

Medicare Employer Group



2023 New York State Employees Medicare

Senior Blue 699 (HMO) Plan E
Senior Blue 699 (HMO) Plan E1

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The difference that matters

We know that understanding Medicare and choosing a health plan are not always easy. Everyone is different, and Highmark Blue Cross Blue Shield of Western New York is here to help guide you to the plan that works best for you.



Robust local network

Our Medicare Advantage plans connect you to the doctors and hospitals you trust the most. When you choose Blue, you carry the security of a card accepted at all Western New York hospitals and the region's leading health systems and medical practices, including:

- Buffalo Medical Group
- Catholic Health
- Erie County Medical Center
- Kaleida Health
- Roswell Park Comprehensive Cancer Center
- UBMD Physicians' Group
- UPMC Hamot
- Upper Allegheny Health Systems



Security of a card accepted worldwide

When you travel, feel safe knowing we're your direct link to emergency care anywhere. Just show your member ID card at any hospital in the world and you'll receive care.



Ring the bell for Blue Concierge

Our exclusive Blue Concierge service connects you with a dedicated, knowledgeable team ready to help you get the most from your Medicare coverage. Our Blue Concierge team can help you understand your benefits and how they work, find providers, and even assist in scheduling appointments with doctors and specialists.



We're here to help

Please call us if you have any questions regarding your plan options.
1-844-836-6182 (TTY 711)

We're available:

Monday – Friday, 8 a.m. – 5 p.m. EST

PLAN NAME: Senior Blue 699 (HMO) Plan E (2023)

Physician and other health professional services	In-Network
Primary doctor	\$10
Specialist	\$30
Radiation therapy	\$30
Emergency room (waived if admitted)	\$65
Urgent care (waived if admitted)	\$35
Ambulance	\$100
Telemedicine	Covered in full

More than 20 preventive services	In-Network
Flu shots – Part B	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full
All other preventive screenings and tests	Covered in full

Hospital, home health care, and skilled services	In-Network
Hospital (inpatient)	Covered in full per stay
Observation	\$65
Outpatient surgery – hospital	\$75
Outpatient surgery – ambulatory center	\$75
Home health care	Covered in full
Skilled nursing facility (100 days per benefit period)	Covered in full per stay
Dialysis	Covered in full

Mental health / chemical dependence services	In-Network
Mental health (inpatient, 190-day lifetime limit)	Covered in full per stay
Mental health (outpatient)	\$40
Mental health (with psychiatrist)	\$40
Alcohol substance abuse (inpatient)	Covered in full per stay
Alcohol substance abuse (outpatient)	\$40

Laboratory and X-ray services		In-Network
Laboratory testing		Covered in full
X-rays		\$30
Advanced radiology — MRI, MRA, PET, and CT		\$30
Rehabilitation services		In-Network
Physical, occupational, and speech therapy		\$20
Chiropractor		\$20
Acupuncture & Massage Therapy		N/A
Cardiac rehab		\$20
Vision		In-Network
Routine vision exam		Covered in full
Medical vision exam		\$30
Allowance (lenses and frames)		\$200 annual allowance
Hearing		In-Network
Routine hearing exam — TruHearing™		\$45
Diagnostic hearing exam		\$30
Hearing aid benefit — TruHearing™		\$699/\$999
Dental		In-Network
Dental		\$200 annual allowance
Supplies, equipment, and devices		In-Network
Durable medical equipment		\$0 compression stockings; 20% all other items
Prosthetics		\$0 diabetic shoes/inserts; 20% all other items
Diabetic supplies – Part B		Covered in full
Fitness program		In-Network
SilverSneakers® (“Steps” program included)		Covered in full
Prescription drugs – Part B		In-Network
Immunosuppressive drugs		Covered in full
Oral chemotherapy drugs		Covered in full
Physician administered injectables		Covered in full
Nebulizer inhalation solution		Covered in full
Part B drugs (other)		Covered in full

Prescription drugs – Part D**	In-Network
Prescription drug (Rx)	\$0/\$15/\$30/\$50/\$50
Mail order	Tier 1 - Tier 4: 2 copays for a 90 day supply
Shingles vaccine	Covered in full
Coverage gap/donut hole	No coverage gap

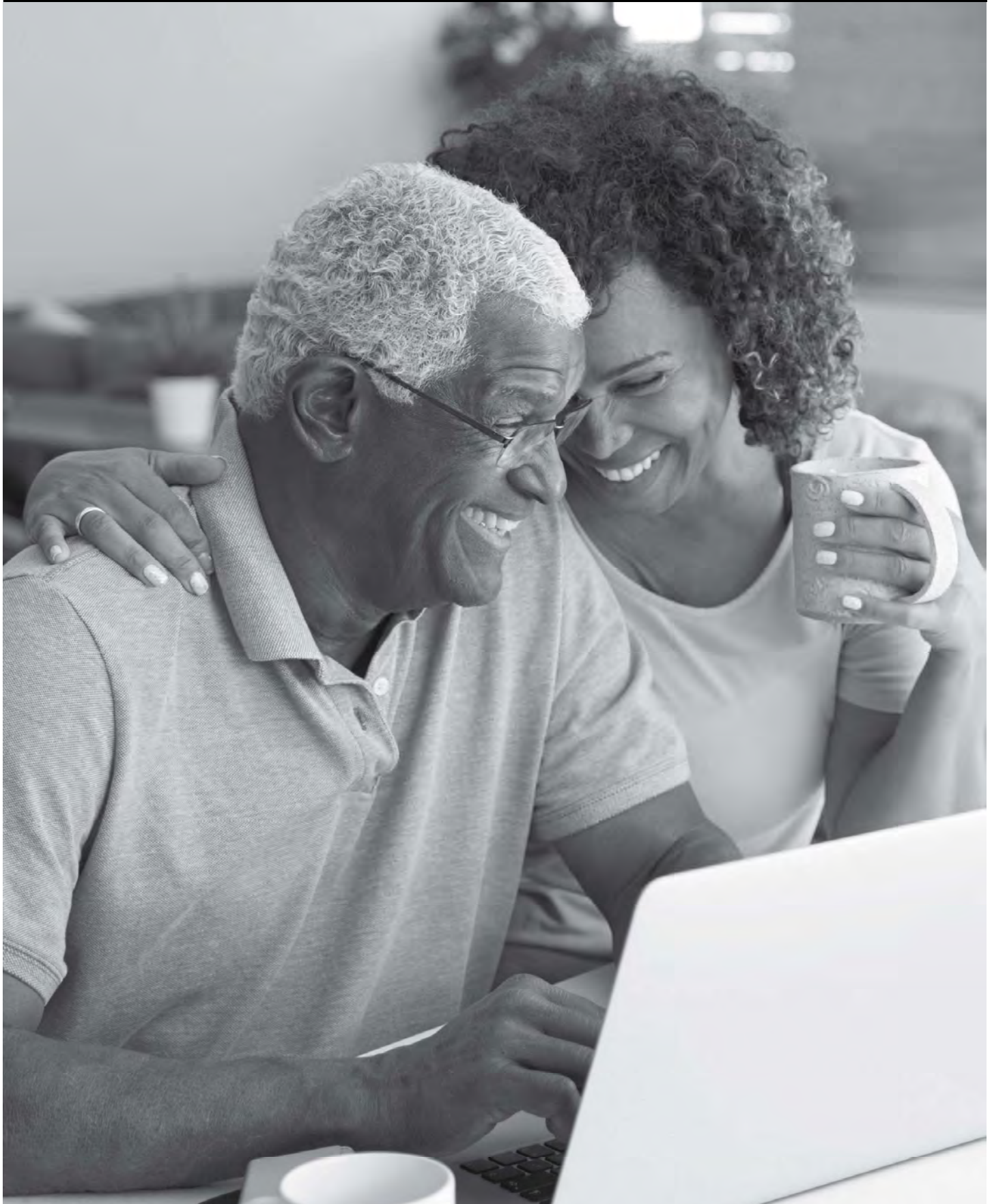
General product information	In-Network
In-network out-of-pocket maximum	\$3,000
Combined out-of-pocket maximum	N/A
Prescription deductible	N/A

****Important Message: If you have prescription cost sharing more than \$35/month - What You Pay for Insulin – The maximum copayment for a one-month supply of covered insulin products is \$35, no matter what cost-sharing tier it is on or if you have not met your Rx deductible (if applicable).**

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Highmark BCBSWNY is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. Highmark Blue Cross Blue Shield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Onduo is an independent company that provides a diabetes management program on behalf of Highmark. TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing aid benefit. SilverSneakers® is a registered trademark of Tivity Health, Inc. Tivity Health is an independent company that administers the SilverSneakers gym benefit. American Well is an independent company that provides telemedicine services. American Well does not provide Blue Cross and/or Blue Shield products or services and it is solely responsible for its telemedicine services. Other pharmacies/physicians/providers are available in our network. Out of-network/noncontracted providers are under no obligation to treat Highmark BCBSWNY members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

THE CARD ACCEPTED BY OVER 90% OF DOCTORS.*



* According to data compiled by the Blue Cross Blue Shield Association in July 2021.



Medicare Sales: 1-855-215-9237 (TTY 711)

Monday-Friday: 8 a.m. - 5 p.m.

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Primary doctor	\$10
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请拨打您的身份证背面的号码（TTY：711）。

Senior Blue HMO

Coordinated care and cost savings

- Care coordinated with your primary doctor
- Typically lower premiums
- Affordable copays for doctor visits



An HMO (Health Maintenance Organization) is a type of Medicare Advantage plan that takes the place of Original Medicare. With an HMO plan, you must receive care from doctors and hospitals within the plan's network, except for emergency or urgent care. Part D prescription drug coverage is included in most of these plans.

