA, PA
GILOTRIF TAB 40MG	5	NM, LA, PA
ICLUSIG	5	NM, LA, PA
<i>imatinib mesylate</i> 100mg	5	QL (90 tabs / 30 days), NM, PA
<i>imatinib mesylate</i> 400mg	5	QL (60 tabs / 30 days), NM, PA
IMBRUVICA	5	NM, LA, PA
INLYTA 1mg	5	QL (180 tabs / 30 days), NM, LA, PA
INLYTA 5mg	5	QL (120 tabs / 30 days), NM, LA, PA
INREBIC	5	NM, LA, PA
IRESSA	5	NM, LA, PA
JAKAFI	5	QL (60 tabs / 30 days), NM, LA, PA
LENVIMA 4 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 8 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 10 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 12MG DAILY DOSE	5	NM, LA, PA
LENVIMA 14 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 18 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 20 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 24 MG DAILY DOSE	5	NM, LA, PA
LORBRENA	5	NM, LA, PA
MEKINIST	5	NM, LA, PA
MEKTOVI	5	NM, LA, PA
NERLYNX	5	NM, LA, PA
NEXAVAR	5	NM, LA, PA
PIQRAY 200MG DAILY DOSE	5	NM, PA
PIQRAY 250MG DAILY DOSE	5	NM, PA
PIQRAY 300MG DAILY DOSE	5	NM, PA
RYDAPT	5	NM, PA
SPRYCEL	5	NM, PA
STIVARGA	5	NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
SUTENT	5	NM, PA
TAFINLAR	5	NM, LA, PA
TAGRISSE	5	NM, LA, PA
TARCEVA 25mg	5	QL (90 tabs / 30 days), NM, LA, PA
TARCEVA 100mg, 150mg	5	QL (30 tabs / 30 days), NM, LA, PA
TASIGNA	5	NM, PA
TURALIO	5	NM, LA, PA
TYKERB	5	NM, LA, PA
VITRAKVI	5	NM, LA, PA
VIZIMPRO	5	NM, LA, PA
VOTRIENT	5	NM, LA, PA
XALKORI	5	NM, LA, PA
XOSPATA	5	NM, LA, PA
ZELBORAF	5	NM, LA, PA
ZYDELIG	5	NM, LA, PA
ZYKADIA	5	NM, LA, PA

MISCELLANEOUS

<i>bexarotene</i>	5	NM, PA
<i>hydroxyurea</i> CAPS	2	
LONSURF	5	NM, PA
MATULANE	5	LA
SYLATRON KIT 200MCG	5	PA
SYLATRON KIT 300MCG	5	PA
SYLATRON KIT 600MCG	5	PA
SYNRIBO	5	NM, PA
<i>tretinoin (chemotherapy)</i>	5	
XPOVIO 60 MG ONCE WEEKLY	5	NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY	5	NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY	5	NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY	5	NM, LA, PA

PLATINUM-BASED AGENTS

<i>carboplatin</i>	3	B/D
<i>cisplatin</i> SOLN	3	B/D
<i>oxaliplatin inj 50mg</i>	5	B/D
<i>oxaliplatin inj 50mg/10ml</i>	4	B/D
<i>oxaliplatin inj 100mg</i>	5	B/D
<i>oxaliplatin inj 100mg/20ml</i>	4	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
PROTECTIVE AGENTS		
<i>dexrazoxane hcl</i>	5	B/D
<i>leucovorin calcium SOLR</i>	4	B/D
<i>leucovorin calcium TABS</i>	3	
<i>leucovorin calcium solr</i>	4	B/D
MESNEX TABS	5	
TOPOISOMERASE INHIBITORS		
<i>etoposide SOLN</i>	3	B/D
<i>irinotecan hcl</i>	4	B/D
<i>toposar</i>	3	B/D
<i>topotecan hcl</i>	5	B/D
TOPOTECAN INJ 4MG/4ML	5	B/D
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
<i>amlodipine--benazepril hcl cap 10-20 mg</i>	1	GC
<i>amlodipine-benazepril hcl cap 2.5-10 mg</i>	1	GC
<i>amlodipine-benazepril hcl cap 5-10 mg</i>	1	GC
<i>amlodipine-benazepril hcl cap 5-20 mg</i>	1	GC
<i>amlodipine-benazepril hcl cap 5-40 mg</i>	1	GC
<i>amlodipine-benazepril hcl cap 10-40mg</i>	1	GC
<i>benazepril & hydrochlorothiazide</i>	1	GC
<i>captopril & hydrochlorothiazide</i>	1	GC
<i>enalapril maleate & hydrochlorothiazide</i>	1	GC
<i>fosinopril sodium & hydrochlorothiazide</i>	1	GC
<i>lisinopril & hydrochlorothiazide</i>	1	GC
<i>quinapril-hydrochlorothiazide</i>	1	GC
ACE INHIBITORS		
<i>benazepril hcl TABS</i>	1	GC
<i>captopril TABS</i>	1	GC
<i>enalapril maleate TABS</i>	1	GC
<i>fosinopril sodium</i>	1	GC
<i>lisinopril TABS</i>	1	GC
<i>moexipril hcl</i>	1	GC
<i>perindopril erbumine</i>	1	GC
<i>quinapril hcl</i>	1	GC
<i>ramipril</i>	1	GC
<i>trandolapril</i>	1	GC
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone</i>	3	

PA - Prior Authorization QL - Quantity Limits ST - Step Therapy NM - Not available at mail-order B/D - Covered under Medicare B or D LA - Limited Access GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>spironolactone</i> TABS	1	GC
ALPHA BLOCKERS		
<i>doxazosin mesylate</i> TABS	2	
<i>prazosin hcl</i>	3	
<i>terazosin hcl</i>	1	GC
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-olmesartan medoxomil</i>	1	GC
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	GC
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	GC
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	GC
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	GC
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-12.5mg</i>	1	GC
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-25mg</i>	1	GC
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-12.5mg</i>	1	GC
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-25mg</i>	1	GC
<i>amlodipine-valsartan-hydrochlorothiazide 10-320-25mg</i>	1	GC
<i>candesartan cilexetil-hydrochlorothiazide</i>	1	GC
ENTRESTO	3	
<i>irbesartan-hydrochlorothiazide</i>	1	GC
<i>losartan-hydrochlorothiazide</i>	1	GC
<i>olmesartan medoxomil-amlodipine-hydrochlorothiazide</i>	1	GC
<i>olmesartan medoxomil-hydrochlorothiazide</i>	1	GC
<i>telmisartan-amlodipine</i>	1	GC
<i>telmisartan-hydrochlorothiazide</i>	1	GC
<i>valsartan-hydrochlorothiazide</i>	1	GC
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil</i>	1	GC
EDARBI	4	
<i>irbesartan</i>	1	GC
<i>losartan potassium</i>	1	GC
<i>olmesartan medoxomil</i> TABS	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>telmisartan</i>	1	GC
<i>valsartan</i>	1	GC
ANTIARRHYTHMICS		
<i>amiodarone hcl soln</i>	2	
<i>amiodarone tab 100mg</i>	4	
<i>amiodarone tab 200mg</i>	1	GC
<i>amiodarone tab 400mg</i>	4	
<i>disopyramide phosphate</i>	4	
<i>dofetilide</i>	4	
<i>flecainide acetate</i>	3	
<i>mexiletine hcl</i>	4	
MULTAQ	4	
NORPACE CR	4	
<i>pacerone 100mg, 400mg</i>	4	
<i>pacerone 200mg</i>	1	GC
<i>propafenone hcl</i>	3	
<i>propafenone hcl 12hr</i>	4	
<i>quinidine gluconate</i>	4	
<i>quinidine sulfate</i>	2	
<i>sorine</i>	2	
<i>sotalol hcl</i>	2	
<i>sotalol hcl (afib/afl)</i>	2	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
ALTOPREV	5	ST
<i>atorvastatin calcium TABS</i>	1	GC
<i>fluvastatin sodium</i>	1	GC
LIVALO	4	ST
<i>lovastatin</i>	1	GC
<i>pravastatin sodium</i>	1	GC
<i>rosuvastatin calcium</i>	1	GC, QL (30 tabs / 30 days)
<i>simvastatin TABS 5mg, 10mg, 20mg, 40mg</i>	1	GC
<i>simvastatin TABS 80mg</i>	1	GC, QL (30 tabs / 30 days)
ZYPITAMAG	4	ST
ANTILIPEMICS, MISCELLANEOUS		
ANTARA	4	
<i>cholestyramine</i>	4	
<i>cholestyramine light</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>choline fenofibrate</i>	4	
<i>colesevelam hcl</i>	3	
<i>colestipol hcl gran</i>	4	
<i>colestipol hcl pack</i>	4	
<i>colestipol hcl tabs</i>	3	
<i>ezetimibe</i>	4	
<i>ezetimibe-simvastatin</i>	1	GC
<i>fenofibrate TABS 48mg, 54mg, 145mg, 160mg</i>	3	
<i>fenofibrate micronized 67mg, 134mg, 200mg</i>	3	
<i>gemfibrozil TABS</i>	2	
JUXTAPID	5	NM, LA, PA
KYNAMRO	5	PA
<i>niacin er (antihyperlipidemic) 500mg</i>	4	QL (90 tabs / 30 days)
<i>niacin er (antihyperlipidemic) 750mg, 1000mg</i>	4	
<i>niacor</i>	3	
PRALUENT	5	PA; Lower cost version - Tier 4
<i>prevalite</i>	4	
VASCEPA	4	
BETA-BLOCKER/DIURETIC COMBINATIONS		
<i>atenolol & chlorthalidone</i>	2	
<i>bisoprolol & hydrochlorothiazide</i>	1	GC
<i>metoprolol & hctz tab 50-25mg</i>	3	
<i>metoprolol & hctz tab 100-25mg</i>	3	
<i>metoprolol & hctz tab 100-50mg</i>	3	
<i>propranolol & hydrochlorothiazide</i>	3	
BETA-BLOCKERS		
<i>acebutolol hcl CAPS</i>	2	
<i>atenolol TABS</i>	1	GC
<i>bisoprolol fumarate</i>	2	
BYSTOLIC 2.5mg, 5mg, 10mg	4	QL (30 tabs / 30 days)
BYSTOLIC 20mg	4	QL (60 tabs / 30 days)
<i>carvedilol</i>	1	GC
<i>labetalol hcl TABS</i>	3	
<i>metoprolol succinate</i>	2	
<i>metoprolol tartrate SOCT</i>	3	
<i>metoprolol tartrate SOLN</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>metoprolol tartrate</i> TABS 25mg, 50mg, 100mg	1	GC
<i>nadolol</i> TABS	4	
<i>pindolol</i>	3	
<i>propranolol cap er</i>	3	
<i>propranolol hcl</i> TABS	3	
<i>propranolol oral sol</i>	3	
<i>timolol maleate</i> TABS	3	

CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS

<i>amlodipine besylate-atorvastatin calcium</i>	1	GC
---	---	----

CALCIUM CHANNEL BLOCKERS

<i>amlodipine besylate</i> TABS	1	GC
<i>cartia xt cap 120/24hr</i>	3	
<i>cartia xt cap 180/24hr</i>	3	
<i>cartia xt cap 240/24hr</i>	3	
<i>cartia xt cap 300/24hr</i>	3	
<i>dilt-xr cap</i>	3	
<i>diltiazem cap 180mg cd</i>	3	
<i>diltiazem cap 240mg cd</i>	3	
<i>diltiazem cap 360mg cd</i>	3	
<i>diltiazem cap er/12hr</i>	4	
<i>diltiazem hcl</i> TABS	2	
<i>diltiazem hcl coated beads</i>	3	
<i>diltiazem hcl coated beads cap sr 24hr</i>	3	
<i>diltiazem hcl extended release beads cap sr</i>	3	
<i>diltiazem inj</i>	2	
<i>felodipine</i>	2	
<i>isradipine</i>	4	
<i>matzim la</i>	3	
<i>nicardipine hcl</i> CAPS	4	
<i>nifedipine</i> TB24	3	
<i>nifedipine er</i>	3	
<i>nimodipine</i> CAPS	5	
<i>nisoldipine</i>	4	
NYMALIZE	5	
<i>taztia xt</i>	3	
<i>verapamil cap er</i> 100mg, 120mg, 180mg, 200mg, 240mg, 300mg	3	
<i>verapamil cap er</i> 360mg	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>verapamil hcl</i> SOLN	4	
<i>verapamil hcl</i> TABS	1	GC
<i>verapamil hcl tab er</i>	2	
<i>DIGITALIS GLYCOSIDES</i>		
<i>digitek .25mg</i>	3	PA; PA if 70 years and older
<i>digitek .125mg</i>	3	QL (30 tabs / 30 days)
<i>digox 125mcg</i>	3	QL (30 tabs / 30 days)
<i>digox 250mcg</i>	3	PA; PA if 70 years and older
<i>digoxin</i> TABS 125mcg	3	QL (30 tabs / 30 days)
<i>digoxin</i> TABS 250mcg	3	PA; PA if 70 years and older
<i>digoxin inj</i>	4	
<i>digoxin sol 50mcg/ml</i>	4	PA; PA if 70 years and older
<i>DIRECT RENIN INHIBITORS/COMBINATIONS</i>		
<i>aliskiren fumarate</i>	4	
TEKTURNA	4	
TEKTURNA HCT	4	
<i>DIURETICS</i>		
<i>acetazolamide</i> CP12	4	
<i>acetazolamide</i> TABS	3	
<i>amiloride & hydrochlorothiazide</i>	2	
<i>amiloride hcl</i> TABS	3	
<i>bumetanide</i>	3	
<i>chlorothiazide tabs</i>	3	
<i>chlorthalidone</i>	3	
<i>furosemide</i> SOLN	2	
<i>furosemide</i> TABS	1	GC
<i>furosemide inj</i>	2	
<i>hydrochlorothiazide</i> CAPS; TABS	1	GC
<i>indapamide</i>	2	
<i>methazolamide</i> TABS	4	
<i>methyclothiazide</i>	3	
<i>metolazone</i>	3	
<i>spironolactone & hydrochlorothiazide</i>	3	
<i>toremide tabs</i>	2	
<i>triamterene & hydrochlorothiazide cap</i> <i>37.5-25 mg</i>	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>triamterene & hydrochlorothiazide tabs</i>	1	GC
MISCELLANEOUS		
BIDIL	3	
<i>clonidine hcl TABS</i>	1	GC
<i>clonidine hcl ptwk</i>	4	
CORLANOR TABS	4	
DEMSER	5	PA
<i>hydralazine hcl SOLN</i>	4	
<i>hydralazine hcl TABS</i>	2	
<i>midodrine hcl</i>	3	
<i>minoxidil TABS</i>	2	
NORTHERA	5	NM, LA, PA
<i>ranolazine</i>	3	
NITRATES		
ISORDIL TITRADOSE 40mg	5	
<i>isosorb mononitrate tab</i>	2	
<i>isosorbide dinitrate</i>	3	
<i>isosorbide dinitrate er</i>	4	
<i>isosorbide mononitrate er</i>	2	
<i>minitran</i>	3	
NITRO-BID	3	
NITRO-DUR DIS 0.3MG/HR	4	
NITRO-DUR DIS 0.8MG/HR	4	
<i>nitroglycerin SUBL</i>	3	
<i>nitroglycerin td patch</i>	3	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS	5	QL (90 tabs / 30 days), NM, LA, PA
<i>ambrisentan</i>	5	QL (30 tabs / 30 days), NM, LA, PA
<i>bosentan 62.5mg</i>	5	QL (120 tabs / 30 days), NM, LA, PA
<i>bosentan 125mg</i>	5	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT	5	QL (30 tabs / 30 days), NM, LA, PA
REMODULIN	5	NM, LA, PA
<i>sildenafil citrate tab 20 mg (pulmonary hypertension)</i>	3	QL (90 tabs / 30 days), NM, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
TRACLEER TABS 62.5mg	5	QL (120 tabs / 30 days), NM, LA, PA
TRACLEER TABS 125mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>treprostinil</i>	5	NM, LA, PA
VENTAVIS	5	NM, PA

CENTRAL NERVOUS SYSTEM

ANTIANSXIETY

<i>alprazolam tab 0.5mg</i>	2	QL (150 tabs / 30 days)
<i>alprazolam tab 0.25mg</i>	2	QL (150 tabs / 30 days)
<i>alprazolam tab 1mg</i>	2	QL (150 tabs / 30 days)
<i>alprazolam tab 2mg</i>	2	QL (150 tabs / 30 days)
<i>bupirone hcl</i> TABS 5mg, 7.5mg, 10mg, 15mg	2	
<i>bupirone hcl</i> TABS 30mg	4	
<i>fluvoxamine maleate</i> TABS	2	
<i>lorazepam</i> SOLN	2	
<i>lorazepam</i> TABS	2	QL (150 tabs / 30 days)
<i>lorazepam intensol</i>	3	QL (150 mL / 30 days)

ANTICONVULSANTS

APTIOM 200mg	5	QL (180 tabs / 30 days)
APTIOM 400mg	5	QL (90 tabs / 30 days)
APTIOM 600mg, 800mg	5	QL (60 tabs / 30 days)
BANZEL SUS 40MG/ML	5	PA
BANZEL TAB 200MG	5	PA
BANZEL TAB 400MG	5	PA
BRIVIACT INJ 50MG/5ML	4	PA
BRIVIACT SOL 10MG/ML	5	PA
BRIVIACT TAB 10MG	5	PA
BRIVIACT TAB 25MG	5	PA
BRIVIACT TAB 50MG	5	PA
BRIVIACT TAB 75MG	5	PA
BRIVIACT TAB 100MG	5	PA
<i>carbamazepine</i> CHEW; TABS	3	
<i>carbamazepine</i> CP12; SUSP; TB12	4	
CELONTIN	4	
<i>clobazam</i>	3	PA
<i>clonazepam</i> TABS 2mg	2	QL (300 tabs / 30 days)
<i>clonazepam</i> TABS .5mg, 1mg	2	QL (90 tabs / 30 days)
<i>clonazepam</i> TBDP 2mg	3	QL (300 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>clonazepam</i> TBDP .125mg, .25mg, .5mg, 1mg	3	QL (90 tabs / 30 days)
<i>clorazepate dipotassium</i>	4	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIASTAT ACUDIAL	4	
DIASTAT PEDIATRIC	4	
<i>diazepam</i> TABS	2	QL (120 tabs / 30 days), PA; PA if 65 years and older
<i>diazepam gel</i>	4	
<i>diazepam inj</i>	3	
<i>diazepam intensol</i>	3	QL (240 mL / 30 days), PA; PA if 65 years and older
<i>diazepam oral soln 1 mg/ml</i>	3	QL (1200 mL / 30 days), PA; PA if 65 years and older
DILANTIN CAP 30MG	3	
DILANTIN CAP 100MG	3	
DILANTIN CHEW TAB 50MG	3	
DILANTIN-125 SUSP	4	
<i>divalproex sodium</i> CSDR; TB24	4	
<i>divalproex sodium</i> TBEC	3	
EPIDIOLEX	5	QL (600 mL / 30 days), NM, LA, PA
<i>epitol</i>	3	
<i>ethosuximide</i> CAPS; SOLN	4	
<i>felbamate</i> SUSP	5	
<i>felbamate</i> TABS	4	
FYCOMPA SUSP	5	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	4	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg	5	QL (60 tabs / 30 days), PA
FYCOMPA TABS 8mg, 10mg, 12mg	5	QL (30 tabs / 30 days), PA
<i>gabapentin</i> CAPS 100mg	2	QL (1080 caps / 30 days)
<i>gabapentin</i> CAPS 300mg	2	QL (360 caps / 30 days)
<i>gabapentin</i> CAPS 400mg	2	QL (270 caps / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>gabapentin</i> SOLN	3	QL (2160 mL / 30 days)
<i>gabapentin</i> TABS 600mg	3	QL (180 tabs / 30 days)
<i>gabapentin</i> TABS 800mg	3	QL (120 tabs / 30 days)
<i>lamotrigine</i> CHEW	3	
<i>lamotrigine</i> TABS	2	
<i>lamotrigine</i> TB24; TBDP	4	
<i>levetiracetam</i> SOLN	4	
<i>levetiracetam</i> TABS; TB24	3	
<i>levetiracetam in sodium chloride</i>	4	
<i>levetiracetam oral soln 100 mg/ml</i>	3	
LYRICA CAPS 25mg, 50mg, 75mg, 100mg, 150mg	3	QL (120 caps / 30 days)
LYRICA CAPS 200mg	3	QL (90 caps / 30 days)
LYRICA CAPS 225mg, 300mg	3	QL (60 caps / 30 days)
LYRICA SOLN	3	QL (946 mL / 30 days)
<i>oxcarbazepine</i> SUSP	4	
<i>oxcarbazepine</i> TABS	3	
PEGANONE	4	
<i>phenobarbital</i> ELIX	4	PA; PA if 70 years and older
<i>phenobarbital</i> TABS	3	PA; PA if 70 years and older
PHENOBARBITAL SODIUM SOLN 65mg/ml	4	PA; PA if 70 years and older
<i>phenobarbital sodium</i> SOLN 130mg/ml	4	PA; PA if 70 years and older
PHENYTEK	3	
<i>phenytoin</i> CHEW; SUSP	3	
<i>phenytoin sodium extended</i>	3	
<i>phenytoin sodium inj 50mg/ml</i>	3	
<i>pregabalin</i> CAPS 25mg, 50mg, 75mg, 100mg, 150mg	3	QL (120 caps / 30 days)
<i>pregabalin</i> CAPS 200mg	3	QL (90 caps / 30 days)
<i>pregabalin</i> CAPS 225mg, 300mg	3	QL (60 caps / 30 days)
<i>pregabalin</i> SOLN	3	QL (946 mL / 30 days)
<i>primidone</i> TABS	2	
<i>roweepra</i>	3	
<i>roweepra xr</i>	3	
SPRITAM	4	
<i>subvenite tab</i>	2	
SYMPAZAN 5mg	4	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
SYMPAZAN 10mg, 20mg	5	PA
<i>tiagabine hcl</i>	4	
<i>topiramate</i> CPSP	3	
<i>topiramate</i> TABS	2	
<i>valproate sodium</i> SOLN 100mg/ml	4	
<i>valproate sodium</i> SOLN 250mg/5ml	3	
<i>valproic acid</i> CAPS	3	
<i>vigabatrin powd pack 500mg</i>	5	QL (180 packets / 30 days), NM, LA, PA
<i>vigabatrin tab 500mg</i>	5	QL (180 tabs / 30 days), NM, LA, PA
<i>vigadrone</i>	5	QL (180 packets / 30 days), NM, LA, PA
VIMPAT 50mg	4	QL (120 tabs / 30 days)
VIMPAT 100mg, 150mg, 200mg	5	QL (60 tabs / 30 days)
VIMPAT INJ 200MG/20ML	5	
VIMPAT SOL 10MG/ML	5	QL (1200 mL / 30 days)
<i>zonisamide</i> CAPS	3	