Senior Blue HMO is partnered with the region's leading health systems and medical practices, including:

- Buffalo Medical Group
- Catholic Health
- Erie County Medical Center
- Kaleida Health
- Roswell Park Comprehensive Cancer Center
- UBMD Physicians' Group
- UPMC Hamot
- Upper Allegheny Health System

We also have over 7,000 participating providers and facilities in counties that border our service area, including Bradford Regional Medical Center, Encompass Health Rehabilitation Hospital of the Mid-Cities, Highland Hospital, Rochester General, St. James Hospital, Strong Memorial Hospital, Unity Hospital, and UPMC Cole.

All Senior Blue HMO plans provide worldwide emergency and urgent care, giving you peace of mind knowing you're covered at home or on the go.

Vision benefits

All of our Medicare Advantage plans include coverage for:



- Annual routine eye exam*
- Glasses or contacts after cataract surgery*



- Glaucoma screening
- Diagnostic eye exam
- Diabetic retinal eye exam

With Highmark Blue Cross Blue Shield of Western New York, you can find the right optometrists, ophthalmologists, and other medical providers to meet your health care needs. Visit [medicare.highmark.com](https://www.medicare.highmark.com) to see if your provider participates with our plan. Our website includes both a provider directory in PDF format and an easy provider search tool.

Vision allowance*

If you're enrolled in a plan that offers a vision allowance, you can use those dollars to purchase:



- Contacts (conventional or disposable)
- Frames



- Lenses (single vision, bifocal, trifocal, lenticular)
- Lens enhancements (antireflective coating, tint, scratch-resistant)

Use your vision dollars to purchase from our Davis Vision providers.

AMERICA'S BEST
CONTACTS & EYEGLASSES

 **Visionworks**

Walmart 
RETAIL LOCATIONS



For more information or to locate a provider near you, visit [davisvision.com](https://www.davisvision.com) or contact Davis Vision at 1-800-999-5431 (TTY 711)
Monday – Friday, 8 a.m. – 11 p.m., Saturday, 9 a.m. – 4 p.m.,
Sunday, noon – 4 p.m.

* You must see a Davis Vision provider in order for coverage to be considered in network.

Dental allowance

Dental care is important to your overall health. That's why most of our plans provide you with a dental allowance to help cover some of your dental care costs.



It's simple — there's no dental network, so you can see any dentist you choose. You pay up front for your dental care, complete the dental reimbursement form, attach your itemized bill and paid receipt, and mail these materials to us.

Your annual dental allowance can be used for:



- Cleanings
- Periodontal cleanings
- Crowns
- Fillings

You can also use your dental allowance for any other dental services you may need throughout the year.

Reimbursement



Please allow 4–6 weeks for processing and reimbursement once we receive your request. If you have any questions, need help completing the reimbursement form, or need extra copies, please call us.

1-800-329-2792 (TTY 711)

October 1 – March 31, 8 a.m. – 8 p.m. EST, 7 days a week

April 1 – September 30, 8 a.m. – 8 p.m. EST, Monday – Friday

Better hearing, better health

Good hearing is important to your overall health. That’s why we offer a hearing-aid benefit through TruHearing®. Our benefit covers up to two hearing aids per year (one per ear) and makes payments more affordable at \$999 per hearing aid or less.

Our hearing benefit gives you:

- State-of-the-art technology — natural, clear, lifelike sound in virtually all environments.
- Personalized care — meet with a local provider for your hearing exam, plus three follow-up visits for fittings and adjustments.
- Peace of mind — all hearing aids come with free first-year follow-up provider visits, 60-day trial period, three-year extended warranty, and 80 free batteries per aid.*

TruHearing Advanced 32 channels 6 programs	TruHearing Premium* 48 channels 6 programs	Routine Exam In-Network**
Retail: \$2,720/aid	Retail: \$3,250/aid	
See your Evidence of Coverage for discounted cost	See your Evidence of Coverage for discounted cost	See your Evidence of Coverage for exam fee

*Rechargeable battery option is available on select styles for an additional \$50 per hearing aid.

**Must be performed by a TruHearing network provider.

Call TruHearing to learn more and schedule an appointment:

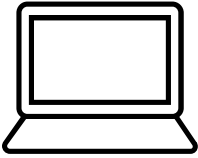
1-844-319-7440 (TTY 711)

Hours: 8 a.m. – 8 p.m. EST, Monday – Friday

Visit: truhearing.com/select

*Three follow-up visits must be used within one year after the date of initial purchase. Free battery offer is not applicable to the purchase of rechargeable hearing-aid models. Three-year warranty includes repairs and one-time loss-and-damage replacement. Hearing-aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant.

Access your benefits wherever you go

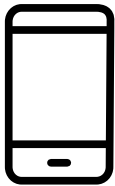


Manage your plan online

As a Highmark Blue Cross Blue Shield of Western New York member, you have a personalized member homepage.* Here you can access key resources to help manage your plan online, 24/7.

Visit **medicare.highmark.com** to get started. You can:

- View plan benefits.
- Access recent claims.
- Find a nearby doctor, hospital, or pharmacy.
- Compare treatment options and estimate health care and pharmacy costs.
- Review your doctor.
- View and order replacement member ID cards.



Mobile app

With our user-friendly mobile app, you can view plan information, search for providers, and view the status of your claims. Download the app by searching for Blue Cross Blue Shield of Western New York in the App Store (Apple devices) or Google Play (Android devices).



Away From Home Care®

Spend up to 12 months each year out of your local service area and remain covered through that locality's Blue Cross and/or Blue Shield health plan. Perfect for retirees who enjoy traveling.

*The personal information you enter is secure and protected.

\$0 preventive services

It's safer, easier, and more cost-effective to prevent health issues than to treat them. That's why we offer you more than 20 Medicare-covered preventive services at a \$0 copay.*

These services include:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual wellness visit
- Bone density test to measure bone mass
- Behavioral therapy for cardiovascular disease
- Cardiovascular screening (blood tests such as cholesterol, lipids, triglycerides)
- Cervical and vaginal cancer screening
 - Pap smear and pelvic exam
- Colorectal cancer screening
 - Barium enema
 - Colonoscopy
 - Fecal occult blood test
 - Flexible sigmoidoscopy
- CT screening for lung cancer
- COVID-19 vaccine
- Depression screening
- Diabetes screening
- Diabetes self-management training
- EKG as a result of the Welcome to Medicare initial preventive physical exam (IPPE)
- Flu (influenza) vaccine**
- Hepatitis B vaccine
- Hepatitis C virus screening (HCV)
- HIV screening
- Immunizations Part B (other)
- Mammogram (breast cancer screening)
- Medical nutrition therapy services
- Medical Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Pneumonia (pneumococcal) vaccine
- Prostate cancer screening
- Sexually transmitted infections (STI) screening and counseling
- Tobacco-use cessation counseling to stop smoking or tobacco use
- Welcome to Medicare IPPE

*A \$0 copay applies when using an in-network provider. To find an in-network provider near you, contact Customer Service. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

** You have the option to go to your doctor or any in-network pharmacy to receive your flu vaccine. Pharmacies will bill us directly; there is no paperwork involved.

\$0 care management



At Highmark Blue Cross Blue Shield of Western New York, we know everyone has health and wellness needs as unique as they are. We've assembled a team of health care professionals who work with you to optimize your overall health.

Our nationally accredited Care Management team is made up of registered nurses, wellness coaches, respiratory therapists, and health educators. They meet with you and your doctor over the phone and find personalized solutions to improve and maintain your health.

Program highlights

- Optimize health and meet your wellness goals
- Improve chronic condition management
- Receive active support, encouragement, and education
- Assist in finding the best doctor or specialist for your needs
- Help with referrals and prior authorizations

How to qualify

Every member is eligible for care management. If you have questions or concerns about your health care, contact Member Service to learn more.

In-home care

\$0 Care at HomeSM



Everyone hopes for a life of independence and quality as they age. We want to help make that happen. That's why we've partnered with Landmark to create **Care at Home**.

Eligibility for **Care at Home** depends on your medical history. It may be an option if you are living with a certain set of chronic illnesses, especially if you are managing multiple conditions.

Even if you don't need to use the **Care at Home** program today, know that it's here to support you and your family down the road.

This program is a no-cost service that works in partnership with your primary care doctor to coordinate your care. The **Care at Home** team makes traditional house calls and offers 24/7 support — allowing you to get care and support in the comfort of your own home.

Care at Home can help with scheduling and preparing for doctor appointments, managing your medications, and monitoring your health condition to avoid relapses or worsening symptoms.

For questions or to speak to a **Care at Home** representative, please call 1-844-300-0509 (TTY 711), Monday – Friday, 9 a.m. – 9 p.m.

medicare.highmark.com

Health and wellness



Wellness rewards program

Preventive health is important to your overall well-being. With our rewards program, you'll receive a \$20 Prepaid Card* after receiving each of these preventive services:

- Annual wellness visit
- Colorectal cancer screening**
- Breast cancer screening**



\$0 fitness benefit

It's easy to stay active with our no-cost SilverSneakers® fitness program. After you receive your SilverSneakers ID number, you'll have access to:

- More than 16,000 fitness locations nationwide.
- Home exercise programs with walking, strength, and yoga workouts.
- Online resources to track your progress.

To learn more or to find the closest location, visit silversneakers.com or call 1-888-423-4632 (TTY 711), Monday – Friday, 8 a.m. – 8 p.m. EST



Chiropractor, acupuncture, and massage services

Professional massages, acupuncture, and chiropractic care contribute to your overall well-being, including:

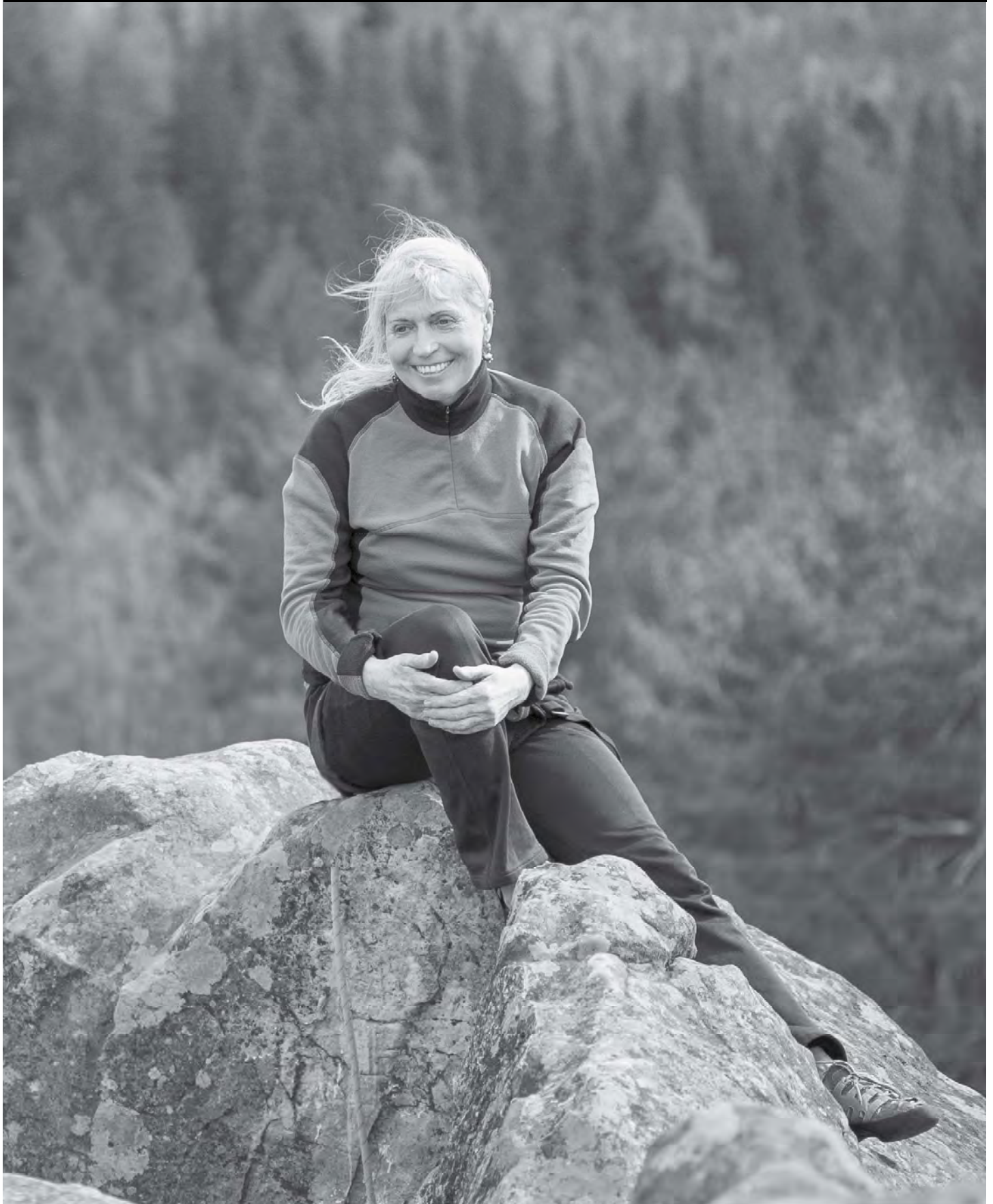
- Easing muscle tension.
- Reducing stress.
- Lowering blood pressure.
- Improving sleep quality.

Your plan offers a \$20 copay for chiropractic visits (see you Evidence of Coverage for details on the number of covered visits per year) and an annual allowance for reimbursement on massage and acupuncture care.

* One Prepaid Card per service, per member, per calendar year.

** Consult with your doctor to see if this service is right for you.

THE CARD THAT OPENS DOORS IN 50 STATES.*



* According to data compiled by the Blue Cross Blue Shield Association in July 2021.

\$0 Tier 1 medications

If your plan offers \$0 Tier 1 preferred generics, all of the medications listed below are available to you at a \$0 copay under your Part D drug benefit. The medications listed are in Tier 1 in our list of covered drugs (or formulary).*

alendronate	indapamide
allopurinol	irbesartan
amlodipine	irbesartan-hydrochlorothiazide
amlodipine-benazepril	Jantoven
atenolol	latanoprost
atorvastatin	levothyroxine
benazepril	Levoxyl
bisoprolol-hydrochlorothiazide	lisinopril
carvedilol	lisinopril-hydrochlorothiazide
chlorhexidine gluconate mouthwash	lithium carbonate
ciprofloxacin HCl	losartan
citalopram	losartan-hydrochlorothiazide
clonidine HCl	lovastatin
clopidogrel	meloxicam
dexamethasone	metformin
doxazosin	metformin er
enalapril maleate	metoprolol tartrate
enalapril-hydrochlorothiazide	mirtazapine
famotidine	moexipril
fluoxetine	naproxen
fluticasone propionate-salmeterol	olmesartan
inhalation aerosol powder	olmesartan-hydrochlorothiazide
breath-activated	omeprazole
fluticasone propionate-salmeterol	pantoprazole
blister with inhalation device	paroxetine HCl
fosinopril	perindopril erbumine
furosemide	Periogard mouthwash
gabapentin	pioglitazone
gemfibrozil	pravastatin
glimepiride	prednisone tablet B/D
glipizide	quinapril
glipizide er/xl	quinapril-hydrochlorothiazide
glipizide-metformin	ramipril
hydrochlorothiazide	rosuvastatin
IBU	sertraline
ibuprofen	Shingrix (PF)

simvastatin
spironolactone
sulfamethoxazole-trimethoprim
tamsulosin
terazosin
timolol maleate
topiramate
trandolapril

trazodone
triamterene-hydrochlorothiazide
Unithroid
valsartan
valsartan-hydrochlorothiazide
warfarin
Wixela Inhub

* List of \$0 Tier 1 medications updated 7/1/2021. Please refer to our formulary for a complete list of Tier 1 drugs, including dosage form and strength.

Mail-order prescriptions through Express Scripts®

Enjoy the convenience of home-delivered medications that you take on a regular basis from Express Scripts' mail-order pharmacy. Prescriptions are delivered about eight days after your script is received. Delivery is free. With Express Scripts:

- You get mail-order Tier 1 generics as low as \$0.
- You pay only 1, 2, or 2.5 copays per 90-day supply. Prescriptions based on plan design. Please verify on your benefit summary.
- Mail-order does not apply to Tier 5 drugs.

General requirements

Please order between a 30-day supply and a 90-day supply of your medication.

Filling prescriptions through the mail-order pharmacy

You have four ways to get started with home delivery:



ePrescribe

Ask your doctor to send your prescriptions electronically to the Express Scripts pharmacy.



Phone

Call the pharmacy services number on the back of your member ID card.



Online

Go to **[express-scripts.com](https://www.express-scripts.com)** and register for an account.



Mail

Visit **[medicare.highmark.com](https://www.medicare.highmark.com)** to print an order form and mail it in.

Prescription drug coverage gap

For Senior Blue 699 and Forever Blue 799 plans, you may need additional information on stages commonly referred to in Part D drug coverage. These phases in drug coverage, such as the coverage gap (or “donut hole”) and the catastrophic drug phase, may change what you pay for your prescriptions.

You may not end up in the catastrophic drug phase, but you should be aware of how your drug plan works just in case.

Stage 1 Deductible

As you start filling prescriptions for the year

There is no deductible for these plans, so you begin in the next coverage phase.

Stage 2 Initial coverage

As you continue to fill prescriptions

You pay your regular tier copay or coinsurance for your prescriptions.

Stage 3 Coverage gap (donut hole)

Because there is no coverage gap for these plans, this payment stage would not apply to you

You will continue to pay your regular tier copay or coinsurance for your prescriptions.

Stage 4 Catastrophic coverage

After you go through the donut hole

Once your total out-of-pocket costs reach \$7,050, your cost will not exceed your initial coverage level copay or coinsurance. You pay:

- Your initial coverage stage copay or coinsurance.
- 5% coinsurance of the cost of the drug.
- \$4.15 for a generic drug or drug that is treated like a generic, and \$10.35 for all other drugs.

Understanding your prescription drug options

What is a formulary?