ANTIDEMENTIA

<i>donepezil hydrochloride</i> TABS 5mg	2	QL (30 tabs / 30 days)
<i>donepezil hydrochloride</i> TABS 10mg	2	
<i>donepezil hydrochloride</i> TBDP 5mg	2	QL (30 tabs / 30 days)
<i>donepezil hydrochloride</i> TBDP 10mg	2	
<i>galantamine hydrobromide</i> SOLN	4	
<i>galantamine hydrobromide</i> TABS	4	QL (60 tabs / 30 days)
<i>galantamine hydrobromide er</i>	4	QL (30 caps / 30 days)
<i>memantine hcl cp24</i>	4	PA; PA if < 30 yrs
<i>memantine soln</i>	4	PA; PA if < 30 yrs
<i>memantine tabs</i>	3	PA; PA if < 30 yrs
NAMZARIC	4	
<i>rivastigmine tartrate</i> 1.5mg, 3mg	4	QL (90 caps / 30 days)
<i>rivastigmine tartrate</i> 4.5mg, 6mg	4	QL (60 caps / 30 days)
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	4	QL (30 patches / 30 days)
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	4	QL (30 patches / 30 days)
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	4	QL (30 patches / 30 days)

ANTIDEPRESSANTS

<i>amitriptyline hcl</i> TABS	3	
-------------------------------	---	--

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>amoxapine tab 25mg</i>	3	
<i>amoxapine tab 50mg</i>	3	
<i>amoxapine tab 100mg</i>	3	
<i>amoxapine tab 150mg</i>	3	
<i>bupropion hcl TABS</i>	3	
<i>bupropion hcl TB12</i>	2	
<i>bupropion hcl TB24 150mg, 300mg</i>	3	
<i>citalopram hydrobromide SOLN</i>	3	
<i>citalopram hydrobromide TABS</i>	1	GC
<i>clomipramine hcl CAPS</i>	4	PA
<i>desipramine hcl TABS</i>	4	
<i>desvenlafaxine succinate</i>	4	QL (30 tabs / 30 days), PA
<i>doxepin hcl CAPS; CONC</i>	3	
<i>duloxetine hcl CPEP 20mg</i>	3	QL (180 caps / 30 days)
<i>duloxetine hcl CPEP 30mg</i>	3	QL (120 caps / 30 days)
<i>duloxetine hcl CPEP 60mg</i>	3	QL (60 caps / 30 days)
EMSAM	5	QL (30 patches / 30 days), PA
<i>escitalopram oxalate SOLN</i>	4	
<i>escitalopram oxalate TABS</i>	1	GC
FETZIMA 20mg	4	QL (180 caps / 30 days), PA
FETZIMA 40mg	4	QL (90 caps / 30 days), PA
FETZIMA 80mg, 120mg	4	QL (30 caps / 30 days), PA
FETZIMA TITRATION PACK	4	PA
<i>fluoxetine cap 10mg</i>	1	GC
<i>fluoxetine cap 20mg</i>	1	GC
<i>fluoxetine cap 40mg</i>	1	GC
<i>fluoxetine hcl SOLN</i>	2	
<i>imipramine hcl TABS</i>	3	
<i>maprotiline hcl</i>	4	
MARPLAN TAB 10MG	4	QL (180 tabs / 30 days)
<i>mirtazapine TABS</i>	2	
<i>mirtazapine TBDP</i>	3	
<i>nefazodone hcl</i>	4	
<i>nortriptyline hcl CAPS</i>	2	
<i>nortriptyline hcl SOLN</i>	4	
<i>paroxetine er tab</i>	4	QL (60 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>paroxetine hcl tabs</i>	2	
PAXIL SUSP	4	QL (900 mL / 30 days)
<i>phenelzine sulfate TABS</i>	3	
<i>protriptyline hcl</i>	4	
<i>sertraline hcl CONC</i>	4	
<i>sertraline hcl TABS</i>	1	GC
<i>tranylcypromine sulfate</i>	4	
<i>trazodone hcl TABS 50mg, 100mg, 150mg</i>	1	GC
<i>trimipramine maleate CAPS 25mg</i>	4	QL (240 caps / 30 days)
<i>trimipramine maleate CAPS 50mg</i>	4	QL (120 caps / 30 days)
<i>trimipramine maleate CAPS 100mg</i>	4	QL (60 caps / 30 days)
TRINTELLIX 5mg	4	QL (120 tabs / 30 days)
TRINTELLIX 10mg	4	QL (60 tabs / 30 days)
TRINTELLIX 20mg	4	QL (30 tabs / 30 days)
<i>venlafaxine hcl CP24</i>	2	
<i>venlafaxine hcl TABS</i>	3	
VIIBRYD STARTER PACK	4	
VIIBRYD TAB	4	QL (30 tabs / 30 days)

ANTIPARKINSONIAN AGENTS

<i>amantadine hcl CAPS</i>	3	QL (120 caps / 30 days)
<i>amantadine hcl SYRP</i>	2	
<i>amantadine hcl TABS</i>	3	
APOKYN	5	QL (20 cartridges / 30 days), NM, LA, PA
<i>benztropine mesylate inj</i>	4	
<i>benztropine mesylate tab 0.5mg</i>	3	PA; PA if 70 years and older
<i>benztropine mesylate tab 1mg</i>	3	PA; PA if 70 years and older
<i>benztropine mesylate tab 2mg</i>	3	PA; PA if 70 years and older
<i>bromocriptine mesylate CAPS; TABS</i>	4	
<i>carbidopa TABS</i>	5	
<i>carbidopa-levodopa TABS</i>	2	
<i>carbidopa-levodopa TBCR</i>	3	
<i>carbidopa-levodopa TBDP</i>	4	
<i>carbidopa/levodopa/entacapone</i>	4	
<i>entacapone</i>	4	
NEUPRO	4	
<i>pramipexole dihydrochloride</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>pramipexole tab 0.5mg</i>	2	
<i>pramipexole tab 0.25mg</i>	2	
<i>pramipexole tab 0.75mg</i>	2	
<i>pramipexole tab 0.125mg</i>	2	
<i>pramipexole tab 1.5mg</i>	2	
<i>pramipexole tab 1mg</i>	2	
<i>rasagiline mesylate TABS</i>	4	
<i>ropinirole hydrochloride</i>	4	
<i>ropinirole tab 0.5mg</i>	2	
<i>ropinirole tab 0.25mg</i>	2	
<i>ropinirole tab 1mg</i>	2	
<i>ropinirole tab 2mg</i>	2	
<i>ropinirole tab 3mg</i>	2	
<i>ropinirole tab 4mg</i>	2	
<i>ropinirole tab 5mg</i>	2	
<i>selegiline hcl CAPS; TABS</i>	3	
<i>trihexyphenidyl hcl</i>	3	PA; PA if 70 years and older

ANTIPSYCHOTICS

ABILIFY MAINTENA	5	QL (1 injection / 28 days)
<i>aripiprazole odt</i>	5	QL (60 tabs / 30 days)
<i>aripiprazole oral solution 1 mg/ml</i>	5	QL (900 mL / 30 days)
<i>aripiprazole tab</i>	4	QL (30 tabs / 30 days)
ARISTADA 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	5	QL (1 injection / 28 days)
ARISTADA 1064mg/3.9ml	5	QL (1 injection / 56 days)
ARISTADA INITIO	5	
<i>chlorpromazine hcl TABS</i>	4	
CHLORPROMAZINE INJ	4	
<i>clozapine odt 12.5mg, 25mg</i>	4	PA
<i>clozapine odt 100mg</i>	4	QL (270 tabs / 30 days), PA
<i>clozapine odt 150mg</i>	4	QL (180 tabs / 30 days), PA
<i>clozapine odt 200mg</i>	5	QL (135 tabs / 30 days), PA
<i>clozapine tab 25mg</i>	3	
<i>clozapine tab 50mg</i>	3	
<i>clozapine tab 100mg</i>	4	QL (270 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>clozapine tab 200mg</i>	4	QL (135 tabs / 30 days)
FANAPT	4	QL (60 tabs / 30 days)
FANAPT TITRATION PACK	4	
<i>fluphenazine decanoate SOLN</i>	4	
<i>fluphenazine hcl</i>	4	
GEODON SOLR	4	QL (6 mL / 3 days)
<i>haloperidol TABS</i>	3	
<i>haloperidol conc 2mg/ml</i>	2	
<i>haloperidol decanoate SOLN</i>	4	
<i>haloperidol lactate inj 5mg/ml</i>	3	
INVEGA SUST INJ 39 MG/0.25 ML	4	QL (1 injection / 28 days)
INVEGA SUST INJ 78 MG/0.5 ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 117 MG/0.75 ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 156MG/ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 234 MG/1.5 ML	5	QL (1 injection / 28 days)
INVEGA TRINZA	5	QL (1 injection / 90 days)
LATUDA 20mg, 60mg, 80mg	4	QL (60 tabs / 30 days)
LATUDA 40mg, 120mg	4	QL (30 tabs / 30 days)
<i>loxapine succinate</i>	3	
<i>molindone hcl</i>	4	
NUPLAZID CAPS	5	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10MG	5	QL (30 tabs / 30 days), NM, LA, PA
NUPLAZID TABS 17MG	5	QL (60 tabs / 30 days), NM, LA, PA
<i>olanzapine SOLR</i>	4	QL (3 vials / 1 day)
<i>olanzapine TABS 2.5mg</i>	3	QL (240 tabs / 30 days)
<i>olanzapine TABS 5mg</i>	3	QL (120 tabs / 30 days)
<i>olanzapine TABS 7.5mg, 15mg, 20mg</i>	3	QL (30 tabs / 30 days)
<i>olanzapine TABS 10mg</i>	3	QL (60 tabs / 30 days)
<i>olanzapine TBDP 5mg, 15mg, 20mg</i>	4	QL (30 tabs / 30 days)
<i>olanzapine TBDP 10mg</i>	4	QL (60 tabs / 30 days)
<i>paliperidone 1.5mg, 3mg, 9mg</i>	5	QL (30 tabs / 30 days)
<i>paliperidone 6mg</i>	5	QL (60 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>perphenazine</i> TABS	4	
PERSERIS	5	QL (1 injection / 30 days)
<i>pimozide</i>	4	
<i>quetiapine fumarate</i> TABS	2	
<i>quetiapine fumarate</i> TB24 50mg, 300mg, 400mg	4	QL (60 tabs / 30 days)
<i>quetiapine fumarate</i> TB24 150mg, 200mg	4	QL (30 tabs / 30 days)
REXULTI 1mg	5	QL (90 tabs / 30 days)
REXULTI 2mg	5	QL (60 tabs / 30 days)
REXULTI 3mg, 4mg	5	QL (30 tabs / 30 days)
REXULTI .5mg	5	QL (180 tabs / 30 days)
REXULTI .25mg	5	QL (360 tabs / 30 days)
RISPERDAL INJ 12.5MG	4	QL (2 injections / 28 days)
RISPERDAL INJ 25MG	4	QL (2 injections / 28 days)
RISPERDAL INJ 37.5MG	5	QL (2 injections / 28 days)
RISPERDAL INJ 50MG	5	QL (2 injections / 28 days)
<i>risperidone</i> SOLN	3	QL (240 mL / 30 days)
<i>risperidone</i> TABS	2	
<i>risperidone</i> TBDP .5mg	4	QL (90 tabs / 30 days)
<i>risperidone</i> TBDP .25mg, 1mg, 2mg, 3mg, 4mg	4	QL (60 tabs / 30 days)
SAPHRIS 2.5mg	4	QL (240 tabs / 30 days)
SAPHRIS 5mg	4	QL (120 tabs / 30 days)
SAPHRIS 10mg	4	QL (60 tabs / 30 days)
<i>thioridazine hcl</i> TABS	3	
<i>thiothixene</i>	4	
<i>trifluoperazine hcl</i>	3	
VERSACLOZ	5	QL (600 mL / 30 days), PA
VRAYLAR 1.5mg	5	QL (60 caps / 30 days), PA
VRAYLAR 3mg, 4.5mg, 6mg	5	QL (30 caps / 30 days), PA
VRAYLAR THERAPY PACK	4	PA
<i>ziprasidone hcl</i>	4	QL (60 caps / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ZYPREXA RELPREVV 300mg	5	QL (2 vials / 28 days), PA
ZYPREXA RELPREVV 405mg	5	QL (1 vial / 28 days), PA
ZYPREXA RELPREVV INJ 210MG	4	QL (2 vials / 28 days), PA

ATTENTION DEFICIT HYPERACTIVITY DISORDER

<i>amphetamine-dextroamphetamine cap sr 24hr 5 mg</i>	4	QL (90 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 10 mg</i>	4	QL (90 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 15 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 20 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 25 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 30 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine tab 5 mg</i>	3	QL (360 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	3	QL (240 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 10 mg</i>	3	QL (180 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	3	QL (90 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 15 mg</i>	3	QL (120 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 20 mg</i>	3	QL (90 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 30 mg</i>	3	QL (60 tabs / 30 days)
<i>atomoxetine hcl 10mg, 18mg, 25mg</i>	4	QL (120 caps / 30 days)
<i>atomoxetine hcl 40mg</i>	4	QL (60 caps / 30 days)
<i>atomoxetine hcl 60mg, 80mg, 100mg</i>	4	QL (30 caps / 30 days)
<i>dexmethylphenidate hcl TABS 2.5mg, 5mg</i>	3	QL (120 tabs / 30 days)
<i>dexmethylphenidate hcl TABS 10mg</i>	3	QL (60 tabs / 30 days)
<i>guanfacine er (adhd)</i>	3	PA; PA if 70 years and older
<i>metadate er tab 20mg</i>	4	QL (90 tabs / 30 days)
<i>methylphenidate hcl CHEW</i>	4	QL (180 tabs / 30 days)
<i>methylphenidate hcl CP24 10mg</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl</i> TABS 5mg, 10mg	3	QL (180 tabs / 30 days)
<i>methylphenidate hcl</i> TABS 20mg	3	QL (90 tabs / 30 days)
<i>methylphenidate hcl oral soln</i> 5mg/5ml	4	QL (1800 mL / 30 days)
<i>methylphenidate hcl oral soln</i> 10mg/5ml	4	QL (900 mL / 30 days)
<i>methylphenidate tab 10mg er</i>	4	QL (90 tabs / 30 days)
<i>methylphenidate tab 20mg er</i>	4	QL (90 tabs / 30 days)
VYVANSE CAPS 10mg, 20mg, 30mg	4	QL (60 caps / 30 days)
VYVANSE CAPS 40mg, 50mg, 60mg, 70mg	4	QL (30 caps / 30 days)
VYVANSE CHEW 10mg, 20mg, 30mg	4	QL (60 tabs / 30 days)
VYVANSE CHEW 40mg, 50mg, 60mg	4	QL (30 tabs / 30 days)

HYPNOTICS

HETLIOZ	5	NM, LA, PA
SILENOR 3mg	3	QL (60 tabs / 30 days)
SILENOR 6mg	3	QL (30 tabs / 30 days)
<i>temazepam</i> 7.5mg	2	QL (30 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
<i>temazepam</i> 15mg	2	QL (60 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
<i>zolpidem tartrate</i> TABS	2	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year

MIGRAINE

AIMOVIG	3	QL (1 pen / 30 days), PA
<i>dihydroergotamine mesylate inj 1 mg/ml</i>	5	
<i>dihydroergotamine mesylate nasal</i>	5	QL (8 mL / 30 days)
<i>eletriptan hydrobromide</i>	4	QL (12 tabs / 30 days)
EMGALITY SOAJ	3	QL (2 pens / 30 days), PA
EMGALITY SOSY 120mg/ml	3	QL (2 syringes / 30 days), PA
<i>ergotamine w/ caffeine</i> TABS	4	
<i>frovatriptan succinate</i>	4	QL (18 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>naratriptan hcl</i>	3	QL (12 tabs / 30 days)
<i>rizatriptan benzoate</i>	3	QL (18 tabs / 30 days)
<i>rizatriptan benzoate odt</i>	3	QL (18 tabs / 30 days)
<i>sumatriptan SOLN 5mg/act</i>	4	QL (24 inhalers / 30 days)
<i>sumatriptan SOLN 20mg/act</i>	4	QL (12 inhalers / 30 days)
<i>sumatriptan inj 4mg/0.5ml</i>	4	QL (18 injections / 30 days)
<i>sumatriptan inj 6mg/0.5ml</i>	4	QL (12 injections / 30 days)
<i>sumatriptan succinate TABS</i>	2	QL (12 tabs / 30 days)
<i>zolmitriptan TABS</i>	4	QL (12 tabs / 30 days)
<i>zolmitriptan odt</i>	4	QL (12 tabs / 30 days)
MISCELLANEOUS		
AUSTEDO 6mg	5	QL (60 tabs / 30 days), NM, LA, PA
AUSTEDO 9mg, 12mg	5	QL (120 tabs / 30 days), NM, LA, PA
GRALISE 300mg	4	QL (180 tabs / 30 days), PA
GRALISE 600mg	4	QL (90 tabs / 30 days), PA
GRALISE STARTER	4	PA
<i>lithium carbonate CAPS</i>	1	GC
<i>lithium carbonate TABS</i>	2	
<i>lithium carbonate er</i>	2	
LITHIUM SOLN 8MEQ/5ML	4	
LYRICA CR 82.5mg, 165mg	3	QL (90 tabs / 30 days), PA
LYRICA CR 330mg	3	QL (60 tabs / 30 days), PA
NUEDEXTA	4	QL (60 caps / 30 days), PA
<i>pyridostigmine tab 60mg</i>	3	
<i>riluzole</i>	3	
SAVELLA 12.5mg	4	QL (480 tabs / 30 days)
SAVELLA 25mg	4	QL (240 tabs / 30 days)
SAVELLA 50mg	4	QL (120 tabs / 30 days)
SAVELLA 100mg	4	QL (60 tabs / 30 days)
SAVELLA TITRATION PACK	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>tetrabenazine</i> 12.5mg	5	QL (240 tabs / 30 days), NM, PA
<i>tetrabenazine</i> 25mg	5	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
BETASERON	5	QL (14 syringes / 28 days), NM, PA
<i>dalfampridine</i>	5	NM, PA
GILENYA CAP 0.5MG	5	QL (28 caps / 28 days), NM, PA
<i>glatiramer acetate</i> 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatiramer acetate</i> 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
<i>glatopa</i> 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatopa</i> 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
MUSCULOSKELETAL THERAPY AGENTS		
<i>baclofen</i> TABS 10mg, 20mg	2	
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg	3	PA; PA if 70 years and older
<i>dantrolene sodium</i> CAPS	4	
<i>tizanidine hcl</i> TABS	2	
NARCOLEPSY/CATAPLEXY		
<i>armodafinil</i> 50mg	4	QL (90 tabs / 30 days), PA
<i>armodafinil</i> 150mg, 200mg, 250mg	4	QL (30 tabs / 30 days), PA
<i>modafinil</i> 100mg	4	QL (30 tabs / 30 days), PA
<i>modafinil</i> 200mg	4	QL (60 tabs / 30 days), PA
XYREM	5	QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
<i>acamprosate calcium</i>	4	
<i>buprenorphine hcl</i> SUBL	3	QL (90 tabs / 30 days), PA
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 2-0.5mg	4	QL (90 films / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine hcl-naloxone hcl dihydrate 4-1mg</i>	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl dihydrate 8-2mg</i>	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl dihydrate 12-3mg</i>	4	QL (60 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl</i>	2	QL (90 tabs / 30 days)
<i>bupropion hcl (smoking deterrent)</i>	3	
CHANTIX	4	PA
CHANTIX CONTINUING MONTH	4	PA
CHANTIX STARTER PACK	4	PA
<i>disulfiram TABS</i>	3	
<i>naloxone inj 0.4mg/ml</i>	3	
<i>naloxone inj 1mg/ml</i>	3	
<i>naltrexone hcl TABS</i>	3	
NARCAN	3	
NICOTROL INHALER	4	
NICOTROL NS	4	
VIVITROL	5	

ENDOCRINE AND METABOLIC

ANDROGENS

ANADROL-50	5	PA
ANDRODERM	4	QL (30 patches / 30 days), PA
<i>oxandrolone TABS 2.5mg</i>	3	PA
<i>oxandrolone TABS 10mg</i>	4	PA
<i>testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm</i>	4	QL (300 grams / 30 days), PA
<i>testosterone cypionate SOLN 100mg/ml, 200mg/ml</i>	3	PA
<i>testosterone enanthate SOLN</i>	3	PA