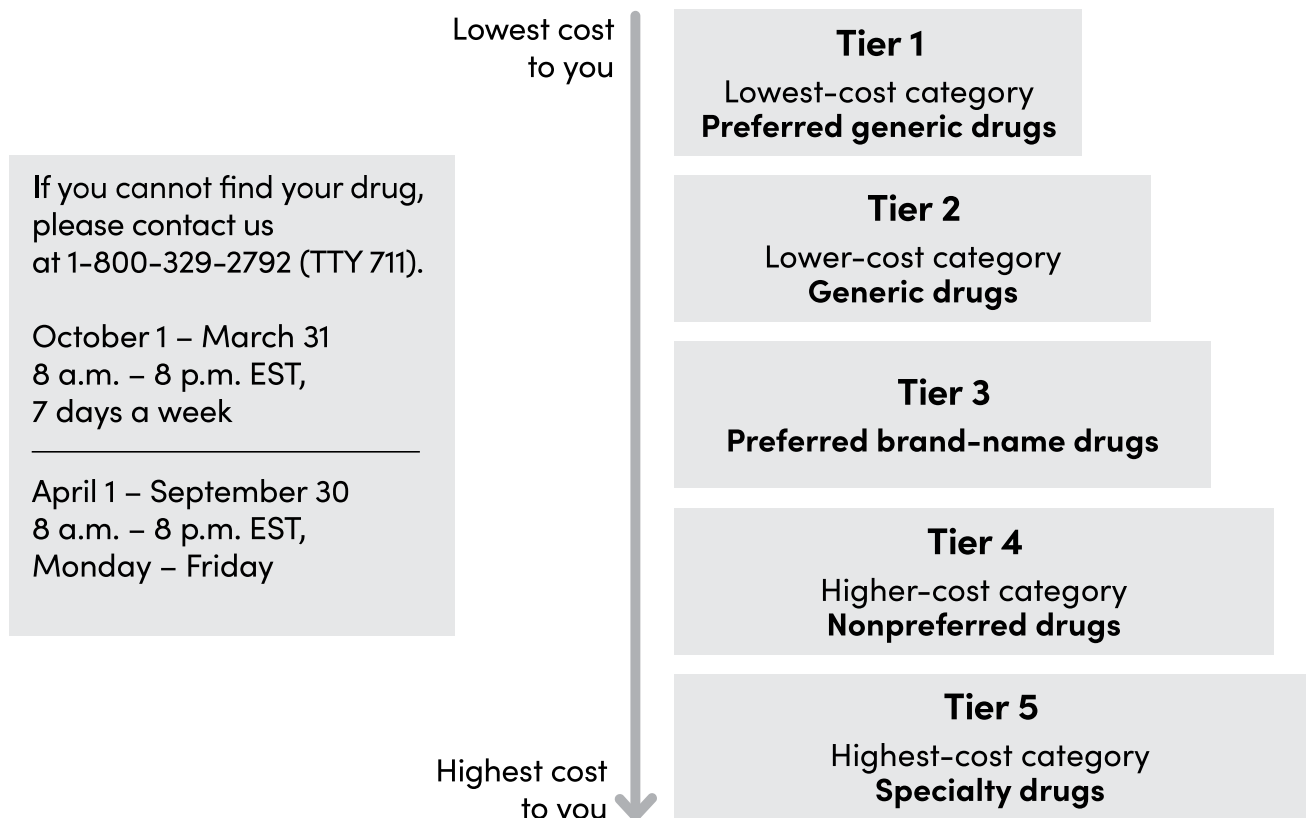
A formulary is a list of the medications that are covered under your Part D prescription drug benefit. A committee of doctors and pharmacists creates these lists by evaluating medications based on their cost, effectiveness, and availability. The formulary covers both generic and brand-name drugs.

Prescription drug tiers

The formulary will also tell you which of the five cost-sharing tiers the drug is in and whether there are any restrictions on your drug. To save money, your best option is to choose drugs that are on the first or second tier of your formulary.

How can I find out if my drug is on the formulary?

Visit [medicare.highmark.com](https://www.medicare.highmark.com) for more information. You can also search for a specific drug name or category of drug. Use the index in the back of the formulary to find drugs listed in alphabetical order.



Senior Blue HMO, BlueSaver HMO, Freedom Nation PPO, Forever Blue PPO, or Freedom PPO

2023 Medicare Part D: 5 Tier Fundamental Formulary

(List of Covered Plans)

Senior Blue 651 HMO
Senior Blue Select HMO
BlueSaver HMO
Senior Blue Basic HMO
Senior Blue 699 HMO
Freedom Nation PPO
Forever Blue Value PPO
Forever Blue 751 PPO
Forever Blue 799 Value PPO
Forever Blue 799 PPO

(List of Covered Drugs)

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

This formulary was updated on 9/1/2022.

Important message about what you pay for vaccines — Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible (if applicable). Call Member Service for more information.

Important message about what you pay for insulin — You won't pay more than \$35 for a one-month supply of each Part D insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible (if applicable).

For more recent information or other questions, please contact:

Highmark Blue Cross Blue Shield of Western New York Customer Service at 1-800-329-2792.

For TTY users, 711 National Relay Service, Oct. 1 – March 31, 8 a.m. – 8 p.m. EST, seven days a week, and April 1 – Aug. 30, 8 a.m. – 8 p.m. EST, Monday – Friday.

Visit [medicare.highmark.com](https://www.medicare.highmark.com).

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 Highmark Blue Cross Blue Shield of Western New York.

When it refers to “plan” or “our plan,” it means 2023 Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO.

This document includes a list of the drugs (formulary) for our plan, which is current as of Jan. 1, 2023. 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 Jan. 1, 2024, and from time to time during the year.

What is the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO Formulary?

A formulary is a list of covered drugs selected by our plans 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 plans will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at one of our plan’s network pharmacies, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO Formulary (drug list) change?

- Most changes in drug coverage happen on Jan. 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

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

- **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 how to request an exception, and you can find information in the section below entitled “How do I request an exception to the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO 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 both. 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 31-day supply of the drug.
 - If we make these other changes, 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 how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on Jan. 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of Jan. 1, 2023. To get updated information about the drugs covered by our plans, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website at [medicare.highmark.com](https://www.medicare.highmark.com).

How do I use the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO Formulary?

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

Medical Condition

The formulary begins on page 9. 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 – Hypertension & Lipids.” If you know what your drug is used for, look for the category name in the list that begins on page 9. 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 at the end of this document. 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 plans cover 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 plans require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plans before you fill your prescriptions. If you don't get approval, our plans may not cover the drug.
- **Quantity Limits:** For certain drugs, our plans limit the amount of the drug that is covered. For example, our plans provide 31 tablets, per 31 days, per prescription of 100mg losartan. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plans require 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 plans may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plans 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 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online document(s) that explain(s) 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 plans 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 Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO?" on page 6 for information about how to request an exception.

What if my drug is not on the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO Formulary?

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

If you learn that our plan does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by our plans. When you receive the list, show it to your doctor and ask your doctor to prescribe a similar drug that is covered by our plan.
- You can ask our plan 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 Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO 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 plans limit 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 31-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 31-day supply of medication. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

The above transition process will be implemented to accommodate you if you have an immediate need for a non-formulary drug or a drug that requires prior authorization due to a change in your level of care while you are waiting for an exception request to be processed.

For more information

For more detailed information about your plan's prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about your 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, seven days a week. TTY users should call 1-877-486-2048, or visit **medicare.gov**.

Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Freedom Nation PPO, or Freedom PPO Formulary

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

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ABELCET) and generic drugs are listed in lowercase italics (e.g., *abacavir*).

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

The following is a Formulary Format Example Only:

Drug Name	Fundamental Drug Tier	Requirements/Limits
Anti-Infectives		
XYZ DRUG	NF	QL-28

Table of Contents

Anti - Infectives.....	5
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Autonomic / Cns Drugs, Neurology / Psych.....	18
Cardiovascular, Hypertension / Lipids.....	31
Dermatologicals/Topical Therapy.....	37
Diagnostics / Miscellaneous Agents.....	41
Ear, Nose / Throat Medications.....	43
Endocrine/Diabetes.....	43
Gastroenterology.....	47
Immunology, Vaccines / Biotechnology.....	49
Miscellaneous Supplies.....	51
Musculoskeletal / Rheumatology.....	52
Obstetrics / Gynecology.....	53
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Respiratory And Allergy.....	58
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List of Abbreviations

T1: Cost-Sharing Tier 1 includes preferred generic drugs. This is the lowest cost-sharing tier.

T2: Cost-Sharing Tier 2 includes generic drugs.

T3: Cost-Sharing Tier 3 includes preferred brand name drugs and may include some single-sourced drugs (those generic drugs made by a single manufacturer).

T4: Cost-Sharing Tier 4 includes non-preferred brand name drugs and may include some single-sourced generic drugs (those generic drugs made by a single manufacturer).

T5: Cost-Sharing Tier 5 includes specialty drugs. This is the highest cost-sharing tier.

LA: Limited access

PA: Prior authorization required

PA-BvD: This drug may be covered under Medicare part B or D depending on the circumstance. Information may need to be submitted describing the use and setting of the drug to make the determination.

PA-NS: Prior authorization required for new starts only

QL: Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.

QL: Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.

SI: Select Insulin Drug under the Part D Senior Savings Model. For complete coverage details on these preferred select insulins see Chapter 6 of your Evidence of Coverage.

ST: Step therapy applies

ST-NS: Step therapy applies to new starts only

Below is a list of drug name formatting patterns that may appear in the following pages.

List of Patterns

lowercase italics: Generic drugs

UPPERCASE BOLD: Brand name drugs

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
<i>abacavir</i>	T2	
<i>abacavir-lamivudine</i>	T2	
ABELCET	T4	PA-BvD
<i>acyclovir oral capsule</i>	T2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	T2	
<i>acyclovir oral tablet</i>	T2	
<i>acyclovir sodium intravenous solution</i>	T4	PA-BvD
<i>adefovir</i>	T4	
<i>albendazole</i>	T5	
<i>amantadine hcl oral capsule</i>	T2	QL (124 EA per 31 days)
<i>amantadine hcl oral solution</i>	T2	
<i>amantadine hcl oral tablet</i>	T2	
AMBISOME	T5	PA-BvD
<i>amikacin injection solution 500 mg/2 ml</i>	T4	
<i>amoxicillin oral capsule</i>	T2	
<i>amoxicillin oral suspension for reconstitution</i>	T2	
<i>amoxicillin oral tablet</i>	T2	
<i>amoxicillin oral tablet,chewable 125 mg, 250 mg</i>	T2	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet,chewable</i>	T2	
<i>amphotericin b</i>	T4	PA-BvD
<i>ampicillin oral capsule 500 mg</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	T4	
<i>ampicillin-sulbactam injection</i>	T4	
APTIVUS	T5	
ARIKAYCE	T5	PA
<i>atazanavir</i>	T4	
<i>atovaquone</i>	T5	
<i>atovaquone-proguanil</i>	T2	
<i>azithromycin intravenous</i>	T4	
<i>azithromycin oral packet</i>	T2	
<i>azithromycin oral tablet</i>	T2	
<i>aztreonam</i>	T4	
BICILLIN C-R	T3	
BICILLIN L-A	T4	