ANTIDIABETICS, INJECTABLE

ALCOHOL SWABS	3	
BASAGLAR KWIKPEN	3	
BD ULTRAFINE INSULIN SYRINGE	3	
BD ULTRAFINE/NANO PEN NEEDLES	3	
BYDUREON BCISE	3	QL (4 pens / 28 days)
BYDUREON INJ	3	QL (4 vials / 28 days)
BYDUREON PEN	3	QL (4 pens / 28 days)
BYETTA	4	QL (1 pen / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
FIASP	3	
FIASP FLEXTOUCH	3	
GAUZE PADS 2" X 2"	3	
HUMULIN R INJ U-500	5	B/D
HUMULIN R U-500 KWIKPEN	5	
INSULIN PEN NEEDLE	3	
INSULIN SAFETY NEEDLES	3	
INSULIN SYRINGE	3	
LEVEMIR	3	
LEVEMIR FLEXTOUCH	3	
NOVOLIN 70/30	3	(brand RELION not covered)
NOVOLIN 70/30 FLEXPEN	3	(brand RELION not covered)
NOVOLIN N	3	(brand RELION not covered)
NOVOLIN R	3	(brand RELION not covered)
NOVOLOG	3	
NOVOLOG 70/30 FLEXPEN	3	
NOVOLOG FLEXPEN	3	
NOVOLOG MIX 70/30	3	
NOVOLOG PENFILL	3	
OZEMPIC INJ 0.25 OR 0.5MG/DOSE	3	QL (1 pen / 28 days)
OZEMPIC INJ 1MG/DOSE	3	QL (2 pens / 28 days)
SOLIQUA 100/33	3	QL (10 pens / 30 days)
TRESIBA FLEXTOUCH	3	
TRESIBA INJ	3	
TRULICITY	3	QL (4 pens / 28 days)
VICTOZA	3	QL (3 pens / 30 days)
XULTOPHY 100/3.6	3	QL (5 pens / 30 days)
ANTIDIABETICS, ORAL		
<i>acarbose</i> TABS	3	
FARXIGA 5mg	3	QL (60 tabs / 30 days)
FARXIGA 10mg	3	QL (30 tabs / 30 days)
<i>glimepiride</i> 1mg	1	GC, QL (240 tabs / 30 days)
<i>glimepiride</i> 2mg	1	GC, QL (120 tabs / 30 days)
<i>glimepiride</i> 4mg	1	GC, QL (60 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>glip/metform tab 2.5-250mg</i>	1	GC, QL (240 tabs / 30 days)
<i>glip/metform tab 2.5-500mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glip/metform tab 5-500mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glipizide TABS 5mg</i>	1	GC, QL (240 tabs / 30 days)
<i>glipizide TABS 10mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glipizide TB24 2.5mg</i>	1	GC, QL (240 tabs / 30 days)
<i>glipizide TB24 5mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glipizide TB24 10mg</i>	1	GC, QL (60 tabs / 30 days)
<i>glipizide xl 2.5mg</i>	1	GC, QL (240 tabs / 30 days)
<i>glipizide xl 5mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glipizide xl 10mg</i>	1	GC, QL (60 tabs / 30 days)
JANUMET	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	3	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	3	QL (30 tabs / 30 days)
JANUVIA	3	QL (30 tabs / 30 days)
JARDIANCE 10mg	3	QL (60 tabs / 30 days)
JARDIANCE 25mg	3	QL (30 tabs / 30 days)
JENTADUETO	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000 MG	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000 MG	3	QL (30 tabs / 30 days)
<i>metformin er 500mg</i>	1	GC, QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin er 750mg</i>	1	GC, QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin hcl TABS 500mg</i>	1	GC, QL (150 tabs / 30 days)
<i>metformin hcl TABS 850mg</i>	1	GC, QL (90 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>metformin hcl</i> TABS 1000mg	1	GC, QL (75 tabs / 30 days)
<i>nateglinide</i>	1	GC, QL (90 tabs / 30 days)
<i>pioglitazone hcl</i>	1	GC, QL (30 tabs / 30 days)
<i>repaglinide</i> 2mg	1	GC, QL (240 tabs / 30 days)
<i>repaglinide</i> .5mg, 1mg	1	GC, QL (120 tabs / 30 days)
SYNJARDY TAB 5-500MG	3	QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000MG	3	QL (30 tabs / 30 days)
TRADJENTA	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 2.5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000MG	3	QL (30 tabs / 30 days)

BISPHOSPHONATES

<i>alendronate sodium</i> SOLN	4	
<i>alendronate sodium</i> TABS	1	GC
FOSAMAX PLUS D	4	ST
<i>ibandronate sodium</i> SOLN	4	B/D, QL (1 injection / 90 days)
<i>ibandronate sodium</i> TABS	3	B/D
PAMIDRONATE DISODIUM 6mg/ml	3	B/D
<i>pamidronate disodium</i> 30mg/10ml, 90mg/10ml	3	B/D
<i>pamidronate inj</i> 30mg	3	B/D
<i>pamidronate inj</i> 90mg	3	B/D
<i>risedronate sodium</i>	4	
<i>zoledronic acid inj</i> 5mg/100ml	4	B/D, NM
<i>zoledronic inj</i> 4mg/5ml	4	B/D, NM

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
CALCIUM RECEPTOR AGONISTS		
<i>cinacalcet hcl</i> 30mg, 90mg	5	B/D, QL (120 tabs / 30 days), NM
<i>cinacalcet hcl</i> 60mg	5	B/D, QL (60 tabs / 30 days), NM
SENSIPAR 30mg, 90mg	5	B/D, QL (120 tabs / 30 days), NM
SENSIPAR 60mg	5	B/D, QL (60 tabs / 30 days), NM
CHELATING AGENTS		
CHEMET	4	
DEPEN TITRATABS	5	
JADENU	5	NM, LA, PA
JADENU SPRINKLE	5	NM, LA, PA
<i>kionex sus 15gm/60ml</i>	3	
LOKELMA	3	
<i>sodium polystyrene sulfonate powder</i>	3	
<i>sodium polystyrene sulfonate susp</i>	3	
<i>sps susp 15gm/60ml</i>	3	
<i>trientine hcl</i>	5	PA
CONTRACEPTIVES		
<i>altavera tab</i>	2	
<i>alyacen 1/35</i>	2	
<i>apri</i>	2	
<i>aranelle</i>	3	
<i>aubra</i>	2	
<i>aviane</i>	2	
<i>balziva</i>	3	
<i>bekyree</i>	3	
<i>blisovi fe 1.5/30</i>	2	
<i>briellyn</i>	3	
<i>camila</i>	2	
<i>caziant pak</i>	3	
<i>cryselle-28</i>	2	
<i>cyclafem 1/35</i>	2	
<i>cyclafem 7/7/7</i>	2	
<i>cyred tab</i>	2	
<i>dasetta 1/35</i>	2	
<i>dasetta 7/7/7</i>	2	
<i>deblitane</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>delyla</i>	2	
<i>desogestrel & ethinyl estradiol</i>	2	
<i>desogestrel-ethinyl estradiol (biphasic)</i>	3	
<i>drospirenone-ethinyl estradiol</i>	3	
ELLA	4	
<i>emoquette</i>	2	
<i>enpresse-28</i>	2	
<i>enskyce</i>	2	
<i>errin</i>	2	
<i>estarylla tab 0.25-35</i>	2	
<i>ethynodiol diacet & eth estrad</i>	3	
<i>ethynodiol tab 1-50</i>	3	
<i>falmina</i>	2	
<i>femynor</i>	2	
<i>gianvi</i>	3	
<i>heather</i>	2	
<i>incassia</i>	2	
<i>introvale</i>	3	
<i>isibloom</i>	2	
<i>jasmiel</i>	3	
<i>jolessa tab 0.15-0.03 mg</i>	3	
<i>jolivette</i>	2	
<i>juleber</i>	2	
<i>junel 1.5/30</i>	2	
<i>junel 1/20</i>	2	
<i>junel fe 1.5/30</i>	2	
<i>junel fe 1/20</i>	2	
<i>kariva</i>	3	
<i>kelnor 1/35</i>	3	
<i>kelnor 1/50</i>	3	
<i>kurvelo</i>	2	
<i>larin 1.5/30</i>	2	
<i>larin 1/20</i>	2	
<i>larin fe 1.5/30</i>	2	
<i>larin fe 1/20</i>	2	
<i>larissia tab</i>	2	
<i>leena</i>	3	
<i>lessina</i>	2	
<i>levonest</i>	2	
<i>levonor/ethi tab</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>levonorgestrel & eth estradiol</i>	2	
<i>levonorgestrel-ethinyl estradiol (91-day)</i>	3	
<i>levora 0.15/30-28</i>	2	
<i>loryna</i>	3	
<i>low-ogestrel</i>	2	
<i>lutera</i>	2	
<i>lyza</i>	2	
<i>marlissa</i>	2	
<i>medroxyprogesterone acetate (contraceptive)</i>	2	
<i>microgestin 1.5/30</i>	2	
<i>microgestin 1/20</i>	2	
<i>microgestin fe 1.5/30</i>	2	
<i>microgestin fe 1/20</i>	2	
<i>mili</i>	2	
<i>mono-linyah tab 0.25-35</i>	2	
<i>myzilra</i>	2	
<i>necon 0.5/35-28</i>	3	
<i>necon 7/7/7</i>	2	
<i>nikki</i>	3	
<i>nora-be tab</i>	2	
<i>norethindrone (contraceptive)</i>	2	
<i>norethindrone acet & eth estra</i>	2	
<i>norgest/ethi tab 0.25/35</i>	2	
<i>norgestimate-ethinyl estradiol (triphasic) 0.18-25/0.215-25/0.25-25 mg-mcg</i>	3	
<i>norgestimate-ethinyl estradiol (triphasic) 0.18-35/0.215-35/0.25-35 mg-mcg</i>	2	
<i>norlyroc</i>	2	
<i>nortrel 0.5/35 (28)</i>	3	
<i>nortrel 1/35</i>	2	
<i>nortrel 7/7/7</i>	2	
NUVARING	4	
<i>ocella tab 3-0.03mg</i>	3	
<i>orsythia</i>	2	
<i>philith</i>	3	
<i>pimtrea</i>	3	
<i>pirmella 1/35</i>	2	
<i>portia-28</i>	2	
<i>previfem</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>quasense</i>	3	
<i>reclipsen</i>	2	
<i>setlakin tab</i>	3	
<i>sharobel</i>	2	
<i>sprintec 28</i>	2	
<i>sronyx</i>	2	
<i>syeda</i>	3	
<i>tarina fe 1/20</i>	2	
<i>tilia fe</i>	3	
<i>tri-estarylla</i>	2	
<i>tri-legest fe</i>	3	
<i>tri-linyah</i>	2	
<i>tri-lo marzia</i>	3	
<i>tri-lo-estarylla</i>	3	
<i>tri-lo-sprintec</i>	3	
<i>tri-mili</i>	2	
<i>tri-previfem</i>	2	
<i>tri-sprintec</i>	2	
<i>tri-vylibra</i>	2	
<i>tri-vylibra lo</i>	3	
<i>trinessa</i>	2	
<i>trinessa lo</i>	3	
<i>trivora-28</i>	2	
<i>tulana</i>	2	
<i>velivet</i>	3	
<i>vienva</i>	2	
<i>viorele</i>	3	
<i>vyfemla</i>	3	
<i>vylibra</i>	2	
<i>xulane</i>	4	
<i>zarah</i>	3	
<i>zovia 1/35e</i>	3	
ENDOMETRIOSIS		
<i>danazol CAPS</i>	4	
SYNAREL	5	
ENZYME REPLACEMENTS		
ALDURAZYME	5	NM, LA, PA
CARBAGLU	5	NM, LA, PA
CERDELGA	5	NM, PA
CEREZYME	5	NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
CYSTADANE	5	NM, LA
CYSTAGON	4	NM, LA, PA
FABRAZYME	5	NM, LA, PA
KUVAN	5	NM, LA, PA
<i>levocarnitine (metabolic modifiers)</i>	4	B/D
LUMIZYME	5	NM, LA, PA
<i>miglustat</i>	5	NM, PA
NAGLAZYME	5	NM, LA, PA
NITYR	5	NM, LA, PA
ORFADIN	5	NM, LA, PA
<i>sodium phenylbutyrate</i>	5	NM, PA

ESTROGENS

DELESTROGEN 10mg/ml	4	
<i>estradiol PTWK</i>	3	
<i>estradiol TABS</i>	2	
<i>estradiol vaginal cream</i>	4	
<i>estradiol vaginal tab</i>	3	
<i>estradiol valerate OIL</i>	3	
<i>fyavolv</i>	3	
<i>jinteli</i>	3	
<i>norethindrone acetate-ethinyl estradiol</i>	3	
<i>yuvaferm vaginal tablet 10mcg</i>	3	

GLUCOCORTICOIDS

<i>cortisone acetate TABS</i>	4	
DEXAMETHASONE CONC	4	
<i>dexamethasone ELIX; SOLN</i>	3	
<i>dexamethasone TABS</i>	2	
<i>dexamethasone sodium phosphate</i>	2	
<i>fludrocortisone acetate TABS</i>	2	
<i>hydrocortisone TABS</i>	3	
<i>methylpr ss inj</i>	3	B/D
<i>methylpred pak 4mg</i>	2	
<i>methylpred tab 4mg</i>	3	B/D
<i>methylpred tab 8mg</i>	3	B/D
<i>methylpred tab 16mg</i>	3	B/D
<i>methylpred tab 32mg</i>	3	B/D
<i>methylprednisolone acetate</i>	2	B/D
<i>pred sod pho sol 5mg/5ml</i>	4	B/D
<i>prednisolone sodium phosphate SOLN</i> 15mg/5ml	2	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>prednisolone sol 15mg/5ml</i>	2	B/D
<i>prednisolone sol 25mg/5ml</i>	4	B/D
PREDNISON CON 5MG/ML	4	B/D
<i>prednisone pak 5mg</i>	2	
<i>prednisone pak 10mg</i>	2	
<i>prednisone sol 5mg/5ml</i>	4	B/D
<i>prednisone tab 1mg</i>	1	GC, B/D
<i>prednisone tab 2.5mg</i>	1	GC, B/D
<i>prednisone tab 5mg</i>	1	GC, B/D
<i>prednisone tab 10mg</i>	1	GC, B/D
<i>prednisone tab 20mg</i>	1	GC, B/D
<i>prednisone tab 50mg</i>	1	GC, B/D
SOLU-CORTEF	4	
GLUCOSE ELEVATING AGENTS		
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	3	
PROGLYCEM SUS 50MG/ML	4	
MISCELLANEOUS		
<i>cabergoline</i>	4	
<i>calcitonin (salmon)</i>	3	B/D
FORTEO	5	NM, PA
GENOTROPIN	5	NM, PA
GENOTROPIN MINIQUICK .2mg	3	NM, PA
GENOTROPIN MINIQUICK .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	NM, PA
INCRELEX	5	NM, LA, PA
KORLYM	5	NM, LA, PA
LUPRON DEP-PED INJ 7.5MG	5	NM, PA
LUPRON DEP-PED INJ 11.25MG (3-MONTH)	5	NM, PA
LUPRON DEPOT-PED (1-MONTH)	5	NM, PA
LUPRON DEPOT-PED (3-MONTH)	5	NM, PA
NATPARA	5	NM, PA
<i>octreotide acetate 50mcg/ml, 100mcg/ml, 200mcg/ml</i>	4	NM, PA
<i>octreotide acetate 500mcg/ml, 1000mcg/ml</i>	5	NM, PA
PROLIA	4	QL (1 injection / 180 days), NM
<i>raloxifene hcl</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
SIGNIFOR	5	NM, LA, PA
SOMATULINE DEPOT	5	NM, PA
SOMAVERT	5	NM, LA, PA
TYMLOS	5	NM, PA
XGEVA	5	NM, PA
PHOSPHATE BINDER AGENTS		
AURYXIA	5	QL (360 tabs / 30 days), PA
<i>calcium acetate (phosphate binder) CAPS</i>	4	QL (360 caps / 30 days)
<i>calcium acetate (phosphate binder) TABS</i>	3	QL (360 tabs / 30 days)
<i>sevelamer carbonate PACK 2.4gm</i>	5	QL (180 packets / 30 days)
<i>sevelamer carbonate PACK .8gm</i>	5	QL (540 packets / 30 days)
<i>sevelamer carbonate TABS</i>	4	QL (540 tabs / 30 days)
PROGESTINS		
<i>medroxyprogesterone acetate tab</i>	1	GC
<i>norethindrone acetate TABS</i>	3	
THYROID AGENTS		
<i>levo-t</i>	2	
<i>levothyroxine sodium TABS</i>	2	
<i>levoxyl</i>	2	
<i>liothyronine sodium TABS</i>	3	
<i>methimazole TABS</i>	2	
<i>propylthiouracil TABS</i>	3	
SYNTHROID	4	
<i>unithroid</i>	2	
VASOPRESSINS		
<i>desmopressin acetate spray</i>	4	
<i>desmopressin acetate spray refrigerated</i>	4	
<i>desmopressin acetate tabs</i>	3	
<i>desmopressin inj 4mcg/ml</i>	4	
STIMATE	5	NM
GASTROINTESTINAL		
ANTIEMETICS		
<i>aprepitant</i>	4	B/D
<i>aprepitant pak 80mg & 125mg</i>	4	B/D
<i>compro</i>	4	
<i>dronabinol</i>	4	B/D, QL (60 caps / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
EMEND SUSR	4	B/D
<i>granisetron hcl SOLN</i>	3	
<i>granisetron hcl TABS</i>	4	B/D
<i>meclizine hcl TABS</i>	2	
<i>metoclopramide hcl SOLN</i>	2	
<i>metoclopramide hcl TABS</i>	1	GC
<i>metoclopramide hcl inj</i>	2	
<i>ondansetron hcl TABS</i>	3	B/D
<i>ondansetron hcl inj</i>	2	
<i>ondansetron hcl oral soln</i>	4	B/D
<i>ondansetron odt</i>	2	B/D
<i>prochlorperazine inj</i>	4	
<i>prochlorperazine maleate TABS</i>	2	
<i>prochlorperazine supp</i>	4	
<i>promethazine hcl SYRP; TABS</i>	2	PA; PA if 70 years and older
<i>promethazine hcl inj</i>	4	PA; PA if 70 years and older
SANCUSO	5	QL (4 patches / 28 days)
<i>scopolamine patch</i>	4	QL (10 patches / 30 days), PA; PA if 70 years and older
TRANSDERM-SCOP	4	QL (10 patches / 30 days), PA; PA if 70 years and older

ANTISPASMODICS

<i>dicyclomine hcl cap 10mg</i>	3	
<i>dicyclomine hcl soln 10mg/5ml</i>	4	
<i>dicyclomine hcl tab 20mg</i>	3	
<i>glycopyrrolate tab 1mg</i>	3	
<i>glycopyrrolate tab 2mg</i>	3	

H2-RECEPTOR ANTAGONISTS

<i>famotidine SUSR</i>	4	
<i>famotidine TABS 20mg, 40mg</i>	1	GC
<i>famotidine in nacl</i>	2	
<i>famotidine inj</i>	2	
<i>ranitidine hcl TABS 150mg, 300mg</i>	1	GC
<i>ranitidine hcl inj</i>	3	
<i>ranitidine inj</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>ranitidine syrup</i>	3	
INFLAMMATORY BOWEL DISEASE		
APRISO	3	QL (120 caps / 30 days)
<i>balsalazide disodium</i>	4	
<i>budesonide ec</i>	5	
<i>colocort enema 100mg</i>	4	
DELZICOL	4	
<i>hydrocortisone (enema)</i>	4	
<i>mesalamine CPDR</i>	4	
<i>mesalamine ENEM</i>	4	
<i>mesalamine SUPP</i>	4	
<i>mesalamine TBEC 800mg</i>	4	
<i>mesalamine w/ cleanser</i>	4	
<i>sulfasalazine TABS</i>	2	
<i>sulfasalazine ec</i>	3	
LAXATIVES		
<i>constulose</i>	2	
<i>enulose</i>	2	
<i>gavilyte-c</i>	2	
<i>gavilyte-g</i>	2	
<i>gavilyte-n/flavor pack</i>	2	
<i>generlac</i>	2	
GOLYTELY	3	
KRISTALOSE	4	
<i>lactulose SOLN</i>	2	
<i>lactulose (encephalopathy)</i>	2	
MOVIPREP	4	
NULYTELY/FLAVOR PACKS	3	
<i>peg 3350-kcl-sod bicarb-sod chloride-sod sulfate</i>	2	
<i>peg 3350-potassium chloride-sod bicarbonate-sod chloride</i>	2	
<i>peg 3350/electrolytes</i>	2	
SUPREP BOWEL PREP KIT	4	
<i>trilyte</i>	2	
MISCELLANEOUS		
<i>alosetron hcl</i>	5	PA
AMITIZA CAP 8MCG	3	QL (180 caps / 30 days)
AMITIZA CAP 24MCG	3	QL (60 caps / 30 days)
<i>amoxicillin-clarithromycin w/ lansoprazole</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>cromolyn sodium (mastocytosis)</i>	5	
<i>diphenoxylate w/ atropine</i> LIQD	4	
<i>diphenoxylate w/ atropine</i> TABS	3	
GATTEX	5	NM, LA, PA
LINZESS	3	QL (30 caps / 30 days)
<i>loperamide hcl</i> CAPS	2	
<i>misoprostol</i> TABS	3	
MOVANTIK 12.5mg	3	QL (60 tabs / 30 days)
MOVANTIK 25mg	3	QL (30 tabs / 30 days)
RELISTOR SOLN	5	PA
<i>sucralfate</i> TABS	3	
SYMPROIC	3	
<i>ursodiol</i> CAPS	3	
<i>ursodiol</i> TABS	4	
XIFAXAN 550mg	5	PA

PANCREATIC ENZYMES

CREON	3	
ZENPEP	4	

PROTON PUMP INHIBITORS

DEXILANT	4	QL (30 caps / 30 days)
<i>esomeprazole magnesium</i>	4	QL (30 caps / 30 days)
<i>esomeprazole sodium inj</i>	4	
<i>lansoprazole</i> CPDR	3	QL (30 caps / 30 days)
<i>lansoprazole</i> TBDD	4	QL (30 tabs / 30 days)
<i>omeprazole cap 10mg</i>	1	GC
<i>omeprazole cap 20mg</i>	1	GC
<i>omeprazole cap 40mg</i>	1	GC
<i>pantoprazole sodium</i> SOLR	4	
<i>pantoprazole sodium tbec</i>	2	
PRILOSEC	3	
<i>rabeprazole sodium</i>	3	QL (30 tabs / 30 days)