Drug Name	Drug Tier	Requirements/Limits
BIKTARVY	T5	QL (31 EA per 31 days)
<i>caspofungin intravenous recon soln 50 mg</i>	T5	
<i>caspofungin intravenous recon soln 70 mg</i>	T4	
CAYSTON	T5	PA
<i>cefaclor oral capsule 500 mg</i>	T2	
<i>cefadroxil oral capsule</i>	T2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	T2	
<i>cefadroxil oral tablet</i>	T2	
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	T4	
<i>cefdinir oral capsule</i>	T2	
<i>cefepime injection</i>	T4	
<i>cefixime oral capsule</i>	T4	
<i>cefoxitin</i>	T4	
<i>cefpodoxime</i>	T2	
<i>cefprozil</i>	T2	
<i>ceftazidime</i>	T4	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	T2	
<i>cefuroxime axetil oral tablet</i>	T2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	T4	
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	T4	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	T2	
<i>cephalexin oral suspension for reconstitution</i>	T2	
<i>chloroquine phosphate oral tablet 250 mg</i>	T2	PA; QL (50 EA per 30 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	T2	PA; QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	T4	
<i>ciprofloxacin hcl oral tablet 100 mg, 750 mg</i>	T2	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg</i>	T1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T4	
<i>clarithromycin</i>	T2	
<i>clindamycin hcl</i>	T2	
<i>clindamycin in 5 % dextrose</i>	T4	
CLINDAMYCIN PEDIATRIC	T2	
<i>clindamycin phosphate injection</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	T4	
<i>clotrimazole mucous membrane</i>	T2	
COARTEM	T4	
<i>colistin (colistimethate na)</i>	T4	
COMPLERA	T5	
CRESEMBA ORAL	T5	
<i>dapsone oral</i>	T2	
<i>daptomycin intravenous recon soln 350 mg</i>	T5	
<i>daptomycin intravenous recon soln 500 mg</i>	T4	
DELSTRIGO	T5	QL (31 EA per 31 days)
DESCOVY ORAL TABLET 200-25 MG	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
DIFICID ORAL TABLET	T5	QL (20 EA per 10 days)
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T4	
<i>doxycycline hyclate oral capsule</i>	T2	
<i>doxycycline hyclate oral tablet 100 mg</i>	T2	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg</i>	T4	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T2	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	T4	
<i>doxycycline monohydrate oral tablet</i>	T2	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
<i>efavirenz oral capsule 200 mg</i>	T4	
<i>efavirenz oral capsule 50 mg</i>	T2	
<i>efavirenz oral tablet</i>	T4	
<i>efavirenz-emtricitabin-tenofovir</i>	T5	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	T5	QL (31 EA per 31 days)
<i>emtricitabine</i>	T2	
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	T5	
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	T4	
EMTRIVA ORAL SOLUTION	T3	
EMVERM	T5	
<i>entecavir</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	T5	PA; QL (28 EA per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	T5	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET	T5	PA; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	T4	
<i>ertapenem</i>	T4	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	T4	
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	T4	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T4	
<i>erythromycin ethylsuccinate oral tablet</i>	T4	
<i>erythromycin oral tablet</i>	T4	
<i>ethambutol</i>	T2	
<i>etravirine</i>	T5	
EVOTAZ	T5	
<i>famciclovir</i>	T2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	T4	
<i>fluconazole oral suspension for reconstitution</i>	T3	
<i>fluconazole oral tablet</i>	T2	
<i>flucytosine</i>	T5	
<i>fosamprenavir</i>	T5	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T4	
<i>gentamicin injection solution 40 mg/ml</i>	T4	
GENVOYA	T5	
<i>griseofulvin microsize</i>	T4	
<i>griseofulvin ultramicrosize</i>	T4	
HARVONI ORAL PELLETS IN PACKET	T5	PA; QL (28 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	T5	PA; QL (28 EA per 28 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	T2	QL (93 EA per 31 days)
<i>imipenem-cilastatin</i>	T4	
IMPAVIDO	T5	
INTELENCE ORAL TABLET 25 MG	T4	
ISENTRESS HD	T5	

Drug Name	Drug Tier	Requirements/Limits
ISENTRESS ORAL POWDER IN PACKET	T5	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
<i>isoniazid oral</i>	T2	
<i>itraconazole</i>	T4	PA
<i>ivermectin oral</i>	T2	PA
JULUCA	T5	
<i>ketoconazole oral</i>	T2	
<i>lamivudine</i>	T3	
<i>lamivudine-zidovudine</i>	T3	
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T3	
<i>levofloxacin intravenous</i>	T4	
<i>levofloxacin oral</i>	T2	
LEXIVA ORAL SUSPENSION	T4	
<i>linezolid in dextrose 5%</i>	T4	
<i>linezolid oral suspension for reconstitution</i>	T5	
<i>linezolid oral tablet</i>	T4	
<i>lopinavir-ritonavir oral solution</i>	T4	
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	T3	
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	T5	
<i>maraviroc</i>	T5	
<i>mefloquine</i>	T2	
<i>meropenem</i>	T4	
<i>methenamine hippurate</i>	T2	
<i>metronidazole in nacl (iso-os)</i>	T4	
<i>metronidazole oral tablet</i>	T2	
<i>micafungin</i>	T5	
<i>minocycline oral capsule</i>	T2	
<i>minocycline oral tablet</i>	T4	
<i>moxifloxacin oral</i>	T2	
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	T4	
<i>nafcillin injection recon soln 10 gram</i>	T5	
<i>neomycin</i>	T2	
<i>nevirapine oral suspension</i>	T4	
<i>nevirapine oral tablet</i>	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>nevirapine oral tablet extended release 24 hr</i>	T4	
<i>nitazoxanide</i>	T5	
<i>nitrofurantoin</i>	T5	QL (1800 ML per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	T2	QL (90 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	T2	QL (180 EA per 365 days)
<i>nitrofurantoin monohyd/m-cryst</i>	T2	QL (90 EA per 365 days)
NORVIR ORAL POWDER IN PACKET	T4	
NORVIR ORAL SOLUTION	T4	
<i>nystatin oral</i>	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	T4	
ORACEA	T4	
<i>oseltamivir oral capsule 30 mg</i>	T2	QL (170 EA per 365 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	T2	QL (90 EA per 365 days)
<i>oseltamivir oral suspension for reconstitution</i>	T3	QL (1080 ML per 365 days)
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	T4	
<i>oxacillin injection recon soln 1 gram, 2 gram</i>	T4	
<i>paromomycin</i>	T4	
PASER	T3	
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	T4	
<i>penicillin g potassium injection recon soln 20 million unit</i>	T4	
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	T4	
<i>penicillin v potassium</i>	T2	
<i>pentamidine inhalation</i>	T4	PA-BvD; QL (1 EA per 28 days)
<i>pentamidine injection</i>	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	T4	
<i>posaconazole oral tablet,delayed release (dr/ec)</i>	T5	
<i>praziquantel</i>	T4	
PREVYMIS ORAL	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	T5	
PRIFTIN	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>primaquine</i>	T3	
<i>pyrazinamide</i>	T4	
<i>pyrimethamine</i>	T5	PA
<i>quinine sulfate</i>	T4	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T4	
REYATAZ ORAL POWDER IN PACKET	T5	
<i>ribavirin oral capsule</i>	T3	
<i>ribavirin oral tablet 200 mg</i>	T3	
<i>rifabutin</i>	T4	
<i>rifampin intravenous</i>	T4	
<i>rifampin oral</i>	T3	
<i>rimantadine</i>	T2	
<i>ritonavir</i>	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL SOLUTION	T5	
SELZENTRY ORAL TABLET 25 MG	T4	
SELZENTRY ORAL TABLET 75 MG	T5	
SIRTURO	T5	
<i>streptomycin</i>	T5	
STRIBILD	T5	
<i>sulfadiazine</i>	T4	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	T2	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	T1	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	T4	
SYMTUZA	T5	QL (31 EA per 31 days)
TEFLARO	T5	
<i>tenofovir disoproxil fumarate</i>	T3	
<i>terbinafine hcl oral</i>	T2	QL (90 EA per 180 days)
<i>tetracycline</i>	T4	
<i>tigecycline</i>	T5	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TIVICAY PD	T5	
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA; QL (224 EA per 56 days)
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin inhalation</i>	T5	PA
<i>tobramycin sulfate injection solution 10 mg/ml</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>tobramycin sulfate injection solution 40 mg/ml</i>	T2	
TRECATOR	T4	
<i>trimethoprim</i>	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T5	QL (186 EA per 31 days)
TRIZIVIR	T5	
<i>valacyclovir</i>	T2	
<i>valganciclovir oral recon soln</i>	T5	
<i>valganciclovir oral tablet</i>	T3	
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	T4	
<i>vancomycin oral capsule 125 mg</i>	T4	PA; QL (124 EA per 31 days)
<i>vancomycin oral capsule 250 mg</i>	T4	PA; QL (248 EA per 31 days)
VEMLIDY	T5	QL (31 EA per 31 days)
VIRACEPT ORAL TABLET	T5	
VIREAD ORAL POWDER	T5	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	T5	
<i>voriconazole intravenous</i>	T5	PA
<i>voriconazole oral suspension for reconstitution</i>	T5	
<i>voriconazole oral tablet</i>	T4	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T5	QL (27 EA per 365 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	T3	QL (9 EA per 365 days)
<i>zidovudine</i>	T2	
Antineoplastic / Immunosuppressant Drugs		
<i>abiraterone oral tablet 250 mg</i>	T5	PA-NS; QL (124 EA per 31 days)
<i>abiraterone oral tablet 500 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
AFINITOR ORAL TABLET 10 MG	T5	PA-NS; QL (31 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (60 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
<i>anastrozole</i>	T2	
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)
<i>azathioprine oral tablet 50 mg</i>	T2	PA-BvD
BALVERSA	T5	PA-NS
<i>bexarotene oral</i>	T5	PA-NS
<i>bexarotene topical</i>	T5	PA-NS; QL (60 GM per 28 days)
<i>bicalutamide</i>	T2	
BOSULIF ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	T5	PA-NS; QL (31 EA per 31 days)
BRAFTOVI ORAL CAPSULE 75 MG	T5	PA-NS; QL (186 EA per 31 days)
BRUKINSA	T5	PA-NS; QL (124 EA per 31 days)
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 300 MG	T5	PA-NS; QL (31 EA per 31 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	T5	PA-NS; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	T5	PA-NS; QL (84 EA per 28 days)
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA; QL (63 EA per 28 days)
<i>cyclophosphamide oral capsule</i>	T2	PA-BvD
<i>cyclophosphamide oral tablet</i>	T3	PA-BvD
<i>cyclosporine modified</i>	T2	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
DROXIA	T3	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
EMCYT	T5	
ENVARBUS XR	T4	PA-BvD
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA	T5	PA-NS; QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>erlotinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 7.5 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>everolimus (immunosuppressive)</i>	T5	PA-BvD
<i>exemestane</i>	T4	
EXKIVITY	T5	PA-NS; QL (124 EA per 31 days)
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
GENGRAF	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
<i>hydroxyurea</i>	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NS; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NS; QL (31 EA per 31 days)
IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG	T5	PA-NS; QL (31 EA per 31 days)
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
INQOVI	T5	PA-NS; QL (5 EA per 28 days)
INREBIC	T5	PA-NS; QL (124 EA per 31 days)
IRESSA	T5	PA-NS; QL (31 EA per 31 days)
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
<i>lapatinib</i>	T5	PA-NS; QL (186 EA per 31 days)
<i>lenalidomide</i>	T5	PA-NS; QL (21 EA per 28 days)
LENVIMA	T5	PA-NS
<i>letrozole</i>	T2	
<i>leucovorin calcium oral</i>	T3	
LEUKERAN	T5	
<i>leuprolide subcutaneous kit</i>	T5	
LONSURF	T5	PA-NS
LORBRENA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
LORBRENA ORAL TABLET 25 MG	T5	PA-NS; QL (93 EA per 31 days)
LUMAKRAS	T5	PA-NS; QL (248 EA per 31 days)
LUPRON DEPOT	T5	ST
LUPRON DEPOT (3 MONTH)	T5	ST
LUPRON DEPOT (4 MONTH)	T5	ST
LUPRON DEPOT (6 MONTH)	T5	ST
LYNPARZA	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T3	
MATULANE	T5	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	T3	PA
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	T4	PA
<i>megestrol oral tablet</i>	T3	PA-NS
MEKINIST ORAL TABLET 0.5 MG	T5	PA-NS; QL (93 EA per 31 days)
MEKINIST ORAL TABLET 2 MG	T5	PA-NS; QL (31 EA per 31 days)
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
<i>mercaptopurine</i>	T2	
MESNEX ORAL	T5	
<i>methotrexate sodium</i>	T2	PA-BvD
<i>methotrexate sodium (pf) injection solution</i>	T2	PA-BvD
<i>mycophenolate mofetil oral capsule</i>	T2	PA-BvD
<i>mycophenolate mofetil oral suspension for reconstitution</i>	T5	PA-BvD
<i>mycophenolate mofetil oral tablet</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
<i>nilutamide</i>	T5	
NINLARO	T5	PA-NS; QL (3 EA per 28 days)
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	T5	PA
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	T4	PA
ODOMZO	T5	PA-NS; LA; QL (31 EA per 31 days)
ONUREG	T5	PA-NS; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NS; QL (31 EA per 31 days)
PEMAZYRE	T5	PA-NS; QL (14 EA per 21 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	T5	PA-NS; QL (56 EA per 28 days)
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T5	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RETEVMO ORAL CAPSULE 40 MG	T5	PA-NS; QL (186 EA per 31 days)
RETEVMO ORAL CAPSULE 80 MG	T5	PA-NS; QL (124 EA per 31 days)
REVLIMID ORAL CAPSULE 2.5 MG, 20 MG	T5	PA-NS; QL (21 EA per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL SOLUTION	T4	PA-BvD
SCEMBLIX ORAL TABLET 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SCEMBLIX ORAL TABLET 40 MG	T5	PA-NS; QL (310 EA per 31 days)
SIGNIFOR	T5	PA
<i>sirolimus oral solution</i>	T5	PA-BvD
<i>sirolimus oral tablet</i>	T4	PA-BvD
SOLTAMOX	T5	
<i>sorafenib</i>	T5	PA-NS; QL (124 EA per 31 days)
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>sunitinib</i>	T5	PA-NS; QL (31 EA per 31 days)
SYNRIBO	T5	
TABLOID	T4	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
<i>tacrolimus oral</i>	T2	PA-BvD
TAFINLAR	T5	PA-NS; QL (124 EA per 31 days)
TAGRISSE	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T2	
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
TAZVERIK	T5	PA-NS; QL (248 EA per 31 days)
TEPMETKO	T5	PA-NS; QL (62 EA per 31 days)
THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 200 MG	T5	PA-NS; QL (56 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
<i>toremifene</i>	T5	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	T5	ST
<i>tretinoin (antineoplastic)</i>	T5	
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
TRUSELTIQ ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
TRUSELTIQ ORAL CAPSULE 75 MG/DAY (25 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
TUKYSA ORAL TABLET 150 MG	T5	PA-NS; QL (124 EA per 31 days)
TUKYSA ORAL TABLET 50 MG	T5	PA-NS; QL (248 EA per 31 days)