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

<i>alfuzosin hcl</i>	2	QL (30 tabs / 30 days)
<i>dutasteride</i> CAPS	3	QL (30 caps / 30 days)
<i>dutasteride-tamsulosin hcl</i>	4	QL (30 caps / 30 days)
<i>finasteride</i> TABS 5mg	2	
<i>silodosin</i>	4	
<i>tamsulosin hcl</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
-----------	-----------	---------------------

MISCELLANEOUS

<i>bethanechol chloride</i> TABS	3	
<i>potassium citrate (alkalinizer) er tabs</i>	4	

URINARY ANTISPASMODICS

<i>darifenacin hydrobromide</i>	4	
MYRBETRIQ 25mg	4	QL (60 tabs / 30 days)
MYRBETRIQ 50mg	4	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> SYRP	3	
<i>oxybutynin chloride</i> TABS	3	
<i>oxybutynin chloride</i> TB24 5mg	3	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> TB24 10mg, 15mg	3	QL (60 tabs / 30 days)
OXYTROL	4	
<i>solifenacin succinate</i>	4	QL (30 tabs / 30 days)
<i>tolterodine tartrate cap er</i>	4	QL (30 caps / 30 days), ST
<i>tolterodine tartrate tabs</i>	4	ST
TOVIAZ	3	QL (30 tabs / 30 days)
<i>trospium chloride</i> TABS	3	QL (60 tabs / 30 days)

VAGINAL ANTI-INFECTIVES

<i>clindamycin phosphate vaginal</i>	3	
<i>metronidazole vaginal</i>	4	
<i>terconazole vaginal</i>	3	
<i>vandazole</i>	4	

HEMATOLOGIC

ANTICOAGULANTS

COUMADIN	3	
ELIQUIS	3	
ELIQUIS STARTER PACK	3	
<i>enoxaparin sodium</i>	4	
<i>fondaparinux sodium</i> 2.5mg/0.5ml	4	
<i>fondaparinux sodium</i> 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	5	
FRAGMIN 2500unit/0.2ml, 5000unit/0.2ml	4	
FRAGMIN 7500unit/0.3ml, 10000unit/ml, 12500unit/0.5ml, 15000unit/0.6ml, 18000unt/0.72ml, 95000unit/3.8ml	5	
<i>heparin sod (porcine) in d5w</i>	3	
<i>heparin sod inj 1000/ml</i>	3	B/D
<i>heparin sod inj 5000/ml</i>	3	B/D
<i>heparin sod inj 10000/ml</i>	3	B/D

PA - Prior Authorization QL - Quantity Limits ST - Step Therapy NM - Not available at mail-order B/D - Covered under Medicare B or D LA - Limited Access GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>heparin sod inj 20000/ml</i>	3	B/D
HEPARIN SODIUM/NAACL 0.45%	3	
<i>jantoven</i>	1	GC
PRADAXA	4	
<i>warfarin sodium</i>	1	GC
XARELTO	3	
XARELTO STARTER PACK	3	

HEMATOPOIETIC GROWTH FACTORS

GRANIX	5	NM, PA
NEUPOGEN	5	NM, PA
PROCRIT 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	3	NM, PA
PROCRIT 20000unit/ml, 40000unit/ml	5	NM, PA

MISCELLANEOUS

<i>anagrelide hcl</i>	4	
BERINERT	5	QL (24 boxes / 30 days), NM, LA, PA
<i>cilostazol</i>	2	
DROXIA	3	
ENDARI	5	NM, LA, PA
FIRAZYR	5	QL (9 syringes / 30 days), NM, PA
HAEGARDA 2000unit	5	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA 3000unit	5	QL (20 vials / 30 days), NM, LA, PA
<i>icatibant acetate</i>	5	QL (9 syringes / 30 days), NM, PA
<i>pentoxifylline TBCR</i>	2	
PROMACTA PACK	5	QL (360 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg	5	QL (360 tabs / 30 days), NM, LA, PA
PROMACTA TABS 25mg	5	QL (180 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg	5	QL (90 tabs / 30 days), NM, LA, PA
PROMACTA TABS 75mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>tranexamic acid SOLN; TABS</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
PLATELET AGGREGATION INHIBITORS		
<i>aspirin-dipyridamole</i>	4	
BRILINTA	3	
<i>clopidogrel tab 75mg</i>	1	GC
<i>prasugrel hcl</i>	4	
ZONTIVITY	4	

IMMUNOLOGIC AGENTS

DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)

HUMIRA 10mg/0.1ml, 20mg/0.2ml	5	QL (2 injections / 28 days), NM, PA
HUMIRA 40mg/0.4ml	5	QL (6 injections / 28 days), NM, PA
HUMIRA INJ 10MG/0.2ML	5	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 20MG/0.4ML	5	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 40MG/0.8ML	5	QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIATRIC CROHNS DISEASE	5	NM, PA
HUMIRA PEN	5	QL (6 pens / 28 days), NM, PA
HUMIRA PEN CD/UC/HS STARTER	5	NM, PA
HUMIRA PEN INJ CD/UC/HS STARTER	5	NM, PA
HUMIRA PEN INJ PS/UV STARTER	5	NM, PA
HUMIRA PEN-PS/UV STARTER	5	NM, PA
<i>hydroxychloroquine sulfate</i>	3	
<i>leflunomide TABS</i>	3	
<i>methotrexate sodium tabs</i>	3	
REMICADE	5	NM, PA
TREXALL	4	B/D
XATMEP	4	B/D
XELJANZ	5	QL (60 tabs / 30 days), NM, PA
XELJANZ XR	5	QL (30 tabs / 30 days), NM, PA

IMMUNOGLOBULINS

BIVIGAM	5	NM, PA
CARIMUNE NANOFILTERED 12gm	5	NM, PA
FLEBOGAMMA DIF	5	NM, PA
GAMASTAN S/D	3	B/D, NM

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
GAMMAGARD LIQUID	5	NM, PA
GAMMAGARD S/D	5	NM, PA
GAMMAKED	5	NM, PA
GAMMAPLEX	5	NM, PA
GAMMAPLEX 10GM/100ML	5	NM, PA
GAMUNEX-C	5	NM, PA
OCTAGAM	5	NM, PA
PANZYGA	5	NM, PA
PRIVIGEN	5	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE	5	NM, LA, PA
ARCALYST	5	NM, PA
INTRON-A INJ 10MU	5	B/D
INTRON-A INJ 18MU	5	B/D
INTRON-A INJ 25MU	5	B/D
INTRON-A INJ 50MU	5	B/D
IMMUNOSUPPRESSANTS		
<i>azathioprine</i> TABS	3	B/D
BENLYSTA	5	NM, PA
<i>cyclosporine</i> CAPS; SOLN	4	B/D
<i>cyclosporine modified (for microemulsion)</i>	4	B/D
<i>gengraf</i>	4	B/D
<i>mycophenolate mofetil</i> CAPS; TABS	3	B/D
<i>mycophenolate mofetil</i> SUSR	5	B/D
<i>mycophenolate sodium tbec</i>	4	B/D
NULOJIX	5	B/D
PROGRAF PACK	4	B/D
RAPAMUNE SOLN	5	B/D
SANDIMMUNE SOLN 100mg/ml	3	B/D
<i>sirolimus</i> SOLN	5	B/D
<i>sirolimus</i> TABS 2mg	5	B/D
<i>sirolimus</i> TABS .5mg, 1mg	4	B/D
<i>tacrolimus</i> CAPS	4	B/D
ZORTRESS TAB 0.5MG	5	B/D
ZORTRESS TAB 0.25MG	5	B/D
ZORTRESS TAB 0.75MG	5	B/D
ZORTRESS TAB 1MG	5	B/D
VACCINES		
ACTHIB	3	
ADACEL	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
BCG VACCINE	3	
BEXSERO	3	
BOOSTRIX	3	
DAPTACEL	3	
DIPHThERIA/TETANUS TOXOID	3	B/D
ENGERIX-B SUSP	3	B/D
GARDASIL 9	3	
HAVRIX	3	
HIBERIX	3	
IMOVAX RABIES (H.D.C.V.)	3	B/D
INFANRIX	3	
IPOL INACTIVATED IPV	3	
IXIARO	3	
KINRIX	3	
M-M-R II	3	
MENACTRA	3	
MENVEO	3	
PEDIARIX	3	
PEDVAX HIB	3	
PENTACEL	3	
PROQUAD	3	
QUADRACEL	3	
RABAVERT	3	B/D
RECOMBIVAX HB	3	B/D
ROTARIX	3	
ROTATEQ	3	
SHINGRIX	3	QL (2 vials per lifetime)
TDVAX	3	B/D
TENIVAC	3	B/D
TRUMENBA	3	
TWINRIX INJ	3	
TYPHIM VI	3	
VAQTA	3	
VARIVAX	3	
YF-VAX	3	
ZOSTAVAX	3	QL (1 vial per lifetime)

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES

<i>klor-con 8</i>	2	
<i>klor-con 10</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>klor-con m10</i>	2	
<i>klor-con m15</i>	3	
<i>klor-con m20</i>	2	
<i>klor-con pak 20meq</i>	4	
<i>klor-con spr cap 8meq</i>	3	
<i>klor-con spr cap 10meq</i>	3	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	3	
<i>magnesium sulfate</i> SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%	3	
MAGNESIUM SULFATE IN D5W	3	
<i>magnesium sulfate in dextrose</i>	3	
<i>magnesium sulfate inj 50%</i>	3	
<i>potassium chloride</i> CPCR	3	
<i>potassium chloride</i> PACK	4	
<i>potassium chloride</i> SOLN 10%, 20%	4	
<i>potassium chloride</i> TBCR	2	
<i>potassium chloride microencapsulated crystals er</i>	2	
<i>potassium chloride tab cr 10 meq</i>	2	
<i>sodium chloride</i> SOLN 2.5meq/ml	2	
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	2	
<i>tpn electrolytes</i>	4	B/D
IV NUTRITION		
AMINOSYN II INJ 10%	4	B/D
AMINOSYN-PF 7%	4	B/D
AMINOSYN-PF INJ 10%	4	B/D
CLINIMIX 4.25%/DEXTROSE 5%	4	B/D
CLINIMIX 4.25%/DEXTROSE 25%	4	B/D
CLINIMIX 5%/DEXTROSE 15%	4	B/D
CLINIMIX 5%/DEXTROSE 20%	4	B/D
CLINIMIX 5%/DEXTROSE 25%	4	B/D
CLINIMIX INJ 4.25/D10	4	B/D
CLINOLIPID	4	B/D
FREAMINE HBC 6.9%	4	B/D
FREAMINE III	4	B/D
<i>hepatamine</i>	4	B/D
INTRALIPID 30%	4	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
INTRALIPID INJ 20%	4	B/D
NEPHRAMINE	4	B/D
NUTRILIPID INJ 20%	4	B/D
<i>premasol sol 6%</i>	4	B/D
PREMASOL SOL 10%	4	B/D
PROCALAMINE	4	B/D
PROSOL	4	B/D
TRAVASOL	4	B/D
TROPHAMINE INJ 10%	4	B/D

IV REPLACEMENT SOLUTIONS

<i>dextrose 2.5%/nacl 0.45%</i>	2	
<i>dextrose 5%</i>	2	
DEXTROSE 5% /ELECTROLYTE	3	
<i>dextrose 5%/nacl 0.2%</i>	2	
DEXTROSE 5%/NACL 0.3%	4	
<i>dextrose 5%/nacl 0.9%</i>	2	
<i>dextrose 5%/nacl 0.33%</i>	2	
<i>dextrose 5%/nacl 0.45%</i>	2	
<i>dextrose 5%/nacl 0.225%</i>	2	
<i>dextrose 5%/potassium chl</i>	2	
<i>dextrose 10% flex contain</i>	2	
DEXTROSE 10%/NACL 0.2%	3	
<i>dextrose 10%/nacl 0.45%</i>	2	
<i>dextrose 50%</i>	2	
<i>dextrose in lactated ringers</i>	2	
<i>dextrose inj 70%</i>	2	
IONOSOL-MB/DEXTROSE 5%	4	
ISOLYTE P	4	
ISOLYTE S	4	
<i>kcl0.15%/d5w/nacl0.2%</i>	2	
KCL 0.3%/D5W/NACL 0.9%	4	
<i>kcl 0.3%/d5w/nacl 0.45%</i>	2	
<i>kcl 0.15%/d5w/nacl 0.9%</i>	2	
KCL 0.15%/D5W/NACL 0.225%	3	
<i>kcl 0.075%/d5w/nacl 0.45%</i>	2	
<i>kcl/d5w inj 0.3%</i>	2	
<i>kcl/d5w/nacl inj 0.22%/0.45%</i>	2	
<i>kcl/d5w/nacl inj .15/.33%</i>	2	
<i>kcl/d5w/nacl inj .15/.45%</i>	2	
<i>kcl/nacl inj 0.3-0.9</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>kcl/nacl inj 0.15%-0.9%</i>	2	
<i>lactated ringer's</i>	2	
NORMOSOL-M IN D5W	4	
NORMOSOL-R	4	
NORMOSOL-R IN D5W	4	
PLASMA-LYTE A	4	
PLASMA-LYTE-148	4	
<i>pot chloride inj 2meq/ml</i>	2	
<i>potassium chloride SOLN .4meq/ml, 2meq/ml, 10meq/100ml, 10meq/50ml, 20meq/100ml, 40meq/100ml</i>	2	
<i>potassium chloride in nacl</i>	2	
<i>sodium chloride SOLN 3%, 5%</i>	2	
<i>sodium chloride 0.45%</i>	2	
<i>sodium chloride inj 0.9%</i>	2	

VITAMINS

<i>calcitriol CAPS</i>	3	B/D
<i>calcitriol inj</i>	4	B/D
<i>calcitriol oral soln 1 mcg/ml</i>	4	B/D
<i>doxercalciferol CAPS</i>	4	B/D
M-NATAL PLUS	3	
<i>paricalcitol CAPS</i>	4	B/D
PNV FOLIC ACID + IRON MUL	3	
PRENATAL	3	
PRENATAL PLUS	3	
PRENATAL PLUS LOW IRON	3	
RAYALDEE	5	
TRICARE	3	

OPHTHALMIC

ANTI-INFECTIVE/ANTI-INFLAMMATORY

<i>bacitracin-poly-neomycin-hc</i>	3	
BLEPHAMIDE OINT	4	
<i>neomycin-polymy-dexameth</i>	2	
<i>neomycin-polymyxin-hc (ophth)</i>	4	
<i>sulfacetamide sod-prednisolone</i>	2	
TOBRADEX OINT	3	
TOBRADEX ST	3	
<i>tobramycin-dexamethasone</i>	4	
ZYLET	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ANTI-INFECTIVES		
AZASITE	4	
<i>bacitracin (ophthalmic)</i>	3	
<i>bacitracin-polymyxin b (ophth)</i>	2	
BESIVANCE	3	
CILOXAN OINT	3	
<i>ciprofloxacin hcl (ophth)</i>	2	
<i>erythromycin (ophth)</i>	2	
<i>gatifloxacin (ophth)</i>	4	
<i>gentak</i>	2	
<i>gentamicin sulfate soln (ophth)</i>	2	
MOXEZA	3	
<i>moxifloxacin hcl (ophth)</i>	3	
NATACYN	4	
<i>neomycin-bacitracin zn-polymyxin</i>	3	
<i>neomycin-polymyxin-gramicidin</i>	3	
<i>ofloxacin (ophth)</i>	2	
<i>polymyxin b-trimethoprim</i>	2	
<i>sulfacetamide sodium (ophth)</i>	3	
<i>tobramycin (ophth)</i>	2	
<i>trifluridine</i>	3	
ZIRGAN	4	
ANTI-INFLAMMATORIES		
ALREX	3	
<i>bromfenac sodium (ophth)</i>	4	
BROMSITE	4	
<i>dexamethasone sodium phosphate (ophth)</i>	3	
<i>diclofenac sodium (ophth)</i>	3	
DUREZOL	3	
<i>fluorometholone</i>	3	
<i>flurbiprofen sodium</i>	2	
ILEVRO	3	
<i>ketorolac tromethamine (ophth)</i>	3	
LOTEMAX	3	
<i>loteprednol etabonate</i>	3	
<i>prednisolone acetate (ophth)</i>	3	
PREDNISOLONE SODIUM PHOSPHATE (OPHTH)	3	
PROLENSA	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ANTIALLERGICS		
<i>azelastine drop 0.05%</i>	3	
BEPREVE	3	
<i>cromolyn sodium (ophth)</i>	1	GC
LASTACAFT	4	
<i>olopatadine hcl 0.1%</i>	3	
<i>olopatadine hcl 0.2%</i>	4	
PAZEO	3	
ANTIGLAUCOMA		
ALPHAGAN P SOL 0.1%	3	
AZOPT	3	
<i>betaxolol hcl (ophth)</i>	3	
BETOPTIC-S	3	
<i>brimonidine sol 0.2%</i>	2	
<i>brimonidine sol 0.15%</i>	4	
<i>carteolol hcl (ophth)</i>	2	
COMBIGAN	3	
<i>dorzolamide hcl</i>	3	
<i>dorzolamide hcl-timolol maleate</i>	3	
<i>latanoprost SOLN</i>	2	
<i>levobunolol hcl</i>	2	
LUMIGAN	3	
PHOSPHOLINE IODIDE	4	
<i>pilocarpine hcl SOLN</i>	3	
RHOPRESSA	3	
SIMBRINZA	3	
<i>timolol maleate (ophth) soln</i>	1	GC
<i>timolol maleate gel</i>	4	
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	4	
TRAVATAN Z	3	
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	3	
CYSTARAN	5	NM, LA, PA
<i>proparacaine hcl SOLN</i>	3	
RESTASIS	3	QL (60 single use vials / 30 days)
RESTASIS MULTIDOSE	3	QL (1 bottle / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
-----------	-----------	---------------------

RESPIRATORY

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

ANORO ELLIPTA	3	QL (60 blisters / 30 days)
BEVESPI AEROSPHERE	3	QL (1 inhaler / 30 days)
COMBIVENT RESPIMAT	4	QL (2 inhalers / 30 days)
<i>ipratropium-albuterol nebu</i>	3	B/D
TRELEGY ELLIPTA	3	QL (60 blisters / 30 days)

ANTICHOLINERGICS

ATROVENT HFA	4	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA	3	QL (30 blisters / 30 days)
<i>ipratropium bromide SOLN</i>	2	B/D
<i>ipratropium bromide (nasal)</i>	3	

ANTI-HISTAMINES

<i>azelastine spr 0.1%</i>	3	
<i>azelastine spr 0.15%</i>	4	
<i>cetirizine syrup</i>	2	
CLARINEX SYRP	4	
<i>cyproheptadine hcl SYRP; TABS</i>	3	PA; PA if 70 years and older
<i>desloratadine TABS</i>	3	
<i>diphenhydramine hcl inj 50mg/ml</i>	2	
<i>hydroxyzine hcl SYRP</i>	3	PA; PA if 70 years and older
<i>hydroxyzine hcl TABS</i>	2	PA; PA if 70 years and older
<i>hydroxyzine hcl inj</i>	4	PA; PA if 70 years and older
<i>hydroxyzine pamoate CAPS 25mg, 50mg</i>	2	PA; PA if 70 years and older
<i>levocetirizine dihydrochloride SOLN</i>	4	
<i>levocetirizine dihydrochloride TABS</i>	2	
<i>olopatadine hcl (nasal)</i>	4	

BETA AGONISTS

<i>albuterol sulfate AERS 108mcg/act</i>	3	QL (2 inhalers / 30 days); (generic of Proair HFA)
--	---	--

PA - Prior Authorization QL - Quantity Limits ST - Step Therapy NM - Not available at mail-order B/D - Covered under Medicare B or D LA - Limited Access GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>albuterol sulfate</i> AERS 108mcg/act	3	QL (2 inhalers / 30 days); (generic of Ventolin HFA)
<i>albuterol sulfate</i> NEBU	2	B/D
<i>albuterol sulfate</i> SYRP	3	
<i>albuterol sulfate</i> TABS	4	
<i>albuterol sulfate</i> TB12	4	
BROVANA	5	B/D
<i>levalbuterol hcl</i> NEBU	4	B/D
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml</i>	4	B/D
<i>levalbuterol tartrate hfa</i>	3	QL (2 inhalers / 30 days)
PERFOROMIST	5	B/D
SEREVENT DISKUS	3	QL (60 inhalations / 30 days)
<i>terbutaline sulfate</i> TABS	4	
VENTOLIN HFA	3	QL (2 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
<i>montelukast sodium</i> CHEW; TABS	2	
<i>montelukast sodium</i> PACK	4	
<i>zafirlukast</i>	3	
MAST CELL STABILIZERS		
<i>cromolyn sodium nebu</i>	3	B/D
MISCELLANEOUS		
<i>acetylcysteine</i> SOLN 10%, 20%	3	B/D
ARALAST NP	5	NM, LA, PA
DALIRESP	4	
<i>epinephrine (anaphylaxis)</i> .15mg/0.3ml, .3mg/0.3ml	3	(generic of EpiPen)
<i>epinephrine (anaphylaxis)</i> .15mg/0.15ml, .3mg/0.3ml	3	(generic of Adrenaclick)
ESBRIET	5	NM, PA
KALYDECO	5	NM, PA
OFEV	5	NM, PA
ORKAMBI	5	NM, PA
PROLASTIN-C	5	NM, LA, PA
PULMOZYME	5	NM, PA
SYMDEKO	5	NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
SYMJEPI	4	
THEO-24	4	
<i>theophylline sol 80/15ml</i>	4	
<i>theophylline tb12 300 mg</i>	3	
<i>theophylline tb12 450 mg</i>	3	
<i>theophylline tb24</i>	3	
XOLAIR	5	NM, LA, PA
ZEMAIRA	5	NM, LA, PA
NASAL STEROIDS		
<i>flunisolide (nasal)</i>	3	QL (3 bottles / 30 days)
<i>fluticasone propionate (nasal)</i>	2	QL (1 bottle / 30 days)
OMNARIS	4	QL (1 inhaler / 30 days)
STEROID INHALANTS		
ARNUITY ELLIPTA	3	QL (30 inhalations / 30 days)
<i>budesonide (inhalation) .25mg/2ml, .5mg/2ml</i>	4	B/D
FLOVENT DISKUS 50mcg/blist, 100mcg/blist	3	QL (120 inhalations / 30 days)
FLOVENT DISKUS 250mcg/blist	3	QL (240 inhalations / 30 days)
FLOVENT HFA	3	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER	4	QL (2 inhalers / 30 days)
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKUS	3	QL (60 inhalations / 30 days)
ADVAIR HFA	3	QL (1 inhaler / 30 days)
BREO ELLIPTA	3	QL (60 blisters / 30 days)
SYMBICORT	3	QL (1 inhaler / 30 days)
TOPICAL		
DERMATOLOGY, ACNE		
<i>amnestem</i>	4	PA
<i>avita</i>	4	PA
<i>benzoyl peroxide-erythromycin</i>	4	
<i>claravis</i>	4	PA
<i>clindacin-p</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate (topical)</i> GEL; LOTN	4	
<i>clindamycin phosphate (topical)</i> SOLN; SWAB	3	
<i>ery pad 2%</i>	3	
<i>erythromycin (acne aid)</i> GEL	4	
<i>erythromycin (acne aid)</i> SOLN	3	
<i>isotretinoin</i> CAPS	4	PA
<i>myorisan</i>	4	PA
<i>sulfacetamide sodium (acne)</i>	4	
<i>tretinoin</i> CREA	4	PA
<i>tretinoin</i> GEL .01%, .025%	4	PA
<i>zenatane</i>	4	PA
DERMATOLOGY, ANTIBIOTICS		
<i>gentamicin sulfate (topical)</i>	3	
<i>mupirocin</i> OINT	2	
<i>silver sulfadiazine</i> CREA	2	
<i>ssd</i>	2	
SULFAMYLON CREA	4	
DERMATOLOGY, ANTIFUNGALS		
<i>ciclopirox</i> CREA; SUSP	3	
<i>ciclopirox</i> GEL	4	
<i>ciclopirox shampoo 1%</i>	4	
<i>clotrimazole (topical)</i>	3	
<i>clotrimazole w/ betamethasone</i> CREA	3	
<i>ketoconazole cream</i>	3	
<i>nyamyc</i>	3	
<i>nystatin (topical)</i>	3	
<i>nystatin pow 100000</i>	3	
<i>nystop</i>	3	
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin</i>	5	PA
<i>calcipotriene</i> CREA; OINT	4	QL (120 gm / 30 days), PA
<i>calcipotriene</i> SOLN	4	QL (120 mL / 30 days), PA
<i>calcitrene</i>	4	QL (120 gm / 30 days), PA
<i>tazarotene</i> CREA	3	PA
TAZORAC CREA .05%	4	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole shampoo</i>	2	
<i>selenium sulfide</i> LOTN	2	
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort</i> 1%	1	GC
<i>ala-cort</i> 2.5%	2	
<i>alclometasone dipropionate</i>	3	
<i>betamethasone dipropionate (topical)</i> CREA; LOTN	3	
<i>betamethasone dipropionate (topical)</i> OINT	4	
<i>betamethasone dipropionate augmented</i> CREA	3	
<i>betamethasone dipropionate augmented</i> GEL; LOTN; OINT	4	
<i>betamethasone valerate</i> CREA; LOTN; OINT	3	
CORDRAN TAPE	4	
ENSTILAR	4	PA
<i>fluocinolone acetonide</i> CREA; OIL; OINT; SOLN	4	
<i>fluocinolone acetonide oil body</i>	4	
<i>fluocinonide</i> CREA .05%	4	
<i>fluocinonide</i> GEL	4	
<i>fluocinonide</i> SOLN	3	
<i>fluocinonide emulsified base</i>	4	
<i>fluticasone propionate</i> CREA; OINT	3	
<i>halobetasol propionate</i> CREA; OINT	4	
<i>hydrocortisone (topical)</i> CREA 1%	1	GC
<i>hydrocortisone (topical)</i> CREA 2.5%	2	
<i>hydrocortisone (topical)</i> LOTN	3	
<i>hydrocortisone (topical)</i> OINT 2.5%	2	
<i>hydrocortisone butyrate cream 0.1%</i>	4	
<i>hydrocortisone butyrate oint 0.1%</i>	4	
<i>hydrocortisone valerate</i>	4	
<i>mometasone furoate</i> CREA	2	
<i>mometasone furoate</i> OINT; SOLN	3	
TACLONEX SUSP	5	PA
TEXACORT SOLN 2.5%	4	
<i>triamcinolone acetonide (topical)</i> AERS	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>triamcinolone acetonide (topical)</i> CREA; OINT	2	
<i>triamcinolone acetonide (topical)</i> LOTN	3	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo</i>	3	QL (30 mL / 30 days), PA
<i>lidocaine</i> PTCH	4	QL (3 patches / 1 day), PA
<i>lidocaine hcl</i> GEL	3	QL (30 mL / 30 days), PA
<i>lidocaine hcl</i> SOLN 4%	2	QL (50 mL / 30 days), PA
<i>lidocaine oint</i> 5%	4	QL (50 grams / 30 days), PA
<i>lidocaine-prilocaine</i>	3	QL (30 grams / 30 days), PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>ammonium lactate</i> CREA; LOTN	3	
<i>azelaic acid</i> GEL	4	
<i>diclofenac sodium (topical) 1% gel</i>	3	PA
FINACEA FOAM	4	
<i>fluorouracil (topical)</i> CREA 5%	4	
<i>fluorouracil (topical)</i> SOLN	3	
<i>imiquimod</i> CREA 3.75%	5	
<i>imiquimod</i> CREA 5%	4	
<i>metronidazole (topical)</i> CREA; LOTN	4	
<i>metronidazole gel</i> 0.75%	4	
NORITATE	5	
PANRETIN	5	
PICATO .05%	3	QL (2 tubes / 30 days)
PICATO .015%	3	QL (3 tubes / 30 days)
<i>podofilox</i> SOLN	3	
<i>procto-med hc</i>	3	
<i>procto-pak</i>	3	
<i>proctosol hc cre</i> 2.5%	3	
<i>proctozone-hc</i>	3	
<i>rosadan</i>	4	
<i>tacrolimus (topical)</i>	4	
TARGRETIN GEL	5	NM, PA
VALCHLOR	5	NM, LA, PA
ZYCLARA	5	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ZYCLARA PUMP	5	
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion</i>	4	
<i>permethrin cre 5%</i>	3	
DERMATOLOGY, WOUND CARE AGENTS		
<i>acetic acid .25%</i>	2	
REGRANEX	5	PA
SANTYL	4	
<i>sodium chlor sol 0.9% irr</i>	2	
<i>water for irrigation, sterile</i>	2	
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl</i>	4	
<i>chlorhexidine gluconate (mouth-throat)</i>	1	GC
<i>clotrimazole LOZG</i>	4	
<i>lidocaine hcl (mouth-throat)</i>	2	
<i>nystatin (mouth-throat)</i>	3	
<i>paroex sol 0.12%</i>	1	GC
<i>periogard</i>	1	GC
<i>pilocarpine hcl (oral)</i>	4	
<i>triamcinolone acetonide (mouth)</i>	3	
OTIC		
<i>acetic acid (otic)</i>	3	
CIPRO HC	4	
CIPRODEX	3	
<i>flac</i>	4	
<i>fluocinolone acetonide (otic)</i>	4	
<i>neomycin-polymyxin-hc (otic)</i>	3	
<i>ofloxacin (otic)</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Index of Drugs

<i>abacavir sulfate</i>	12	<i>alendronate sodium</i>	47
<i>abacavir sulfate-lamivudine</i>	13	<i>alfuzosin hcl</i>	57
<i>abacavir sulfate-lamivudine-zidovudine</i>	14	ALIMTA	19
ABELCET	11	ALINIA.....	10
ABILIFY MAINTENA.....	37	<i>aliskiren fumarate</i>	29
<i>abiraterone acetate</i>	20	<i>allopurinol tab</i>	7
ABRAXANE	19	<i>alosetron hcl</i>	56
<i>acamprosate calcium</i>	43	ALPHAGAN P SOL 0.1%.....	67
<i>acarbose</i>	45	<i>alprazolam tab 0.25mg</i>	31
<i>acebutolol hcl</i>	27	<i>alprazolam tab 0.5mg</i>	31
<i>acetaminophen w/ codeine 300-15mg</i> 7		<i>alprazolam tab 1mg</i>	31
<i>acetaminophen w/ codeine 300-30mg</i> 7		<i>alprazolam tab 2mg</i>	31
<i>acetaminophen w/ codeine 300-60mg</i> 7		ALREX	66
<i>acetaminophen w/ codeine soln</i>	7	<i>altavera tab</i>	48
<i>acetazolamide</i>	29	ALTOPREV	26
<i>acetic acid</i>	74	ALUNBRIG	21
<i>acetic acid (otic)</i>	74	<i>alyacen 1/35</i>	48
<i>acetylcysteine</i>	69	<i>amantadine hcl</i>	36
<i>acitretin</i>	71	AMBISOME	11
ACTHIB.....	61	<i>ambrisentan</i>	30
ACTIMMUNE	61	<i>amikacin sulfate</i>	10
<i>acyclovir</i>	15	<i>amiloride & hydrochlorothiazide</i>	29
<i>acyclovir sodium</i>	15	<i>amiloride hcl</i>	29
ADACEL	61	AMINOSYN II INJ 10%.....	63
<i>adefovir dipivoxil</i>	15	AMINOSYN-PF 7%	63
ADEMPAS	30	AMINOSYN-PF INJ 10%.....	63
<i>adriamycin</i>	18	<i>amiodarone hcl soln</i>	26
<i>adrucil</i>	19	<i>amiodarone tab 100mg</i>	26
ADVAIR DISKUS.....	70	<i>amiodarone tab 200mg</i>	26
ADVAIR HFA	70	<i>amiodarone tab 400mg</i>	26
AFINITOR.....	21	AMITIZA CAP 24MCG	56
AFINITOR DISPERZ	21	AMITIZA CAP 8MCG.....	56
AIMOVIG.....	41	<i>amitriptyline hcl</i>	34
<i>ala-cort</i>	72	<i>amlodipine besylate</i>	28
<i>albendazole</i>	10	<i>amlodipine besylate-atorvastatin</i> <i>calcium</i>	28
<i>albuterol sulfate</i>	68, 69	<i>amlodipine besylate-olmesartan</i> <i>medoxomil</i>	25
<i>alclometasone dipropionate</i>	72	<i>amlodipine besylate-valsartan tab 10-</i> <i>160 mg</i>	25
ALCOHOL SWABS.....	44	<i>amlodipine besylate-valsartan tab 10-</i>	
ALDURAZYME	51		
ALECENSA.....	21		

320 mg.....	25	sr 24hr 25 mg.....	40
amlodipine besylate-valsartan tab 5-160 mg.....	25	amphetamine-dextroamphetamine cap sr 24hr 30 mg.....	40
amlodipine besylate-valsartan tab 5-320 mg.....	25	amphetamine-dextroamphetamine cap sr 24hr 5 mg.....	40
amlodipine--benazepril hcl cap 10-20 mg.....	24	amphetamine-dextroamphetamine tab 10 mg.....	40
amlodipine-benazepril hcl cap 10-40mg.....	24	amphetamine-dextroamphetamine tab 12.5 mg.....	40
amlodipine-benazepril hcl cap 2.5-10 mg.....	24	amphetamine-dextroamphetamine tab 15 mg.....	40
amlodipine-benazepril hcl cap 5-10 mg.....	24	amphetamine-dextroamphetamine tab 20 mg.....	40
amlodipine-benazepril hcl cap 5-20 mg.....	24	amphetamine-dextroamphetamine tab 30 mg.....	40
amlodipine-benazepril hcl cap 5-40 mg.....	24	amphetamine-dextroamphetamine tab 5 mg.....	40
amlodipine-valsartan-hydrochlorothiazide 10-160-12.5mg ..	25	amphetamine-dextroamphetamine tab 7.5 mg.....	40
amlodipine-valsartan-hydrochlorothiazide 10-160-25mg	25	amphotericin b.....	11
amlodipine-valsartan-hydrochlorothiazide 10-320-25mg	25	ampicillin & sulbactam sodium	17
amlodipine-valsartan-hydrochlorothiazide 5-160-12.5mg	25	ampicillin cap 500mg	17
amlodipine-valsartan-hydrochlorothiazide 5-160-25mg.....	25	ampicillin inj.....	17
ammonium lactate	73	ampicillin sodium	17
amnestem	70	ANADROL-50	44
amoxapine tab 100mg	35	anagrelide hcl	59
amoxapine tab 150mg	35	anastrozole	20
amoxapine tab 25mg	35	ANDRODERM	44
amoxapine tab 50mg	35	ANORO ELLIPTA	68
amoxicillin.....	17	ANTARA	26
amoxicillin & pot clavulanate	17	APOKYN	36
amoxicillin-clarithromycin w/ lansoprazole	56	aprepitant	54
amphetamine-dextroamphetamine cap sr 24hr 10 mg.....	40	aprepitant pak 80mg & 125mg.....	54
amphetamine-dextroamphetamine cap sr 24hr 15 mg.....	40	apri	48
amphetamine-dextroamphetamine cap sr 24hr 20 mg.....	40	APRISO.....	56
amphetamine-dextroamphetamine cap		APTIOM.....	31
		APTIVUS	12
		ARALAST NP	69
		aranelle	48
		ARCALYST	61
		aripiprazole odt.....	37
		aripiprazole oral solution 1 mg/ml	37
		aripiprazole tab.....	37
		ARISTADA	37

ARISTADA INITIO.....	37	BCG VACCINE.....	62
<i>armodafinil</i>	43	BD ULTRAFINE INSULIN SYRINGE	44
ARNUITY ELLIPTA.....	70	BD ULTRAFINE/NANO PEN NEEDLES	44
<i>aspirin-dipyridamole</i>	60	<i>bekyree</i>	48
<i>atazanavir sulfate</i>	12	<i>benazepril & hydrochlorothiazide</i>	24
<i>atenolol</i>	27	<i>benazepril hcl</i>	24
<i>atenolol & chlorthalidone</i>	27	BENDEKA.....	18
<i>atomoxetine hcl</i>	40	BENLYSTA	61
<i>atorvastatin calcium</i>	26	<i>benzoyl peroxide-erythromycin</i>	70
<i>atovaquone</i>	10	<i>benztropine mesylate inj</i>	36
<i>atovaquone-proguanil hcl</i>	12	<i>benztropine mesylate tab 0.5mg</i>	36
ATRIPLA.....	14	<i>benztropine mesylate tab 1mg</i>	36
ATROPINE SULFATE.....	67	<i>benztropine mesylate tab 2mg</i>	36
ATROVENT HFA.....	68	BEPREVE.....	67
<i>aubra</i>	48	BERINERT	59
AUGMENTIN SUS 125/5ML	17	BESIVANCE	66
AURYXIA	54	<i>betamethasone dipropionate (topical)</i> 72	
AUSTEDO	42	<i>betamethasone dipropionate</i>	
AVASTIN	19	<i>augmented</i>	72
<i>aviane</i>	48	<i>betamethasone valerate</i>	72
<i>avita</i>	70	BETASERON	43
<i>azacitidine</i>	19	<i>betaxolol hcl (ophth)</i>	67
AZACTAM INJ	10	<i>bethanechol chloride</i>	58
AZASITE	66	BETOPTIC-S	67
<i>azathioprine</i>	61	BEVESPI AEROSPHERE.....	68
<i>azelaic acid</i>	73	<i>bexarotene</i>	23
<i>azelastine drop 0.05%</i>	67	BEXSERO	62
<i>azelastine spr 0.1%</i>	68	<i>bicalutamide</i>	20
<i>azelastine spr 0.15%</i>	68	BICILLIN L-A	17
<i>azithromycin</i>	16	BIDIL.....	30
AZOPT	67	BIKTARVY	14
<i>aztreonam</i>	10	<i>bisoprolol & hydrochlorothiazide</i>	27
<i>bacitracin (ophthalmic)</i>	66	<i>bisoprolol fumarate</i>	27
<i>bacitracin-polymyxin b (ophth)</i>	66	BIVIGAM	60
<i>bacitracin-poly-neomycin-hc</i>	65	<i>bleomycin sulfate</i>	18
<i>baclofen</i>	43	BLEPHAMIDE	65
<i>balsalazide disodium</i>	56	<i>blisovi fe 1.5/30</i>	48
BALVERSA.....	21	BOOSTRIX.....	62
<i>balziva</i>	48	BORTEZOMIB.....	19
BANZEL SUS 40MG/ML	31	<i>bosentan</i>	30
BANZEL TAB 200MG	31	BOSULIF	21
BANZEL TAB 400MG	31	BRAFTOVI	21
BARACLUDE	15	BREO ELLIPTA	70
BASAGLAR KWIKPEN	44	<i>briellyn</i>	48

BRILINTA	60	<i>calcium acetate (phosphate binder) ...</i>	54
<i>brimonidine sol 0.15%</i>	67	CALQUENCE	21
<i>brimonidine sol 0.2%</i>	67	<i>camila</i>	48
BRIVIACT INJ 50MG/5ML	31	<i>candesartan cilexetil</i>	25
BRIVIACT SOL 10MG/ML	31	<i>candesartan cilexetil-</i>	
BRIVIACT TAB 100MG	31	<i>hydrochlorothiazide</i>	25
BRIVIACT TAB 10MG	31	CAPRELSA	21
BRIVIACT TAB 25MG	31	<i>captopril</i>	24
BRIVIACT TAB 50MG	31	<i>captopril & hydrochlorothiazide</i>	24
BRIVIACT TAB 75MG	31	CARBAGLU	51
<i>bromfenac sodium (ophth)</i>	66	<i>carbamazepine</i>	31
<i>bromocriptine mesylate</i>	36	<i>carbidopa</i>	36
BROMSITE	66	<i>carbidopa/levodopa/entacapone</i>	36
BROVANA	69	<i>carbidopa-levodopa</i>	36
<i>budesonide (inhalation)</i>	70	<i>carboplatin</i>	23
<i>budesonide ec</i>	56	CARIMUNE NANOFILTERED	60
<i>bumetanide</i>	29	<i>carteolol hcl (ophth)</i>	67
<i>buprenorphine hcl</i>	43	<i>cartia xt cap 120/24hr</i>	28
<i>buprenorphine hcl-naloxone hcl</i>		<i>cartia xt cap 180/24hr</i>	28
<i>dihydrate 12-3mg</i>	44	<i>cartia xt cap 240/24hr</i>	28
<i>buprenorphine hcl-naloxone hcl</i>		<i>cartia xt cap 300/24hr</i>	28
<i>dihydrate 2-0.5mg</i>	43	<i>carvedilol</i>	27
<i>buprenorphine hcl-naloxone hcl</i>		<i>caspofungin acetate</i>	11
<i>dihydrate 4-1mg</i>	44	CAYSTON	10
<i>buprenorphine hcl-naloxone hcl</i>		<i>caziant pak</i>	48
<i>dihydrate 8-2mg</i>	44	<i>cefaclor</i>	15
<i>buprenorphine hcl-naloxone hcl sl</i>	44	CEFACTOR MONOHYDRATE ER	15
<i>bupropion hcl</i>	35	<i>cefadroxil</i>	15
<i>bupropion hcl (smoking deterrent)</i>	44	CEFAZOLIN IN DEXTROSE 2GM/100ML-	
<i>bupirone hcl</i>	31	<i>4%</i>	15
<i>butorphanol tartrate</i>	7	<i>cefazolin inj</i>	16
BYDUREON BCISE	44	<i>cefazolin sodium</i>	16
BYDUREON INJ	44	CEFAZOLIN SODIUM 1 GM/50ML	16
BYDUREON PEN	44	<i>cefdinir</i>	16
BYETTA	44	<i>cefepime hcl</i>	16
BYSTOLIC	27	<i>cefixime cap 400mg</i>	16
<i>cabergoline</i>	53	<i>cefixime susr</i>	16
CABOMETYX	21	<i>cefotaxime sodium</i>	16
<i>calcipotriene</i>	71	<i>cefoxitin sodium</i>	16
<i>calcitonin (salmon)</i>	53	<i>cefpodoxime proxetil</i>	16
<i>calcitrene</i>	71	<i>cefprozil</i>	16
<i>calcitriol</i>	65	<i>ceftazidime</i>	16
<i>calcitriol inj</i>	65	CEFTAZIDIME/DEXTROSE	16
<i>calcitriol oral soln 1 mcg/ml</i>	65	<i>ceftriaxone sodium</i>	16