TURALIO	T5	PA-NS; QL (124 EA per 31 days)
VENCLEXTA ORAL TABLET 10 MG	T3	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS; QL (186 EA per 31 days)
VENCLEXTA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
VENCLEXTA STARTING PACK	T5	PA-NS; QL (84 EA per 365 days)
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NS; QL (31 EA per 31 days)
VONJO	T5	PA-NS; QL (124 EA per 31 days)
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
WELIREG	T5	PA-NS; QL (93 EA per 31 days)
XALKORI	T5	PA-NS; QL (62 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	PA-NS
XOSPATA	T5	PA-NS; QL (124 EA per 31 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)	T5	PA-NS; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	T5	PA-NS; QL (4 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	T5	PA-NS; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NS; QL (32 EA per 28 days)
XTANDI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 40 MG	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS; QL (248 EA per 31 days)
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 1 MG	T5	PA-BvD
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA ORAL TABLET	T5	PA-NS; QL (93 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
acetaminophen-codeine oral solution 120-12 mg/5 ml	T2	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	T3	PA; QL (1 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	T3	PA; QL (2 ML per 28 days)
AJOVY AUTOINJECTOR	T3	PA; QL (1.5 ML per 28 days)
AJOVY SYRINGE	T3	PA; QL (1.5 ML per 28 days)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amoxapine</i>	T3	
APTIOM ORAL TABLET 200 MG	T5	QL (186 EA per 31 days)
APTIOM ORAL TABLET 400 MG	T5	QL (93 EA per 31 days)
APTIOM ORAL TABLET 600 MG, 800 MG	T5	QL (62 EA per 31 days)
<i>aripiprazole oral solution</i>	T4	PA-NS
<i>aripiprazole oral tablet</i>	T2	PA-NS
<i>aripiprazole oral tablet,disintegrating</i>	T5	PA-NS
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>asenapine maleate</i>	T4	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T4	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	T4	QL (31 EA per 31 days)
<i>atomoxetine oral capsule 18 mg</i>	T4	QL (124 EA per 31 days)
AUBAGIO	T5	PA; QL (31 EA per 31 days)
<i>baclofen oral tablet</i>	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
<i>benztropine oral</i>	T1	PA
BRIVIACT ORAL SOLUTION	T5	QL (620 ML per 31 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 75 MG	T5	QL (62 EA per 31 days)
BRIVIACT ORAL TABLET 50 MG	T4	QL (62 EA per 31 days)
<i>bromocriptine</i>	T4	
<i>buprenorphine</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	T2	QL (93 EA per 31 days)
<i>buprenorphine hcl sublingual tablet 8 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 12-3 mg,</i> <i>4-1 mg, 8-2 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T2	
<i>bupropion hcl oral tablet extended release 24 hr</i> <i>150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr</i> <i>300 mg</i>	T2	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	T2	QL (62 EA per 31 days)
<i>buspirone</i>	T2	
<i>butorphanol nasal</i>	T2	QL (5 ML per 28 days)
CAPLYTA ORAL CAPSULE 42 MG	T5	PA-NS; QL (31 EA per 31 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T2	
<i>carbamazepine oral tablet</i>	T2	
<i>carbamazepine oral tablet extended release 12 hr</i>	T2	
<i>carbamazepine oral tablet,chewable</i>	T2	
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T4	
<i>celecoxib</i>	T2	ST; QL (62 EA per 31 days)
CELONTIN ORAL CAPSULE 300 MG	T4	
<i>chlorpromazine oral</i>	T4	
<i>citalopram oral solution</i>	T3	
<i>citalopram oral tablet</i>	T1	
<i>clobazam oral suspension</i>	T4	PA-NS; QL (496 ML per 31 days)
<i>clobazam oral tablet</i>	T3	PA-NS; QL (62 EA per 31 days)
<i>clomipramine</i>	T4	PA-NS
<i>clonazepam oral tablet 0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clonazepam oral tablet 1 mg</i>	T2	QL (124 EA per 31 days)
<i>clonazepam oral tablet 2 mg</i>	T2	QL (310 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 1 mg</i>	T2	QL (124 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 2 mg</i>	T2	QL (310 EA per 31 days)
<i>clonidine hcl oral tablet extended release 12 hr</i>	T4	PA
<i>clorazepate dipotassium oral tablet 15 mg</i>	T2	QL (186 EA per 31 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet 100 mg, 25 mg</i>	T2	QL (279 EA per 31 days)
<i>clozapine oral tablet 200 mg</i>	T2	QL (124 EA per 31 days)
<i>clozapine oral tablet 50 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet,disintegrating 100 mg, 25 mg</i>	T4	QL (279 EA per 31 days)
<i>clozapine oral tablet,disintegrating 12.5 mg</i>	T4	QL (93 EA per 31 days)
<i>clozapine oral tablet,disintegrating 150 mg</i>	T4	QL (186 EA per 31 days)
<i>clozapine oral tablet,disintegrating 200 mg</i>	T4	QL (124 EA per 31 days)
<i>cyclobenzaprine oral tablet 10 mg</i>	T2	PA; QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>cyclobenzaprine oral tablet 5 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>dalfampridine</i>	T5	PA; QL (62 EA per 31 days)
<i>dantrolene oral</i>	T2	
<i>desipramine</i>	T2	
<i>desvenlafaxine succinate</i>	T2	QL (31 EA per 31 days)
<i>dexmethylphenidate oral capsule,er biphasic 50-50</i>	T2	QL (31 EA per 31 days)
<i>dexmethylphenidate oral tablet 10 mg</i>	T2	QL (62 EA per 31 days)
<i>dexmethylphenidate oral tablet 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T2	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T2	QL (93 EA per 31 days)
DIACOMIT ORAL CAPSULE 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL CAPSULE 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIAZEPAM INTENSOL	T2	QL (248 ML per 31 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	QL (124 EA per 31 days)
<i>diazepam rectal</i>	T4	
<i>diclofenac potassium oral tablet 50 mg</i>	T2	
<i>diclofenac sodium oral</i>	T2	
<i>diclofenac sodium topical gel 1 %</i>	T2	QL (900 GM per 28 days)
<i>diclofenac-misoprostol</i>	T2	
<i>diflunisal</i>	T2	
<i>dihydroergotamine nasal</i>	T5	PA; QL (8 ML per 31 days)
DILANTIN	T3	
<i>dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	T5	PA; QL (120 EA per 365 days)
<i>dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 240 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>divalproex</i>	T2	
<i>donepezil oral tablet 10 mg, 5 mg</i>	T1	
<i>donepezil oral tablet 23 mg</i>	T2	QL (31 EA per 31 days)
<i>donepezil oral tablet,disintegrating</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>doxepin oral capsule</i>	T2	PA-NS
<i>doxepin oral concentrate</i>	T2	PA-NS
<i>doxepin oral tablet</i>	T2	PA
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG	T4	PA-NS; QL (93 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG	T4	PA-NS; QL (62 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	T4	PA-NS; QL (31 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	T2	QL (62 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg</i>	T2	QL (31 EA per 31 days)
<i>eletriptan oral tablet 20 mg</i>	T4	QL (12 EA per 28 days)
<i>eletriptan oral tablet 40 mg</i>	T4	QL (6 EA per 28 days)
EMGALITY PEN	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	T5	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T2	PA; QL (372 EA per 31 days)
<i>entacapone</i>	T3	
EPIDIOLEX	T5	PA-NS
EPITOL	T2	
EPRONTIA	T4	PA-NS; QL (496 ML per 31 days)
<i>ergotamine-caffeine</i>	T3	PA
<i>escitalopram oxalate oral solution</i>	T2	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet 10 mg</i>	T1	QL (45 EA per 30 days)
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
<i>eszopiclone</i>	T4	PA; QL (31 EA per 31 days)
<i>ethosuximide</i>	T2	
<i>etodolac</i>	T2	
FANAPT ORAL TABLET 1 MG	T4	QL (62 EA per 31 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	T5	QL (62 EA per 31 days)
FANAPT ORAL TABLETS, DOSE PACK	T4	QL (16 EA per 365 days)
<i>felbamate oral suspension</i>	T5	
<i>felbamate oral tablet</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T4	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T2	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr</i>	T2	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 50 mcg/hr</i>	T2	PA; QL (17 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T2	PA; QL (12 EA per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	T3	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T3	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T3	PA-NS; QL (93 EA per 31 days)
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral solution</i>	T2	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T2	
<i>fluphenazine decanoate</i>	T2	
<i>fluphenazine hcl injection</i>	T4	
<i>fluphenazine hcl oral concentrate</i>	T4	
<i>fluphenazine hcl oral tablet</i>	T4	
<i>flurbiprofen oral tablet 100 mg</i>	T2	
<i>fluvoxamine oral capsule,extended release 24hr</i>	T4	
<i>fluvoxamine oral tablet</i>	T2	
FYCOMPA ORAL SUSPENSION	T5	QL (744 ML per 31 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	T5	QL (31 EA per 31 days)
FYCOMPA ORAL TABLET 2 MG	T4	QL (31 EA per 31 days)
<i>gabapentin oral capsule 100 mg, 400 mg</i>	T1	PA-NS; QL (270 EA per 30 days)
<i>gabapentin oral capsule 300 mg</i>	T1	PA-NS; QL (360 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>gabapentin oral solution 250 mg/5 ml</i>	T2	PA-NS; QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	T1	PA-NS; QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	T1	PA-NS; QL (120 EA per 30 days)
<i>galantamine oral capsule,ext rel. pellets 24 hr</i>	T3	
<i>galantamine oral solution</i>	T2	
<i>galantamine oral tablet 12 mg, 8 mg</i>	T3	
<i>galantamine oral tablet 4 mg</i>	T2	
GILENYA ORAL CAPSULE 0.5 MG	T5	PA; QL (31 EA per 31 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	T5	QL (31 ML per 31 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	T5	QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T3	PA; QL (155 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T5	PA; QL (93 EA per 31 days)
<i>haloperidol</i>	T2	
<i>haloperidol decanoate</i>	T2	
<i>haloperidol lactate injection</i>	T2	
<i>haloperidol lactate oral</i>	T2	
HETLIOZ	T5	PA; QL (31 EA per 31 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	T2	PA; QL (5723 ML per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	T2	PA; QL (403 EA per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg</i>	T3	PA; QL (155 EA per 31 days)
<i>hydromorphone oral liquid</i>	T4	PA; QL (1550 ML per 31 days)
<i>hydromorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
<i>ibuprofen oral suspension</i>	T2	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>imipramine hcl</i>	T4	PA-NS
<i>indomethacin oral capsule</i>	T2	
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	T5	QL (3.5 ML per 180 days)