<i>cefuroxime axetil</i>	16	<i>clindamycin cap 75mg</i>	10
<i>cefuroxime sodium</i>	16	<i>clindamycin hcl cap 150 mg</i>	10
<i>celecoxib</i>	7	<i>clindamycin phosphate (topical)</i>	71
CELONTIN	31	<i>clindamycin phosphate in d5w</i>	10
<i>cephalexin</i>	16	CLINDAMYCIN PHOSPHATE IN NAACL..	10
CERDELGA	51	<i>clindamycin phosphate inj</i>	10
CEREZYME	51	<i>clindamycin phosphate vaginal</i>	58
<i>cetirizine syrup</i>	68	<i>clindamycin soln 75mg/5ml</i>	10
<i>cevimeline hcl</i>	74	CLINIMIX 4.25%/DEXTROSE 25%	63
CHANTIX.....	44	CLINIMIX 4.25%/DEXTROSE 5%.....	63
CHANTIX CONTINUING MONTH.....	44	CLINIMIX 5%/DEXTROSE 15%	63
CHANTIX STARTER PACK	44	CLINIMIX 5%/DEXTROSE 20%	63
CHEMET	48	CLINIMIX 5%/DEXTROSE 25%	63
<i>chlorhexidine gluconate (mouth-throat)</i>	74	CLINIMIX INJ 4.25/D10	63
<i>chloroquine phosphate</i>	12	CLINOLIPID	63
<i>chlorothiazide tabs</i>	29	<i>clobazam</i>	31
<i>chlorpromazine hcl</i>	37	<i>clomipramine hcl</i>	35
CHLORPROMAZINE INJ	37	<i>clonazepam</i>	31, 32
<i>chlorthalidone</i>	29	<i>clonidine hcl</i>	30
<i>cholestyramine</i>	26	<i>clonidine hcl ptwk</i>	30
<i>cholestyramine light</i>	26	<i>clopidogrel tab 75mg</i>	60
<i>choline fenofibrate</i>	27	<i>clorazepate dipotassium</i>	32
<i>ciclopirox</i>	71	<i>clotrimazole</i>	74
<i>ciclopirox shampoo 1%</i>	71	<i>clotrimazole (topical)</i>	71
<i>cilostazol</i>	59	<i>clotrimazole w/ betamethasone</i>	71
CILOXAN.....	66	<i>clozapine odt</i>	37
CIMDUO.....	14	<i>clozapine tab 100mg</i>	37
<i>cinacalcet hcl</i>	48	<i>clozapine tab 200mg</i>	38
CIPRO HC.....	74	<i>clozapine tab 25mg</i>	37
CIPRODEX.....	74	<i>clozapine tab 50mg</i>	37
<i>ciprofloxacin</i>	17	COARTEM.....	12
<i>ciprofloxacin hcl (ophth)</i>	66	<i>colchicine w/ probenecid</i>	7
<i>ciprofloxacin hcl tab</i>	17	COLCRYS	7
<i>ciprofloxacin in d5w</i>	17	<i>colesevelam hcl</i>	27
<i>cisplatin</i>	23	<i>colestipol hcl gran</i>	27
<i>citalopram hydrobromide</i>	35	<i>colestipol hcl pack</i>	27
<i>claravis</i>	70	<i>colestipol hcl tabs</i>	27
CLARINEX	68	<i>colistimethate sodium</i>	10
<i>clarithromycin</i>	16	<i>colocort enema 100mg</i>	56
<i>clarithromycin er</i>	16	COMBIGAN.....	67
<i>clarithromycin for susp</i>	16	COMBIVENT RESPIMAT	68
<i>clindacin-p</i>	70	COMETRIQ	21
<i>clindamycin cap 300mg</i>	10	COMPLERA	14
		<i>compro</i>	54

<i>constulose</i>	56	DELZICOL	56
COPIKTRA	21	DEMSEER	30
CORDRAN	72	DEPEN TITRATABS	48
CORLANOR	30	DEPO-PROVERA INJ 400/ML	20
<i>cortisone acetate</i>	52	DESCOVY	14
COTELLIC	22	<i>desipramine hcl</i>	35
COUMADIN	58	<i>desloratadine</i>	68
CREON	57	<i>desmopressin acetate spray</i>	54
CRIXIVAN	12	<i>desmopressin acetate spray refrigerated</i>	54
<i>cromolyn sodium (mastocytosis)</i>	57	<i>desmopressin acetate tabs</i>	54
<i>cromolyn sodium (ophth)</i>	67	<i>desmopressin inj 4mcg/ml</i>	54
<i>cromolyn sodium nebu</i>	69	<i>desogestrel & ethinyl estradiol</i>	49
<i>cryselle-28</i>	48	<i>desogestrel-ethinyl estradiol (biphasic)</i>	49
<i>cyclafem 1/35</i>	48	<i>desvenlafaxine succinate</i>	35
<i>cyclafem 7/7/7</i>	48	<i>dexamethasone</i>	52
<i>cyclobenzaprine hcl</i>	43	DEXAMETHASONE	52
<i>cyclophosphamide</i>	18	<i>dexamethasone sodium phosphate</i>	52
<i>cycloserine</i>	14	<i>dexamethasone sodium phosphate</i> (<i>ophth</i>)	66
<i>cyclosporine</i>	61	DEXILANT	57
<i>cyclosporine modified (for</i> <i>microemulsion)</i>	61	<i>dexmethylphenidate hcl</i>	40
<i>cyproheptadine hcl</i>	68	<i>dexrazoxane hcl</i>	24
<i>cyred tab</i>	48	<i>dextrose 10% flex contain</i>	64
CYSTADANE	52	DEXTROSE 10%/NAACL 0.2%	64
CYSTAGON	52	<i>dextrose 10%/nacl 0.45%</i>	64
CYSTARAN	67	<i>dextrose 2.5%/nacl 0.45%</i>	64
<i>cytarabine</i>	19	<i>dextrose 5%</i>	64
<i>dacarbazine</i>	18	DEXTROSE 5% /ELECTROLYTE	64
<i>dalfampridine</i>	43	<i>dextrose 5%/nacl 0.2%</i>	64
DALIRESP	69	<i>dextrose 5%/nacl 0.225%</i>	64
<i>danazol</i>	51	DEXTROSE 5%/NAACL 0.3%	64
<i>dantrolene sodium</i>	43	<i>dextrose 5%/nacl 0.33%</i>	64
<i>dapsone</i>	10	<i>dextrose 5%/nacl 0.45%</i>	64
DAPTACEL	62	<i>dextrose 5%/nacl 0.9%</i>	64
<i>daptomycin</i>	10	<i>dextrose 5%/potassium chl</i>	64
DAPTOMYCIN	10	<i>dextrose 50%</i>	64
<i>darifenacin hydrobromide</i>	58	<i>dextrose in lactated ringers</i>	64
<i>dasetta 1/35</i>	48	<i>dextrose inj 70%</i>	64
<i>dasetta 7/7/7</i>	48	DIASTAT ACUDIAL	32
DAURISMO	19	DIASTAT PEDIATRIC	32
<i>deblitane</i>	48	<i>diazepam</i>	32
DELESTROGEN	52	<i>diazepam gel</i>	32
DELSTRIGO	14		
<i>delyla</i>	49		

<i>diazepam inj</i>	32	<i>divalproex sodium</i>	32
<i>diazepam intensol</i>	32	<i>docetaxel</i>	19
<i>diazepam oral soln 1 mg/ml</i>	32	DOCETAXEL.....	19
<i>diclofenac potassium</i>	7	<i>dofetilide</i>	26
<i>diclofenac sodium</i>	7	<i>donepezil hydrochloride</i>	34
<i>diclofenac sodium (ophth)</i>	66	<i>dorzolamide hcl</i>	67
<i>diclofenac sodium (topical) 1% gel</i>	73	<i>dorzolamide hcl-timolol maleate</i>	67
<i>diclofenac w/ misoprostol</i>	7	DOVATO	14
<i>dicloxacillin sodium</i>	17	<i>doxazosin mesylate</i>	25
<i>dicyclomine hcl cap 10mg</i>	55	<i>doxepin hcl</i>	35
<i>dicyclomine hcl soln 10mg/5ml</i>	55	<i>doxercalciferol</i>	65
<i>dicyclomine hcl tab 20mg</i>	55	<i>doxorubicin hcl</i>	18
<i>didanosine</i>	12	<i>doxorubicin hcl liposomal</i>	18
DIFICID	16	<i>doxy 100</i>	18
<i>diflunisal</i>	7	<i>doxycycline (monohydrate)</i>	18
<i>digitek</i>	29	<i>doxycycline hyclate</i>	18
<i>digox</i>	29	<i>dronabinol</i>	54
<i>digoxin</i>	29	<i>drospirenone-ethinyl estradiol</i>	49
<i>digoxin inj</i>	29	DROXIA	59
<i>digoxin sol 50mcg/ml</i>	29	<i>duloxetine hcl</i>	35
<i>dihydroergotamine mesylate inj 1</i> <i>mg/ml</i>	41	DUREZOL.....	66
<i>dihydroergotamine mesylate nasal</i>	41	<i>dutasteride</i>	57
DILANTIN CAP 100MG	32	<i>dutasteride-tamsulosin hcl</i>	57
DILANTIN CAP 30MG	32	<i>e.e.s 400</i>	16
DILANTIN CHEW TAB 50MG.....	32	EDARBI.....	25
DILANTIN-125 SUSP.....	32	EDURANT	12
<i>diltiazem cap 180mg cd</i>	28	<i>efavirenz</i>	12
<i>diltiazem cap 240mg cd</i>	28	<i>eletriptan hydrobromide</i>	41
<i>diltiazem cap 360mg cd</i>	28	ELIQUIS.....	58
<i>diltiazem cap er/12hr</i>	28	ELIQUIS STARTER PACK.....	58
<i>diltiazem hcl</i>	28	ELLA.....	49
<i>diltiazem hcl coated beads</i>	28	EMCYT	18
<i>diltiazem hcl coated beads cap sr 24hr</i>	28	EMEND	55
<i>diltiazem hcl extended release beads</i> <i>cap sr</i>	28	EMGALITY	41
<i>diltiazem inj</i>	28	<i>emoquette</i>	49
<i>dilt-xr cap</i>	28	EMSAM	35
<i>diphenhydramine hcl inj 50mg/ml</i>	68	EMTRIVA.....	12
<i>diphenoxylate w/ atropine</i>	57	EMVERM	10
DIPHThERIA/TETANUS TOXOID	62	<i>enalapril maleate</i>	24
<i>disopyramide phosphate</i>	26	<i>enalapril maleate & hydrochlorothiazide</i>	24
<i>disulfiram</i>	44	ENDARI.....	59
		<i>endocet 10-325mg</i>	8
		<i>endocet 2.5-325mg</i>	8

<i>endocet 5-325mg</i>	8	<i>ethosuximide</i>	32
<i>endocet 7.5-325mg</i>	8	<i>ethynodiol diacet & eth estrad</i>	49
ENGERIX-B.....	62	<i>ethynodiol tab 1-50</i>	49
<i>enoxaparin sodium</i>	58	<i>etodolac</i>	7
<i>enpresse-28</i>	49	<i>etodolac er</i>	7
<i>enskyce</i>	49	<i>etoposide</i>	24
ENSTILAR.....	72	EVOTAZ.....	14
<i>entacapone</i>	36	<i>exemestane</i>	20
<i>entecavir</i>	15	<i>ezetimibe</i>	27
ENTRESTO.....	25	<i>ezetimibe-simvastatin</i>	27
<i>enulose</i>	56	FABRAZYME.....	52
EPCLUSA.....	15	<i>falmina</i>	49
EPIDIOLEX.....	32	<i>famciclovir</i>	15
<i>epinephrine (anaphylaxis)</i>	69	<i>famotidine</i>	55
<i>epirubicin hcl</i>	18	<i>famotidine in nacl</i>	55
<i>epitol</i>	32	<i>famotidine inj</i>	55
EPIVIR HBV.....	15	FANAPT.....	38
<i>eplerenone</i>	24	FANAPT TITRATION PACK.....	38
<i>ergotamine w/ caffeine</i>	41	FARXIGA.....	45
ERIVEDGE.....	19	FARYDAK.....	19
ERLEADA.....	20	FASLODEX.....	20
<i>erlotinib hcl</i>	22	<i>febuxostat</i>	7
<i>errin</i>	49	<i>felbamate</i>	32
<i>ertapenem sodium</i>	10	<i>felodipine</i>	28
<i>ery pad 2%</i>	71	<i>femynor</i>	49
<i>ery-tab</i>	16	<i>fenofibrate</i>	27
ERYTHROCIN LACTOBIONATE.....	16	<i>fenofibrate micronized</i>	27
<i>erythrocin stearate</i>	16	<i>fentanyl citrate</i>	8
<i>erythromycin (acne aid)</i>	71	<i>fentanyl patch 100 mcg/hr</i>	8
<i>erythromycin (ophth)</i>	66	<i>fentanyl patch 12 mcg/hr</i>	8
<i>erythromycin base</i>	16	<i>fentanyl patch 25 mcg/hr</i>	8
<i>erythromycin cap 250mg ec</i>	16	<i>fentanyl patch 50 mcg/hr</i>	8
<i>erythromycin ethylsuccinate</i>	16	<i>fentanyl patch 75 mcg/hr</i>	8
<i>erythromycin tab ec</i>	16	FENTORA.....	8
ESBRIET.....	69	FETZIMA.....	35
<i>escitalopram oxalate</i>	35	FETZIMA TITRATION PACK.....	35
<i>esomeprazole magnesium</i>	57	FIASP.....	45
<i>esomeprazole sodium inj</i>	57	FIASP FLEXTOUCH.....	45
<i>estarylla tab 0.25-35</i>	49	FINACEA.....	73
<i>estradiol</i>	52	<i>finasteride</i>	57
<i>estradiol vaginal cream</i>	52	FIRAZYR.....	59
<i>estradiol vaginal tab</i>	52	<i>flac</i>	74
<i>estradiol valerate</i>	52	FLEBOGAMMA DIF.....	60
<i>ethambutol hcl</i>	14	<i>flecainide acetate</i>	26

FLOVENT DISKUS.....	70	<i>fyavolv</i>	52
FLOVENT HFA	70	FYCOMPA	32
<i>fluconazole</i>	11	<i>gabapentin</i>	32, 33
<i>fluconazole inj nacl 200</i>	11	<i>galantamine hydrobromide</i>	34
<i>fluconazole inj nacl 400</i>	11	<i>galantamine hydrobromide er</i>	34
<i>flucytosine</i>	11	GAMASTAN S/D	60
<i>fludrocortisone acetate</i>	52	GAMMAGARD LIQUID.....	61
<i>flunisolide (nasal)</i>	70	GAMMAGARD S/D	61
<i>fluocinolone acetonide</i>	72	GAMMAKED	61
<i>fluocinolone acetonide (otic)</i>	74	GAMMAPLEX	61
<i>fluocinolone acetonide oil body</i>	72	GAMMAPLEX 10GM/100ML.....	61
<i>fluocinonide</i>	72	GAMUNEX-C	61
<i>fluocinonide emulsified base</i>	72	<i>ganciclovir sodium</i>	15
<i>fluorometholone</i>	66	GARDASIL 9	62
<i>fluorouracil</i>	19	<i>gatifloxacin (ophth)</i>	66
<i>fluorouracil (topical)</i>	73	GATTEX	57
<i>fluoxetine cap 10mg</i>	35	GAUZE PADS 2	45
<i>fluoxetine cap 20mg</i>	35	<i>gavilyte-c</i>	56
<i>fluoxetine cap 40mg</i>	35	<i>gavilyte-g</i>	56
<i>fluoxetine hcl</i>	35	<i>gavilyte-n/flavor pack</i>	56
<i>fluphenazine decanoate</i>	38	<i>gemcitabine inj soln</i>	19
<i>fluphenazine hcl</i>	38	<i>gemcitabine inj solr</i>	19
<i>flurbiprofen</i>	7	<i>gemfibrozil</i>	27
<i>flurbiprofen sodium</i>	66	<i>generlac</i>	56
<i>flutamide</i>	20	<i>gengraf</i>	61
<i>fluticasone propionate</i>	72	GENOTROPIN.....	53
<i>fluticasone propionate (nasal)</i>	70	GENOTROPIN MINIQUICK.....	53
<i>fluvastatin sodium</i>	26	<i>gentak</i>	66
<i>fluvoxamine maleate</i>	31	<i>gentamicin in saline</i>	10
<i>fondaparinux sodium</i>	58	<i>gentamicin sulfate</i>	10
FORTEO	53	<i>gentamicin sulfate (topical)</i>	71
FOSAMAX PLUS D.....	47	<i>gentamicin sulfate soln (ophth)</i>	66
<i>fosamprenavir tab 700 mg</i>	12	GENVOYA.....	14
<i>fosinopril sodium</i>	24	GEODON	38
<i>fosinopril sodium & hydrochlorothiazide</i>	24	<i>gianvi</i>	49
FRAGMIN	58	GILENYA CAP 0.5MG.....	43
FREAMINE HBC 6.9%.....	63	GILOTRIF TAB 20MG.....	22
FREAMINE III.....	63	GILOTRIF TAB 30MG.....	22
<i>frovatriptan succinate</i>	41	GILOTRIF TAB 40MG.....	22
<i>fulvestrant</i>	20	<i>glatiramer acetate 20mg/ml</i>	43
<i>furosemide</i>	29	<i>glatiramer acetate 40mg/ml</i>	43
<i>furosemide inj</i>	29	<i>glatopa</i>	43
FUZEON	12	GLEOSTINE	18
		<i>glimepiride</i>	45

<i>glip/metform tab 2.5-250mg</i>	46	HUMIRA PEN.....	60
<i>glip/metform tab 2.5-500mg</i>	46	HUMIRA PEN CD/UC/HS STARTER	60
<i>glip/metform tab 5-500mg</i>	46	HUMIRA PEN INJ CD/UC/HS STARTER.....	60
<i>glipizide</i>	46	HUMIRA PEN INJ PS/UV STARTER.....	60
<i>glipizide xl</i>	46	HUMIRA PEN-PS/UV STARTER.....	60
GLUCAGEN HYPOKIT.....	53	HUMULIN R INJ U-500	45
GLUCAGON EMERGENCY KIT	53	HUMULIN R U-500 KWIKPEN	45
<i>glycopyrrolate tab 1mg</i>	55	<i>hydralazine hcl</i>	30
<i>glycopyrrolate tab 2mg</i>	55	<i>hydrochlorothiazide</i>	29
<i>glydo</i>	73	<i>hydroco/apap tab 10-325mg</i>	8
GOLYTELY	56	<i>hydroco/apap tab 5-325mg</i>	8
GRALISE	42	<i>hydroco/apap tab 7.5-325</i>	8
GRALISE STARTER	42	<i>hydrocodone-acetaminophen 7.5-325</i>	
<i>granisetron hcl</i>	55	<i>mg/15ml</i>	8
GRANIX	59	<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	
<i>griseofulvin microsize</i>	12	8
<i>griseofulvin ultramicrosize</i>	12	<i>hydrocortisone</i>	52
<i>guanfacine er (adhd)</i>	40	<i>hydrocortisone (enema)</i>	56
HAEGARDA.....	59	<i>hydrocortisone (topical)</i>	72
<i>halobetasol propionate</i>	72	<i>hydrocortisone butyrate cream 0.1%</i>	72
<i>haloperidol</i>	38	<i>hydrocortisone butyrate oint 0.1%</i>	72
<i>haloperidol conc 2mg/ml</i>	38	<i>hydrocortisone valerate</i>	72
<i>haloperidol decanoate</i>	38	<i>hydromorphone hcl</i>	8
<i>haloperidol lactate inj 5mg/ml</i>	38	<i>hydroxychloroquine sulfate</i>	60
HARVONI	15	<i>hydroxyurea</i>	23
HAVRIX.....	62	<i>hydroxyzine hcl</i>	68
<i>heather</i>	49	<i>hydroxyzine hcl inj</i>	68
<i>heparin sod (porcine) in d5w</i>	58	<i>hydroxyzine pamoate</i>	68
<i>heparin sod inj 1000/ml</i>	58	HYSINGLA ER	8
<i>heparin sod inj 10000/ml</i>	58	<i>ibandronate sodium</i>	47
<i>heparin sod inj 20000/ml</i>	59	IBRANCE.....	19
<i>heparin sod inj 5000/ml</i>	58	<i>ibu tab 600mg</i>	7
HEPARIN SODIUM/NACL 0.45%	59	<i>ibu tab 800mg</i>	7
<i>hepatamine</i>	63	<i>ibuprofen</i>	7
HERCEPTIN	19	<i>icatibant acetate</i>	59
HERCEPTIN HYLECTA	19	ICLUSIG.....	22
HETLIOZ	41	IDHIFA	19
HIBERIX.....	62	IFEX INJ 3GM	18
HUMIRA	60	<i>ifosfamide inj 1gm/20ml</i>	18
HUMIRA INJ 10MG/0.2ML.....	60	IFOSFAMIDE INJ 3GM	18
HUMIRA KIT 20MG/0.4ML.....	60	<i>ifosfamide inj 3gm/60ml</i>	18
HUMIRA KIT 40MG/0.8ML.....	60	ILEVRO	66
HUMIRA PEDIATRIC CROHNS DISEASE		<i>imatinib mesylate</i>	22
.....	60	IMBRUVICA	22

<i>imipenem-cilastatin</i>	10	<i>isoniazid syp 50mg/5ml</i>	14
<i>imipramine hcl</i>	35	ISORDIL TITRADOSE	30
<i>imiquimod</i>	73	<i>isosorb mononitrate tab</i>	30
IMOVAX RABIES (H.D.C.V.)	62	<i>isosorbide dinitrate</i>	30
<i>incassia</i>	49	<i>isosorbide dinitrate er</i>	30
INCRELEX	53	<i>isosorbide mononitrate er</i>	30
INCRUSE ELLIPTA	68	<i>isotretinoin</i>	71
<i>indapamide</i>	29	<i>isradipine</i>	28
INFANRIX	62	<i>itraconazole</i>	12
INLYTA	22	<i>ivermectin</i>	10
INREBIC	22	IXIARO	62
INSULIN PEN NEEDLE	45	JADENU	48
INSULIN SAFETY NEEDLES	45	JADENU SPRINKLE	48
INSULIN SYRINGE	45	JAKAFI	22
INTELENCE	12	<i>jantoven</i>	59
INTRALIPID 30%	63	JANUMET	46
INTRALIPID INJ 20%	64	JANUMET XR TAB 100-1000	46
INTRON-A INJ 10MU	61	JANUMET XR TAB 50-1000	46
INTRON-A INJ 18MU	61	JANUMET XR TAB 50-500MG	46
INTRON-A INJ 25MU	61	JANUVIA	46
INTRON-A INJ 50MU	61	JARDIANCE	46
<i>introvale</i>	49	<i>jasmiel</i>	49
INVEGA SUST INJ 117 MG/0.75 ML ...	38	JENTADUETO	46
INVEGA SUST INJ 156MG/ML	38	JENTADUETO TAB XR 2.5-1000 MG ...	46
INVEGA SUST INJ 234 MG/1.5 ML	38	JENTADUETO TAB XR 5-1000 MG	46
INVEGA SUST INJ 39 MG/0.25 ML	38	<i>jinteli</i>	52
INVEGA SUST INJ 78 MG/0.5 ML	38	<i>jolessa tab 0.15-0.03 mg</i>	49
INVEGA TRINZA	38	<i>jolivette</i>	49
INVIRASE	12	<i>juleber</i>	49
IONOSOL-MB/DEXTROSE 5%	64	JULUCA	14
IPOL INACTIVATED IPV	62	<i>junel 1.5/30</i>	49
<i>ipratropium bromide</i>	68	<i>junel 1/20</i>	49
<i>ipratropium bromide (nasal)</i>	68	<i>junel fe 1.5/30</i>	49
<i>ipratropium-albuterol nebu</i>	68	<i>junel fe 1/20</i>	49
<i>irbesartan</i>	25	JUXTAPID	27
<i>irbesartan-hydrochlorothiazide</i>	25	KADCYLA	19
IRESSA	22	KALETRA TAB 100-25MG	14
<i>irinotecan hcl</i>	24	KALETRA TAB 200-50MG	14
ISENTRESS	12, 13	KALYDECO	69
ISENTRESS HD	13	<i>kariva</i>	49
<i>isibloom</i>	49	<i>kcl 0.075%/d5w/nacl 0.45%</i>	64
ISOLYTE P	64	KCL 0.15%/D5W/NAACL 0.225%	64
ISOLYTE S	64	<i>kcl 0.15%/d5w/nacl 0.9%</i>	64
<i>isoniazid</i>	14	<i>kcl 0.3%/d5w/nacl 0.45%</i>	64

KCL 0.3%/D5W/NAACL 0.9%	64	larin 1/20	49
kcl/d5w inj 0.3%	64	larin fe 1.5/30	49
kcl/d5w/nacl inj .15/.33%	64	larin fe 1/20	49
kcl/d5w/nacl inj .15/.45%	64	larissia tab	49
kcl/d5w/nacl inj 0.22%/0.45%	64	LASTACAFIT	67
kcl/nacl inj 0.15%-0.9%	65	latanoprost	67
kcl/nacl inj 0.3-0.9	64	LATUDA	38
kcl0.15%/d5w/nacl0.2%	64	leena	49
kelnor 1/35	49	leflunomide	60
kelnor 1/50	49	LENVIMA 10 MG DAILY DOSE	22
ketoconazole	12	LENVIMA 12MG DAILY DOSE	22
ketoconazole cream	71	LENVIMA 14 MG DAILY DOSE	22
ketoconazole shampoo	72	LENVIMA 18 MG DAILY DOSE	22
ketorolac tromethamine (ophth)	66	LENVIMA 20 MG DAILY DOSE	22
KEYTRUDA	19, 20	LENVIMA 24 MG DAILY DOSE	22
KINRIX	62	LENVIMA 4 MG DAILY DOSE	22
kionex sus 15gm/60ml	48	LENVIMA 8 MG DAILY DOSE	22
KISQALI	20	lessina	49
KISQALI FEMARA 200 DOSE	20	letrozole	20
KISQALI FEMARA 400 DOSE	20	leucovorin calcium	24
KISQALI FEMARA 600 DOSE	20	leucovorin calcium solr	24
klor-con 10	62	LEUKERAN	18
klor-con 8	62	leuprolide inj 1mg/0.2	20
klor-con m10	63	levalbuterol hcl	69
klor-con m15	63	levalbuterol hcl soln nebu conc 1.25 mg/0.5ml	69
klor-con m20	63	levalbuterol tartrate hfa	69
klor-con pak 20meq	63	LEVEMIR	45
klor-con spr cap 10meq	63	LEVEMIR FLEXTOUCH	45
klor-con spr cap 8meq	63	levetiracetam	33
KORLYM	53	levetiracetam in sodium chloride	33
KRISTALOSE	56	levetiracetam oral soln 100 mg/ml	33
kurvelo	49	levobunolol hcl	67
KUVAN	52	levocarnitine (metabolic modifiers)	52
KYNAMRO	27	levocetirizine dihydrochloride	68
labetalol hcl	27	levofloxacin	17
lactated ringer's	65	levofloxacin in d5w	17
lactulose	56	levofloxacin inj 25mg/ml	17
lactulose (encephalopathy)	56	levofloxacin oral soln 25 mg/ml	17
lamivudine	13	levonest	49
lamivudine (hbv)	15	levonor/ethi tab	49
lamivudine-zidovudine	14	levonorgestrel & eth estradiol	50
lamotrigine	33	levonorgestrel-ethinyl estradiol (91- day)	50
lansoprazole	57		
larin 1.5/30	49		

<i>levora 0.15/30-28</i>	50	<i>loxapine succinate</i>	38
<i>levo-t</i>	54	LUMIGAN	67
<i>levothyroxine sodium</i>	54	LUMIZYME.....	52
<i>levoxyl</i>	54	LUPRON DEPOT (1-MONTH).....	20
LEXIVA	13	LUPRON DEPOT INJ 11.25MG (3-	
<i>lidocaine</i>	73	MONTH).....	20
<i>lidocaine hcl</i>	73	LUPRON DEPOT-PED (1-MONTH	53
<i>lidocaine hcl (local anesth.)</i>	9	LUPRON DEPOT-PED (3-MONTH	53
<i>lidocaine hcl (mouth-throat)</i>	74	LUPRON DEP-PED INJ 11.25MG (3-	
<i>lidocaine inj 0.5%</i>	9	MONTH).....	53
<i>lidocaine inj 1%</i>	9	LUPRON DEP-PED INJ 7.5MG	53
<i>lidocaine inj 1.5% preservative free (pf)</i>		<i>lutera</i>	50
.....	9	LYNPARZA	20
<i>lidocaine oint 5%</i>	73	LYRICA	33
<i>lidocaine-prilocaine</i>	73	LYRICA CR	42
<i>linezolid in sodium chloride</i>	10	LYSODREN	20
<i>linezolid inj</i>	10	<i>lyza</i>	50
<i>linezolid susp</i>	10	<i>magnesium sulfate</i>	63
<i>linezolid tab 600mg</i>	11	MAGNESIUM SULFATE	63
LINZESS	57	MAGNESIUM SULFATE IN D5W.....	63
<i>liothyronine sodium</i>	54	<i>magnesium sulfate in dextrose</i>	63
<i>lisinopril</i>	24	<i>magnesium sulfate inj 50%</i>	63
<i>lisinopril & hydrochlorothiazide</i>	24	<i>malathion</i>	74
<i>lithium carbonate</i>	42	<i>maprotiline hcl</i>	35
<i>lithium carbonate er</i>	42	<i>marlissa</i>	50
LITHIUM SOLN 8MEQ/5ML.....	42	MARPLAN TAB 10MG.....	35
LIVALO	26	MATULANE	23
LOKELMA	48	<i>matzim la</i>	28
LONSURF	23	MAVYRET	15
<i>loperamide hcl</i>	57	<i>meclizine hcl</i>	55
<i>lopinavir-ritonavir</i>	14	<i>medroxyprogesterone acetate</i>	
<i>lorazepam</i>	31	(contraceptive)	50
<i>lorazepam intensol</i>	31	<i>medroxyprogesterone acetate tab</i>	54
LORBRENA	22	<i>mefloquine hcl</i>	12
<i>lorcet hd tab 10-325mg</i>	8	<i>megestrol ac sus 40mg/ml</i>	20
<i>lorcet plus tab 7.5-325</i>	8	<i>megestrol ac tab 20mg</i>	20
<i>lorcet tab 5-325mg</i>	8	<i>megestrol ac tab 40mg</i>	20
<i>loryna</i>	50	<i>megestrol sus 625mg/5ml</i>	21
<i>losartan potassium</i>	25	MEKINIST	22
<i>losartan-hydrochlorothiazide</i>	25	MEKTOVI.....	22
LOTEMAX	66	<i>meloxicam</i>	7
<i>loteprednol etabonate</i>	66	<i>memantine hcl cp24</i>	34
<i>lovastatin</i>	26	<i>memantine soln</i>	34
<i>low-ogestrel</i>	50	<i>memantine tabs</i>	34

MENACTRA	62	<i>mexiletine hcl</i>	26
MENVEO	62	<i>microgestin 1.5/30</i>	50
<i>mercaptopurine</i>	19	<i>microgestin 1/20</i>	50
<i>meropenem</i>	11	<i>microgestin fe 1.5/30</i>	50
<i>mesalamine</i>	56	<i>microgestin fe 1/20</i>	50
<i>mesalamine w/ cleanser</i>	56	<i>midodrine hcl</i>	30
MESNEX	24	<i>miglustat</i>	52
<i>metadate er tab 20mg</i>	40	<i>mili</i>	50
<i>metformin er</i>	46	<i>minitran</i>	30
<i>metformin hcl</i>	46, 47	<i>minocycline hcl</i>	18
<i>methadone hcl</i>	8	<i>minoxidil</i>	30
<i>methadone hcl 10mg</i>	9	<i>mirtazapine</i>	35
<i>methadone hcl 5mg</i>	9	<i>misoprostol</i>	57
<i>methadone hcl intensol</i>	9	MITIGARE	7
<i>methazolamide</i>	29	<i>mitomycin</i>	18
<i>methenamine hippurate</i>	11	M-M-R II	62
<i>methimazole</i>	54	M-NATAL PLUS	65
<i>methotrexate sodium inj</i>	19	<i>modafinil</i>	43
<i>methotrexate sodium tabs</i>	60	<i>moexipril hcl</i>	24
<i>methyclothiazide</i>	29	<i>molindone hcl</i>	38
<i>methylphenidate hcl</i>	40, 41	<i>mometasone furoate</i>	72
<i>methylphenidate hcl oral soln</i>	41	<i>mondoxyne nl cap 100mg</i>	18
<i>methylphenidate tab 10mg er</i>	41	<i>mono-lynyah tab 0.25-35</i>	50
<i>methylphenidate tab 20mg er</i>	41	<i>montelukast sodium</i>	69
<i>methylpr ss inj</i>	52	<i>morgidox cap 1x50mg</i>	18
<i>methylpred pak 4mg</i>	52	<i>morphine ext-rel tab</i>	9
<i>methylpred tab 16mg</i>	52	<i>morphine sul inj 10mg/ml</i>	9
<i>methylpred tab 32mg</i>	52	<i>morphine sul inj 1mg/ml</i>	9
<i>methylpred tab 4mg</i>	52	<i>morphine sulfate</i>	9
<i>methylpred tab 8mg</i>	52	MORPHINE SULFATE	9
<i>methylprednisolone acetate</i>	52	<i>morphine sulfate oral soln 100mg/5ml</i>	9
<i>metoclopramide hcl</i>	55	<i>morphine sulfate oral soln 10mg/5ml</i>	9
<i>metoclopramide hcl inj</i>	55	<i>morphine sulfate oral soln 20mg/5ml</i>	9
<i>metolazone</i>	29	MOVANTIK	57
<i>metoprolol & hctz tab 100-25mg</i>	27	MOVIPREP	56
<i>metoprolol & hctz tab 100-50mg</i>	27	MOXEZA	66
<i>metoprolol & hctz tab 50-25mg</i>	27	<i>moxifloxacin hcl</i>	17
<i>metoprolol succinate</i>	27	MOXIFLOXACIN HCL	17
<i>metoprolol tartrate</i>	27, 28	<i>moxifloxacin hcl (ophth)</i>	66
<i>metronidazole</i>	11	<i>moxifloxacin hcl in sodium chloride</i>	17
<i>metronidazole (topical)</i>	73	MULTAQ	26
<i>metronidazole gel 0.75%</i>	73	<i>mupirocin</i>	71
<i>metronidazole in nacl</i>	11	MYCAMINE	12
<i>metronidazole vaginal</i>	58	<i>mycophenolate mofetil</i>	61

<i>mycophenolate sodium tbec</i>	61	<i>nicardipine hcl</i>	28
MYLOTARG	20	NICOTROL INHALER	44
<i>myorisan</i>	71	NICOTROL NS	44
MYRBETRIQ	58	<i>nifedipine</i>	28
<i>myzilra</i>	50	<i>nifedipine er</i>	28
<i>nabumetone</i>	7	<i>nikki</i>	50
<i>nadolol</i>	28	<i>nilutamide</i>	21
<i>nafcillin sodium</i>	17	<i>nimodipine</i>	28
NAFCILLIN SODIUM FOR INJ 10GM....	17	NINLARO.....	20
NAGLAZYME	52	<i>nisoldipine</i>	28
<i>nalbuphine hcl</i>	8	NITRO-BID	30
<i>naloxone inj 0.4mg/ml</i>	44	NITRO-DUR DIS 0.3MG/HR.....	30
<i>naloxone inj 1mg/ml</i>	44	NITRO-DUR DIS 0.8MG/HR.....	30
<i>naltrexone hcl</i>	44	<i>nitrofurantoin macrocrystal</i>	11
NAMZARIC	34	<i>nitrofurantoin monohyd macro</i>	11
<i>naproxen</i>	7	<i>nitroglycerin</i>	30
<i>naproxen dr</i>	7	<i>nitroglycerin td patch</i>	30
<i>naproxen sodium</i>	7	NITYR	52
<i>naratriptan hcl</i>	42	<i>nora-be tab</i>	50
NARCAN.....	44	<i>norethindrone (contraceptive)</i>	50
NATACYN	66	<i>norethindrone acet & eth estra</i>	50
<i>nateglinide</i>	47	<i>norethindrone acetate</i>	54
NATPARA	53	<i>norethindrone acetate-ethinyl estradiol</i>	52
NEBUPENT.....	11	<i>norgest/ethi tab 0.25/35</i>	50
<i>necon 0.5/35-28</i>	50	<i>norgestimate-ethinyl estradiol</i> (triphasic) 0.18-25/0.215-25/0.25-25 mg-mcg	50
<i>necon 7/7/7</i>	50	<i>norgestimate-ethinyl estradiol</i> (triphasic) 0.18-35/0.215-35/0.25-35 mg-mcg	50
<i>nefazodone hcl</i>	35	NORITATE	73
<i>neomycin sulfate</i>	10	<i>norlyroc</i>	50
<i>neomycin-bacitracin zn-polymyxin</i>	66	NORMOSOL-M IN D5W.....	65
<i>neomycin-polymy-dexameth</i>	65	NORMOSOL-R.....	65
<i>neomycin-polymyxin-gramicidin</i>	66	NORMOSOL-R IN D5W	65
<i>neomycin-polymyxin-hc (ophth)</i>	65	NORPACE CR	26
<i>neomycin-polymyxin-hc (otic)</i>	74	NORTHERA.....	30
NEPHRAMINE.....	64	<i>nortrel 0.5/35 (28)</i>	50
NERLYNX.....	22	<i>nortrel 1/35</i>	50
NEUPOGEN	59	<i>nortrel 7/7/7</i>	50
NEUPRO	36	<i>nortriptyline hcl</i>	35
<i>nevirapine susp 50 mg/5ml</i>	13	NORVIR PACK.....	13
<i>nevirapine tab 100mg er</i>	13	NORVIR SOLN.....	13
<i>nevirapine tab 200mg</i>	13		
<i>nevirapine tab 400mg er</i>	13		
NEXAVAR	22		
<i>niacin er (antihyperlipidemic)</i>	27		
<i>niacor</i>	27		

NOVOLIN 70/30	45	<i>omeprazole cap 10mg</i>	57
NOVOLIN 70/30 FLEXPEN.....	45	<i>omeprazole cap 20mg</i>	57
NOVOLIN N	45	<i>omeprazole cap 40mg</i>	57
NOVOLIN R	45	OMNARIS	70
NOVOLOG	45	<i>ondansetron hcl</i>	55
NOVOLOG 70/30 FLEXPEN.....	45	<i>ondansetron hcl inj</i>	55
NOVOLOG FLEXPEN	45	<i>ondansetron hcl oral soln</i>	55
NOVOLOG MIX 70/30.....	45	<i>ondansetron odt</i>	55
NOVOLOG PENFILL	45	OPSUMIT	30
NOXAFIL	12	ORFADIN.....	52
NUBEQA.....	21	ORKAMBI	69
NUCYNTA ER	9	<i>orsythia</i>	50
NUDEXTA	42	<i>oseltamivir phosphate</i>	15
NULOJIX	61	<i>oxacillin sodium</i>	17
NULYTELY/FLAVOR PACKS.....	56	<i>oxaliplatin inj 100mg</i>	23
NUPLAZID CAPS.....	38	<i>oxaliplatin inj 100mg/20ml</i>	23
NUPLAZID TABS 10MG.....	38	<i>oxaliplatin inj 50mg</i>	23
NUPLAZID TABS 17MG.....	38	<i>oxaliplatin inj 50mg/10ml</i>	23
NUTRILIPID INJ 20%.....	64	<i>oxandrolone</i>	44
NUVARING	50	<i>oxaprozin</i>	7
<i>nyamyc</i>	71	<i>oxcarbazepine</i>	33
NYMALIZE	28	<i>oxybutynin chloride</i>	58
<i>nystatin</i>	12	<i>oxycodone hcl</i>	9
<i>nystatin (mouth-throat)</i>	74	<i>oxycodone w/ acetaminophen 10-</i>	
<i>nystatin (topical)</i>	71	<i>325mg</i>	9
<i>nystatin pow 100000</i>	71	<i>oxycodone w/ acetaminophen 2.5-</i>	
<i>nystop</i>	71	<i>325mg</i>	9
<i>ocella tab 3-0.03mg</i>	50	<i>oxycodone w/ acetaminophen 5-325mg</i>	
OCTAGAM	61	9
<i>octreotide acetate</i>	53	<i>oxycodone w/ acetaminophen 7.5-</i>	
ODEFSEY	14	<i>325mg</i>	9
ODOMZO.....	20	OXYTROL	58
OFEV	69	OZEMPIC INJ 0.25 OR 0.5MG/DOSE ..	45
<i>ofloxacin (ophth)</i>	66	OZEMPIC INJ 1MG/DOSE.....	45
<i>ofloxacin (otic)</i>	74	<i>pacerone</i>	26
<i>olanzapine</i>	38	<i>paclitaxel</i>	19
<i>olmesartan medoxomil</i>	25	<i>paliperidone</i>	38
<i>olmesartan medoxomil-amlodipine-</i>		<i>pamidronate disodium</i>	47
<i>hydrochlorothiazide</i>	25	PAMIDRONATE DISODIUM.....	47
<i>olmesartan medoxomil-</i>		<i>pamidronate inj 30mg</i>	47
<i>hydrochlorothiazide</i>	25	<i>pamidronate inj 90mg</i>	47
<i>olopatadine hcl (nasal)</i>	68	PANRETIN	73
<i>olopatadine hcl 0.1%</i>	67	<i>pantoprazole sodium</i>	57
<i>olopatadine hcl 0.2%</i>	67	<i>pantoprazole sodium tbec</i>	57

PANZYGA	61	PHENYTEK	33
<i>paricalcitol</i>	65	<i>phenytoin</i>	33
<i>paroex sol 0.12%</i>	74	<i>phenytoin sodium extended</i>	33
<i>paromomycin sulfate</i>	10	<i>phenytoin sodium inj 50mg/ml</i>	33
<i>paroxetine er tab</i>	35	<i>philith</i>	50
<i>paroxetine hcl tabs</i>	36	PHOSPHOLINE IODIDE.....	67
PASER D/R	14	PICATO	73
PAXIL	36	PIFELTRO	13
PAZEO	67	<i>pilocarpine hcl</i>	67
PEDIARIX.....	62	<i>pilocarpine hcl (oral)</i>	74
PEDVAX HIB	62	<i>pimozide</i>	39
<i>peg 3350/electrolytes</i>	56	<i>pimtrea</i>	50
<i>peg 3350-kcl-sod bicarb-sod chloride-</i> <i>sod sulfate</i>	56	<i>pindolol</i>	28
<i>peg 3350-potassium chloride-sod</i> <i>bicarbonate-sod chloride</i>	56	<i>pioglitazone hcl</i>	47
PEGANONE	33	<i>piper/tazoba inj 12-1.5gm</i>	18
PEGASYS.....	15	<i>piper/tazoba inj 2-0.25gm</i>	18
PEGASYS PROCLICK	15	<i>piper/tazoba inj 3-0.375gm</i>	18
PENICILLIN G POT IN DEXTROSE 2MU	17	<i>piper/tazoba inj 36-4.5gm</i>	18
PENICILLIN G POT IN DEXTROSE 3MU	17	<i>piper/tazoba inj 4-0.5gm</i>	18
PENICILLIN G PROCAINE.....	17	PIQRAY 200MG DAILY DOSE.....	22
<i>penicillin g sodium</i>	17	PIQRAY 250MG DAILY DOSE.....	22
<i>penicillin v potassium</i>	17	PIQRAY 300MG DAILY DOSE.....	22
<i>penicillin gk inj 20mu</i>	17	<i>pirmella 1/35</i>	50
<i>penicillin gk inj 5mu</i>	17	<i>piroxicam</i>	7
PENTACEL	62	PLASMA-LYTE A	65
PENTAM 300.....	11	PLASMA-LYTE-148.....	65
<i>pentamidine isethionate</i>	11	PNV FOLIC ACID + IRON MUL.....	65
<i>pentoxifylline</i>	59	<i>podofilox</i>	73
PERFOROMIST	69	<i>polymyxin b-trimethoprim</i>	66
<i>perindopril erbumine</i>	24	POMALYST CAP 1MG.....	21
<i>perio gard</i>	74	POMALYST CAP 2MG.....	21
<i>permethrin cre 5%</i>	74	POMALYST CAP 3MG.....	21
<i>perphenazine</i>	39	POMALYST CAP 4MG.....	21
PERSERIS	39	<i>portia-28</i>	50
<i>pfizerpen-g inj 20mu</i>	18	<i>posaconazole</i>	12
<i>pfizerpen-g inj 5mu</i>	17	<i>pot chloride inj 2meq/ml</i>	65
<i>phenelzine sulfate</i>	36	<i>potassium chloride</i>	63, 65
<i>phenobarbital</i>	33	<i>potassium chloride in nacl</i>	65
<i>phenobarbital sodium</i>	33	<i>potassium chloride microencapsulated</i> <i>crystals er</i>	63
PHENOBARBITAL SODIUM	33	<i>potassium chloride tab cr 10 meq</i>	63
		<i>potassium citrate (alkalinizer) er tabs</i>	58
		PRADAXA	59
		PRALUENT	27

<i>pramipexole dihydrochloride</i>	36	<i>probenecid</i>	7
<i>pramipexole tab 0.125mg</i>	37	PROCALAMINE	64
<i>pramipexole tab 0.25mg</i>	37	<i>prochlorperazine inj</i>	55
<i>pramipexole tab 0.5mg</i>	37	<i>prochlorperazine maleate</i>	55
<i>pramipexole tab 0.75mg</i>	37	<i>prochlorperazine supp</i>	55
<i>pramipexole tab 1.5mg</i>	37	PROCRIT	59
<i>pramipexole tab 1mg</i>	37	<i>procto-med hc</i>	73
<i>prasugrel hcl</i>	60	<i>procto-pak</i>	73
<i>pravastatin sodium</i>	26	<i>proctosol hc cre 2.5%</i>	73
<i>praziquantel</i>	11	<i>proctozone-hc</i>	73
<i>prazosin hcl</i>	25	PROGLYCEM SUS 50MG/ML	53
<i>pred sod pho sol 5mg/5ml</i>	52	PROGRAF	61
<i>prednisolone acetate (ophth)</i>	66	PROLASTIN-C	69
<i>prednisolone sodium phosphate</i>	52	PROLENSA.....	66
PREDNISOLONE SODIUM PHOSPHATE		PROLIA	53
(OPHTH)	66	PROMACTA	59
<i>prednisolone sol 15mg/5ml</i>	53	<i>promethazine hcl</i>	55
<i>prednisolone sol 25mg/5ml</i>	53	<i>promethazine hcl inj</i>	55
PREDNISON CON 5MG/ML	53	<i>propafenone hcl</i>	26
<i>prednisone pak 10mg</i>	53	<i>propafenone hcl 12hr</i>	26
<i>prednisone pak 5mg</i>	53	<i>proparacaine hcl</i>	67
<i>prednisone sol 5mg/5ml</i>	53	<i>propranolol & hydrochlorothiazide</i>	27
<i>prednisone tab 10mg</i>	53	<i>propranolol cap er</i>	28
<i>prednisone tab 1mg</i>	53	<i>propranolol hcl</i>	28
<i>prednisone tab 2.5mg</i>	53	<i>propranolol oral sol</i>	28
<i>prednisone tab 20mg</i>	53	<i>propylthiouracil</i>	54
<i>prednisone tab 50mg</i>	53	PROQUAD	62
<i>prednisone tab 5mg</i>	53	PROSOL	64
<i>pregabalin</i>	33	<i>protriptyline hcl</i>	36
PREMASOL SOL 10%	64	PULMICORT FLEXHALER	70
<i>premasol sol 6%</i>	64	PULMOZYME	69
PRENATAL	65	PURIXAN	19
PRENATAL PLUS	65	<i>pyrazinamide</i>	14
PRENATAL PLUS LOW IRON	65	<i>pyridostigmine tab 60mg</i>	42
<i>prevalite</i>	27	QUADRACEL	62
<i>previfem</i>	50	<i>quasense</i>	51
PREZCOBIX	14	<i>quetiapine fumarate</i>	39
PREZISTA.....	13	<i>quinapril hcl</i>	24
PRIFTIN	14	<i>quinapril-hydrochlorothiazide</i>	24
PRILOSEC	57	<i>quinidine gluconate</i>	26
<i>primaquine phosphate</i>	12	<i>quinidine sulfate</i>	26
PRIMAQUINE PHOSPHATE	12	<i>quinine sulfate</i>	12
<i>primidone</i>	33	RABAVERT.....	62
PRIVIGEN.....	61	<i>rabeprazole sodium</i>	57

<i>raloxifene hcl</i>	53	<i>rivastigmine tartrate</i>	34
<i>ramipril</i>	24	<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	34
<i>ranitidine hcl</i>	55	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	34
<i>ranitidine hcl inj</i>	55	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	34
<i>ranitidine inj</i>	55	<i>rizatRIPTAN benzoate</i>	42
<i>ranitidine syrup</i>	56	<i>rizatRIPTAN benzoate odt</i>	42
<i>ranolazine</i>	30	<i>ropinirole hydrochloride</i>	37
RAPAMUNE.....	61	<i>ropinirole tab 0.25mg</i>	37
<i>rasagiline mesylate</i>	37	<i>ropinirole tab 0.5mg</i>	37
RAYALDEE.....	65	<i>ropinirole tab 1mg</i>	37
REBETOL SOLN.....	15	<i>ropinirole tab 2mg</i>	37
<i>reclipsen</i>	51	<i>ropinirole tab 3mg</i>	37
RECOMBIVAX HB.....	62	<i>ropinirole tab 4mg</i>	37
REGRANEX.....	74	<i>ropinirole tab 5mg</i>	37
RELENZA DISKHALER.....	15	<i>rosadan</i>	73
RELISTOR.....	57	<i>rosuvastatin calcium</i>	26
REMICADE.....	60	ROTARIX.....	62
REMODULIN.....	30	ROTATEQ.....	62
<i>repaglinide</i>	47	<i>roweepra</i>	33
RESCRIPTOR.....	13	<i>roweepra xr</i>	33
RESTASIS.....	67	RUBRACA.....	20
RESTASIS MULTIDOSE.....	67	RYDAPT.....	22
REVLIMID.....	21	SANCUSO.....	55
REXULTI.....	39	SANDIMMUNE.....	61
REYATAZ.....	13	SANTYL.....	74
RHOPRESSA.....	67	SAPHRIS.....	39
<i>ribasphere cap 200mg</i>	15	SAVELLA.....	42
<i>ribasphere tab 200mg</i>	15	SAVELLA TITRATION PACK.....	42
<i>ribasphere tab 600mg</i>	15	<i>scopolamine patch</i>	55
<i>ribavirin 200mg</i>	15	<i>selegiline hcl</i>	37
<i>rifabutin</i>	14	<i>selenium sulfide</i>	72
<i>rifampin</i>	14	SELZENTRY.....	13
RIFATER.....	14	SENSIPAR.....	48
<i>riluzole</i>	42	SEREVENT DISKUS.....	69
<i>rimantadine hydrochloride</i>	15	<i>sertraline hcl</i>	36
<i>risedronate sodium</i>	47	<i>setlakin tab</i>	51
RISPERDAL INJ 12.5MG.....	39	<i>sevelamer carbonate</i>	54
RISPERDAL INJ 25MG.....	39	<i>sharobel</i>	51
RISPERDAL INJ 37.5MG.....	39	SHINGRIX.....	62
RISPERDAL INJ 50MG.....	39	SIGNIFOR.....	54
<i>risperidone</i>	39	<i>sildenafil citrate tab 20 mg (pulmonary</i>	
<i>ritonavir</i>	13		
RITUXAN.....	20		
RITUXAN HYCELA.....	20		

<i>hypertension</i>)	30	<i>sulfacetamide sod-prednisolone</i>	65
SILENOR	41	SULFADIAZINE	10
<i>silodosin</i>	57	<i>sulfamethoxazole-trimethop ds</i>	11
<i>silver sulfadiazine</i>	71	<i>sulfamethoxazole-trimethoprim inj</i>	11
SIMBRINZA	67	<i>sulfamethoxazole-trimethoprim susp</i> .	11
<i>simvastatin</i>	26	<i>sulfamethoxazole-trimethoprim tab</i>	
<i>sirolimus</i>	61	<i>400-80mg</i>	11
SIRTURO.....	14	SULFAMYLON.....	71
SIVEXTRO	11	<i>sulfasalazine</i>	56
<i>sodium chlor sol 0.9% irr</i>	74	<i>sulfasalazine ec</i>	56
<i>sodium chloride</i>	63, 65	<i>sulindac</i>	7
<i>sodium chloride 0.45%</i>	65	<i>sumatriptan</i>	42
<i>sodium chloride inj 0.9%</i>	65	<i>sumatriptan inj 4mg/0.5ml</i>	42
<i>sodium fluoride chew; tab; 1.1 (0.5 f)</i>		<i>sumatriptan inj 6mg/0.5ml</i>	42
<i>mg/ml soln</i>	63	<i>sumatriptan succinate</i>	42
<i>sodium phenylbutyrate</i>	52	SUPRAX	16
<i>sodium polystyrene sulfonate powder</i>	48	SUPREP BOWEL PREP KIT.....	56
<i>sodium polystyrene sulfonate susp</i>	48	SUTENT	23
<i>solifenacin succinate</i>	58	<i>syeda</i>	51
SOLQUA 100/33.....	45	SYLATRON KIT 200MCG	23
SOLTAMOX	21	SYLATRON KIT 300MCG	23
SOLU-CORTEF	53	SYLATRON KIT 600MCG	23
SOMATULINE DEPOT	54	SYMBICORT.....	70
SOMAVERT	54	SYMDEKO.....	69
<i>sorine</i>	26	SYMFI	14
<i>sotalol hcl</i>	26	SYMFI LO	14
<i>sotalol hcl (afib/afl)</i>	26	SYMJEPI.....	70
<i>spironolactone</i>	25	SYMPAZAN	33, 34
<i>spironolactone & hydrochlorothiazide</i>	29	SYMPROIC.....	57
<i>sprintec 28</i>	51	SYMTUZA.....	14
SPRITAM	33	SYNAREL.....	51
SPRYCEL	22	SYNERCID	11
<i>sps susp 15gm/60ml</i>	48	SYNJARDY TAB 12.5-1000MG	47
<i>sronyx</i>	51	SYNJARDY TAB 12.5-500MG	47
<i>ssd</i>	71	SYNJARDY TAB 5-1000MG	47
<i>stavudine</i>	13	SYNJARDY TAB 5-500MG.....	47
STIMATE	54	SYNJARDY XR TAB 10-1000MG	47
STIVARGA	22	SYNJARDY XR TAB 12.5-1000MG	47
<i>streptomycin sulfat</i> e	10	SYNJARDY XR TAB 25-1000MG	47
STRIBILD	14	SYNJARDY XR TAB 5-1000MG	47
<i>subvenite tab</i>	33	SYNRIBO.....	23
<i>sucralfate</i>	57	SYNTHROID.....	54
<i>sulfacetamide sodium (acne)</i>	71	TABLOID	19
<i>sulfacetamide sodium (ophth)</i>	66	TACLONEX	72

<i>tacrolimus</i>	61	<i>thiothixene</i>	39
<i>tacrolimus (topical)</i>	73	<i>tiagabine hcl</i>	34
TAFINLAR.....	23	TIBSOVO.....	20
TAGRISSE.....	23	<i>tigecycline</i>	11
TALZENNA.....	20	<i>tilia fe</i>	51
<i>tamoxifen citrate</i>	21	<i>timolol maleate</i>	28
<i>tamsulosin hcl</i>	57	<i>timolol maleate (ophth) soln</i>	67
TARCEVA	23	<i>timolol maleate gel</i>	67
TARGRETIN	73	<i>timolol maleate ophth soln 0.5% (once-daily)</i>	67
<i>tarina fe 1/20</i>	51	TIVICAY	13
TASIGNA.....	23	<i>tizanidine hcl</i>	43
TAXOTERE.....	19	TOBRADEX	65
<i>tazarotene</i>	71	TOBRADEX ST	65
<i>tazicef</i>	16	<i>tobramycin</i>	10
TAZORAC	71	<i>tobramycin (ophth)</i>	66
<i>taztia xt</i>	28	<i>tobramycin inj 1.2 gm/30ml</i>	10
TDVAX	62	<i>tobramycin inj 1.2gm</i>	10
TECENTRIQ	20	<i>tobramycin inj 10mg/ml</i>	10
TEFLARO	16	<i>tobramycin inj 40mg/ml</i>	10
TEKTURNA	29	<i>tobramycin inj 80mg/2ml</i>	10
TEKTURNA HCT.....	29	<i>tobramycin-dexamethasone</i>	65
<i>telmisartan</i>	26	<i>tolterodine tartrate cap er</i>	58
<i>telmisartan-amlodipine</i>	25	<i>tolterodine tartrate tabs</i>	58
<i>telmisartan-hydrochlorothiazide</i>	25	<i>topiramate</i>	34
<i>temazepam</i>	41	<i>toposar</i>	24
TENIVAC	62	<i>topotecan hcl</i>	24
<i>tenofovir disoproxil fumarate</i>	13	TOPOTECAN INJ 4MG/4ML.....	24
<i>terazosin hcl</i>	25	<i>toremifene citrate</i>	21
<i>terbinafine hcl</i>	12	<i>toremide tabs</i>	29
<i>terbutaline sulfate</i>	69	TOVIAZ.....	58
<i>terconazole vaginal</i>	58	<i>tpn electrolytes</i>	63
<i>testosterone</i>	44	TRACLEER	31
<i>testosterone cypionate</i>	44	TRADJENTA	47
<i>testosterone enanthate</i>	44	<i>tramadol hcl tab 50 mg</i>	8
<i>tetrabenazine</i>	43	<i>tramadol-acetaminophen</i>	8
<i>tetracycline hcl</i>	18	<i>trandolapril</i>	24
TEXACORT SOLN 2.5%	72	<i>tranexamic acid</i>	59
THALOMID	21	TRANSDERM-SCOP	55
THEO-24	70	<i>tranylcypromine sulfate</i>	36
<i>theophylline sol 80/15ml</i>	70	TRAVASOL.....	64
<i>theophylline tb12 300 mg</i>	70	TRAVATAN Z.....	67
<i>theophylline tb12 450 mg</i>	70	<i>trazodone hcl</i>	36
<i>theophylline tb24</i>	70	TRECATOR	14
<i>thioridazine hcl</i>	39		

TRELEGY ELLIPTA.....	68	TRUVADA TAB 100-150.....	14
TRELSTAR DEP INJ 3.75MG	21	TRUVADA TAB 133-200.....	14
TRELSTAR LA INJ 11.25MG.....	21	TRUVADA TAB 167-250.....	14
<i>treprostinil</i>	31	TRUVADA TAB 200-300.....	14
TRESIBA FLEXTOUCH.....	45	<i>tulana</i>	51
TRESIBA INJ.....	45	TURALIO	23
<i>tretinoin</i>	71	TWINRIX INJ	62
<i>tretinoin (chemotherapy)</i>	23	TYBOST	13
TREXALL	60	TYKERB.....	23
<i>triamcinolone acetonide (mouth)</i>	74	TYMLOS	54
<i>triamcinolone acetonide (topical)</i> . 72, 73		TYPHIM VI.....	62
<i>triamterene & hydrochlorothiazide cap</i>		ULORIC.....	7
<i>37.5-25 mg</i>	29	<i>unithroid</i>	54
<i>triamterene & hydrochlorothiazide tabs</i>		<i>ursodiol</i>	57
.....	30	<i>valacyclovir hcl</i>	15
TRICARE	65	VALCHLOR	73
<i>trientine hcl</i>	48	<i>valganciclovir hcl</i>	15
<i>tri-estarylla</i>	51	<i>valproate sodium</i>	34
<i>trifluoperazine hcl</i>	39	<i>valproic acid</i>	34
<i>trifluridine</i>	66	<i>valsartan</i>	26
<i>trihexyphenidyl hcl</i>	37	<i>valsartan-hydrochlorothiazide</i>	25
<i>tri-legest fe</i>	51	<i>vancomycin hcl</i>	11
<i>tri-linyah</i>	51	VANCOMYCIN IN NAACL.....	11
<i>tri-lo marzia</i>	51	<i>vandazole</i>	58
<i>tri-lo-estarylla</i>	51	VAQTA.....	62
<i>tri-lo-sprintec</i>	51	VARIVAX	62
<i>trilyte</i>	56	VASCEPA.....	27
<i>trimethoprim</i>	11	VELCADE.....	20
<i>tri-mili</i>	51	<i>velivet</i>	51
<i>trimipramine maleate</i>	36	VEMLIDY	15
<i>trinessa</i>	51	VENCLEXTA	20
<i>trinessa lo</i>	51	VENCLEXTA STARTING PACK	20
TRINTELLIX	36	<i>venlafaxine hcl</i>	36
<i>tri-previfem</i>	51	VENTAVIS	31
<i>tri-sprintec</i>	51	VENTOLIN HFA.....	69
TRIUMEQ	14	<i>verapamil cap er</i>	28
<i>trivora-28</i>	51	<i>verapamil hcl</i>	29
<i>tri-vylibra</i>	51	<i>verapamil hcl tab er</i>	29
<i>tri-vylibra lo</i>	51	VERSACLOZ.....	39
TROGARZO.....	13	VERZENIO.....	20
TROPHAMINE INJ 10%.....	64	VICTOZA.....	45
<i>tropium chloride</i>	58	VIDEX EC.....	13
TRULICITY.....	45	VIDEX PEDIATRIC	13
TRUMENBA	62	<i>vienva</i>	51

<i>vigabatrin powd pack 500mg</i>	34	XPOVIO 60 MG ONCE WEEKLY	23
<i>vigabatrin tab 500mg</i>	34	XPOVIO 80 MG ONCE WEEKLY	23
<i>vigadrone</i>	34	XPOVIO 80 MG TWICE WEEKLY	23
VIIBRYD STARTER PACK	36	XTANDI.....	21
VIIBRYD TAB	36	<i>xulane</i>	51
VIMPAT	34	XULTOPHY 100/3.6.....	45
VIMPAT INJ 200MG/20ML.....	34	XYREM	43
VIMPAT SOL 10MG/ML	34	YF-VAX	62
<i>vinblastine sulfate</i>	19	<i>yuvaferm vaginal tablet 10mcg</i>	52
<i>vincristine sulfate</i>	19	<i>zafirlukast</i>	69
<i>vinorelbine tartrate</i>	19	<i>zarah</i>	51
<i>viorele</i>	51	ZEJULA	20
VIRACEPT.....	13	ZELBORAF	23
VIRAMUNE	13	ZEMAIRA.....	70
VIREAD.....	13	<i>zenatane</i>	71
VITRAKVI	23	ZENPEP.....	57
VIVITROL	44	ZEPATIER.....	15
VIZIMPRO	23	<i>zidovudine cap 100mg</i>	13
<i>voriconazole</i>	12	<i>zidovudine syp 50mg/5ml</i>	13
VOSEVI.....	15	<i>zidovudine tab 300mg</i>	13
VOTRIENT	23	<i>ziprasidone hcl</i>	39
VRAYLAR.....	39	ZIRGAN	66
VRAYLAR THERAPY PACK.....	39	<i>zoledronic acid inj 5mg/100ml</i>	47
<i>vyfemla</i>	51	<i>zoledronic inj 4mg/5ml</i>	47
<i>vylibra</i>	51	ZOLINZA.....	20
VYVANSE	41	<i>zolmitriptan</i>	42
<i>warfarin sodium</i>	59	<i>zolmitriptan odt</i>	42
<i>water for irrigation, sterile</i>	74	<i>zolpidem tartrate</i>	41
XALKORI	23	<i>zonisamide</i>	34
XARELTO.....	59	ZONTIVITY	60
XARELTO STARTER PACK	59	ZORTRESS TAB 0.25MG	61
XATMEP	60	ZORTRESS TAB 0.5MG.....	61
XELJANZ	60	ZORTRESS TAB 0.75MG	61
XELJANZ XR	60	ZORTRESS TAB 1MG.....	61
XGEVA	54	ZOSTAVAX	62
XIFAXAN	57	<i>zovia 1/35e</i>	51
XIGDUO XR TAB 10-1000MG	47	ZYCLARA.....	73
XIGDUO XR TAB 10-500MG	47	ZYCLARA PUMP	74
XIGDUO XR TAB 2.5-1000MG	47	ZYDELIG	23
XIGDUO XR TAB 5-1000MG	47	ZYKADIA.....	23
XIGDUO XR TAB 5-500MG	47	ZYLET	65
XOLAIR.....	70	ZYPITAMAG	26
XOSPATA	23	ZYPREXA RELPREVV	40
XPOVIO 100 MG ONCE WEEKLY	23	ZYPREXA RELPREVV INJ 210MG	40

ZYTIGA21

Multi-Language & Non-Discrimination Notice

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GlobalHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact **Customer Care at 1-844-280-5555 (toll-free)**.

If you believe that GlobalHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Attn: Director of Compliance and Legal Services, 210 Park Avenue, Ste 2800, Oklahoma City, OK 73102-5621, Fax: (405) 280-5894, or E-mail: compliance@globalhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Care is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-280-5555 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-280-5555 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-280-5555 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-280-5555 (TTY: 711)번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-280-5555 (TTY: 711).

والبكم الصم هاتف (711). اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا: ملحوظة 1-844-280-5555 (برقم)

သတိပဋိရန်။ ။ ခဉ်းဗာ ဗမာစကား ဝေဟတတတ္တိဌ် ဘာသာစကား လုဝိအပူ; အကူအညီမဗားကုဝိ အခဲဲ
ဆော့ငြိုကုဝေးဝေးပါသည့်။ ဖုန်းနံပါတ် 1-844-280-5555 (TTY: 711) ကုဝိ ဝေဝုးုဝိဝါသည့်။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-280-5555 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-280-5555 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-280-5555 (ATS: 711).

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-844-280-5555 (TTY: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-280-5555 (TTY: 711).

1-844-280-5555 (TTY: 711) کریں کال - ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ہیں، بولتے اردو آپ اگر: خبردار 711).

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-844-280-5555 (TTY: 711).

شما برای رایگان بصورت زبانی تسهیلات کنید، می گفتگو فارسی زبان به اگر: توجه
بگیرید تماس با .باشد می فراهم 1-844-280-5555 (TTY: 711)

This formulary was updated on 11/01/2019

For more recent information or other questions, please contact GlobalHealth Customer Care at 1-866-494-3927 or, for TTY users, 711 24 hours a day, seven days a week or visit www.GlobalHealth.com/medicare.



This formulary was updated on 11/01/2019
For more recent information or other questions, please
contact GlobalHealth Customer Care
at 1-866-494-3927 or, for TTY users, 711
24 hours a day, seven days a week
or visit www.GlobalHealth.com/medicare