Drug Name	Drug Tier	Requirements/Limits
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	T5	QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T3	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	T5	QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	T5	QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	T5	QL (2.63 ML per 84 days)
KLOXXADO	T3	
KYNMOBI SUBLINGUAL FILM 10 MG	T4	PA; QL (155 EA per 31 days)
KYNMOBI SUBLINGUAL FILM 15 MG, 20 MG, 25 MG, 30 MG	T5	PA; QL (155 EA per 31 days)
<i>lacosamide oral</i>	T4	
<i>lamotrigine oral tablet</i>	T1	
<i>lamotrigine oral tablet disintegrating, dose pk 25 mg(14)-50 mg (14)-100 mg (7)</i>	T4	
<i>lamotrigine oral tablet extended release 24hr</i>	T4	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	PA-NS; QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
<i>lithium carbonate oral capsule</i>	T1	
<i>lithium carbonate oral tablet</i>	T1	
<i>lithium carbonate oral tablet extended release</i>	T2	
LORAZEPAM INTENSOL	T2	QL (155 ML per 31 days)
<i>lorazepam oral tablet 0.5 mg</i>	T2	QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>lorazepam oral tablet 1 mg</i>	T2	QL (186 EA per 31 days)
<i>lorazepam oral tablet 2 mg</i>	T2	QL (155 EA per 31 days)
<i>loxapine succinate</i>	T2	
MARPLAN	T4	
<i>meloxicam oral tablet</i>	T1	
<i>memantine oral capsule,sprinkle,er 24hr</i>	T2	
<i>memantine oral solution</i>	T2	
<i>memantine oral tablet</i>	T2	
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg</i>	T4	QL (186 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 20 mg</i>	T4	QL (93 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg</i>	T4	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 60 mg</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	T4	QL (186 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	T4	QL (93 EA per 31 days)
<i>mirtazapine oral tablet</i>	T1	
<i>mirtazapine oral tablet,disintegrating</i>	T2	
<i>modafinil</i>	T2	PA; QL (31 EA per 31 days)
<i>molindone</i>	T2	
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<i>morphine oral solution 10 mg/5 ml</i>	T2	PA; QL (2800 ML per 31 days)
<i>morphine oral solution 20 mg/5 ml (4 mg/ml)</i>	T2	PA; QL (1400 ML per 31 days)
<i>morphine oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>morphine oral tablet extended release 100 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>morphine oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T2	PA; QL (100 EA per 31 days)
<i>morphine oral tablet extended release 200 mg</i>	T2	PA; QL (31 EA per 31 days)
<i>nabumetone</i>	T2	
<i>naloxone injection solution</i>	T2	
<i>naloxone injection syringe</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>naloxone nasal</i>	T2	
<i>naltrexone</i>	T2	
NAMZARIC	T3	PA
<i>naproxen oral suspension</i>	T2	
<i>naproxen oral tablet</i>	T1	
<i>naproxen oral tablet, delayed release (dr/ec) 375 mg</i>	T2	
<i>naproxen oral tablet, delayed release (dr/ec) 500 mg</i>	T4	
<i>naproxen sodium oral tablet 550 mg</i>	T2	
<i>naratriptan oral tablet 1 mg</i>	T2	QL (20 EA per 28 days)
<i>naratriptan oral tablet 2.5 mg</i>	T2	QL (8 EA per 28 days)
NARCAN	T3	
NAYZILAM	T5	PA-NS; QL (10 EA per 30 days)
<i>nefazodone</i>	T2	
NEUPRO	T4	
<i>nortriptyline</i>	T2	
NUEDEXTA	T5	PA; QL (62 EA per 31 days)
NUPLAZID	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T5	PA; QL (18 EA per 28 days)
<i>olanzapine intramuscular</i>	T4	
<i>olanzapine oral</i>	T2	QL (31 EA per 31 days)
<i>oxaprozin</i>	T4	
<i>oxcarbazepine</i>	T2	
<i>oxycodone oral capsule</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T4	PA; QL (180 ML per 31 days)
<i>oxycodone oral solution</i>	T2	PA; QL (4133 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T2	PA; QL (138 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	T4	QL (31 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	T4	QL (62 EA per 31 days)
<i>paroxetine hcl oral suspension</i>	T4	
<i>paroxetine hcl oral tablet</i>	T1	
<i>paroxetine hcl oral tablet extended release 24 hr</i>	T4	
PAXIL ORAL SUSPENSION	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>perphenazine</i>	T2	
PERSERIS	T5	QL (1 EA per 28 days)
<i>phenelzine</i>	T3	
<i>phenobarbital</i>	T2	PA-NS
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet,chewable</i>	T2	
<i>phenytoin sodium extended</i>	T2	
<i>pimozide</i>	T4	
<i>piroxicam</i>	T2	
<i>pramipexole oral tablet</i>	T2	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	T2	PA-NS; QL (62 EA per 31 days)
<i>pregabalin oral solution</i>	T2	PA-NS; QL (930 ML per 31 days)
<i>primidone</i>	T2	
<i>protriptyline</i>	T4	
<i>pyridostigmine bromide oral tablet 60 mg</i>	T2	
<i>pyridostigmine bromide oral tablet extended release</i>	T3	
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	T2	QL (62 EA per 31 days)
<i>quetiapine oral tablet extended release 24 hr</i>	T2	QL (62 EA per 31 days)
RADICAVA ORS STARTER KIT SUSP	T5	PA; QL (70 ML per 28 days)
<i>ramelteon</i>	T2	QL (31 EA per 31 days)
<i>rasagiline</i>	T4	
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
REYVOW ORAL TABLET 100 MG	T4	QL (8 EA per 28 days)
REYVOW ORAL TABLET 50 MG	T4	QL (4 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	T3	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	T5	QL (2 EA per 28 days)
<i>risperidone oral solution</i>	T2	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	QL (31 EA per 31 days)
<i>risperidone oral tablet 3 mg</i>	T1	QL (93 EA per 31 days)
<i>risperidone oral tablet 4 mg</i>	T1	QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T4	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 3 mg</i>	T4	QL (93 EA per 31 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	T4	QL (124 EA per 31 days)
<i>rivastigmine</i>	T3	QL (30 EA per 30 days)
<i>rivastigmine tartrate</i>	T2	
<i>rizatriptan oral tablet 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet 5 mg</i>	T2	QL (24 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T2	QL (24 EA per 28 days)
<i>ropinirole oral tablet</i>	T2	
<i>ropinirole oral tablet extended release 24 hr</i>	T4	
ROWEEPRA ORAL TABLET 500 MG	T2	
<i>rufinamide oral suspension</i>	T5	PA-NS
<i>rufinamide oral tablet 200 mg</i>	T4	PA-NS
<i>rufinamide oral tablet 400 mg</i>	T5	PA-NS
SECUADO	T5	QL (31 EA per 31 days)
<i>selegiline hcl</i>	T2	
<i>sertraline oral concentrate</i>	T2	
<i>sertraline oral tablet</i>	T1	
SPRITAM	T4	
<i>sulindac</i>	T2	
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	T4	QL (8 EA per 28 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	T4	QL (32 EA per 28 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 28 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 28 days)
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml</i>	T4	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T4	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	T4	QL (4 ML per 28 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T3	
<i>thiothixene</i>	T2	
<i>tiagabine</i>	T4	
<i>tizanidine</i>	T2	
<i>topiramate oral capsule, sprinkle</i>	T2	
<i>topiramate oral tablet</i>	T1	
<i>tramadol oral tablet 50 mg</i>	T2	PA; QL (240 EA per 30 days)
<i>tramadol-acetaminophen</i>	T2	PA; QL (372 EA per 31 days)
<i>tranylcypromine</i>	T4	
<i>trazodone</i>	T1	
<i>trifluoperazine</i>	T2	
<i>trimipramine</i>	T4	PA-NS
TRINTELLIX	T3	
TRUDHESA	T5	PA; QL (12 ML per 28 days)
UBRELVY ORAL TABLET 100 MG	T5	PA; QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T5	PA; QL (34 EA per 28 days)
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
VALTOCO	T5	PA-NS; QL (10 EA per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	T2	QL (93 EA per 31 days)
<i>venlafaxine oral tablet</i>	T2	
<i>venlafaxine oral tablet extended release 24hr</i>	T2	QL (31 EA per 31 days)
VERSACLOZ	T5	QL (558 ML per 31 days)
<i>vigabatrin</i>	T5	PA-NS
VIGADRONE	T5	PA-NS
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	T3	QL (60 EA per 365 days)
<i>vilazodone</i>	T3	QL (31 EA per 31 days)
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	T4	PA-NS; QL (14 EA per 365 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
XCOPRI	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	T5	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NS
XYREM	T5	PA; QL (540 ML per 30 days)
<i>zaleplon oral capsule 10 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>zaleplon oral capsule 5 mg</i>	T4	PA; QL (93 EA per 31 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT	T5	PA; QL (74 EA per 365 days)
ZEPOSIA STARTER PACK	T5	PA; QL (14 EA per 365 days)
<i>ziprasidone hcl</i>	T2	QL (62 EA per 31 days)
<i>ziprasidone mesylate</i>	T4	
<i>zolmitriptan oral tablet 2.5 mg</i>	T4	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg</i>	T4	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolpidem oral tablet</i>	T2	PA; QL (31 EA per 31 days)
<i>zonisamide</i>	T2	
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 2.9-0.71 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG	T3	QL (93 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T5	QL (2 EA per 28 days)
Cardiovascular, Hypertension / Lipids		
<i>acebutolol</i>	T2	
<i>aliskiren</i>	T4	
<i>amiloride</i>	T2	
<i>amiloride-hydrochlorothiazide</i>	T2	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-atorvastatin</i>	T2	
<i>amlodipine-benazepril</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<i>amlodipine-olmesartan</i>	T2	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T1	
<i>aspirin-dipyridamole</i>	T4	
<i>atenolol</i>	T1	
<i>atenolol-chlorthalidone</i>	T2	
<i>atorvastatin</i>	T1	
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
<i>bisoprolol fumarate</i>	T2	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
BRILINTA	T3	
<i>bumetanide oral</i>	T2	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG	T3	QL (93 EA per 31 days)
BYSTOLIC ORAL TABLET 20 MG	T3	QL (62 EA per 31 days)
BYSTOLIC ORAL TABLET 5 MG	T3	QL (217 EA per 31 days)
CABLIVI INJECTION KIT	T5	PA; QL (31 EA per 31 days)
CAMZYOS	T5	PA; QL (31 EA per 31 days)
<i>candesartan</i>	T2	
<i>candesartan-hydrochlorothiazid</i>	T2	
<i>captopril</i>	T2	
CARTIA XT	T2	
<i>carvedilol</i>	T1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T2	
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T4	
<i>clonidine hcl oral tablet</i>	T1	
<i>clopidogrel oral tablet 75 mg</i>	T1	
<i>colesevelam</i>	T4	
<i>colestipol oral packet</i>	T2	
<i>colestipol oral tablet</i>	T2	
CORLANOR ORAL SOLUTION	T3	PA; QL (420 ML per 28 days)
CORLANOR ORAL TABLET 5 MG	T3	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T3	PA; QL (62 EA per 31 days)
DIGITEK ORAL TABLET 125 MCG (0.125 MG)	T2	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
DIGITEK ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
DIGOX ORAL TABLET 125 MCG (0.125 MG)	T2	QL (62 EA per 31 days)
DIGOX ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
<i>digoxin oral solution</i>	T3	QL (155 ML per 31 days)
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	T2	QL (62 EA per 31 days)
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	T2	QL (31 EA per 31 days)
<i>digoxin oral tablet 62.5 mcg (0.0625 mg)</i>	T2	QL (124 EA per 31 days)
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	T2	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	T2	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	T2	
<i>diltiazem hcl oral tablet</i>	T1	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg</i>	T2	
DILT-XR	T2	
<i>dipyridamole oral</i>	T4	
<i>dofetilide</i>	T4	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA
<i>doxazosin</i>	T1	
EDARBI	T3	
EDARBYCLOR	T3	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 30 days)
<i>enalapril maleate oral tablet</i>	T1	
<i>enalapril-hydrochlorothiazide</i>	T1	
<i>enoxaparin subcutaneous syringe</i>	T4	
ENTRESTO ORAL TABLET 24-26 MG	T3	QL (186 EA per 31 days)
ENTRESTO ORAL TABLET 49-51 MG	T3	QL (93 EA per 31 days)
ENTRESTO ORAL TABLET 97-103 MG	T3	QL (62 EA per 31 days)
<i>eplerenone</i>	T2	
<i>ethacrynic acid</i>	T4	
<i>ezetimibe</i>	T2	
<i>ezetimibe-simvastatin</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>felodipine</i>	T2	
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	T2	
<i>fenofibrate nanocrystallized</i>	T2	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	
<i>fenofibric acid (choline)</i>	T2	
<i>flecainide</i>	T2	
<i>fluvastatin oral capsule</i>	T4	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T4	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T2	
<i>furosemide injection</i>	T2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	T2	
<i>furosemide oral tablet</i>	T1	
<i>gemfibrozil</i>	T1	
<i>heparin (porcine) injection solution</i>	T3	
<i>hydralazine oral</i>	T2	
<i>hydrochlorothiazide</i>	T1	
<i>icosapent ethyl</i>	T2	QL (124 EA per 31 days)
<i>indapamide</i>	T1	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T1	QL (31 EA per 31 days)
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	T2	
<i>isosorbide mononitrate oral tablet</i>	T2	
<i>isosorbide mononitrate oral tablet extended release 24 hr</i>	T1	
<i>isradipine</i>	T2	
JANTOVEN	T1	
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	T5	PA
KERENDIA	T4	PA; QL (31 EA per 31 days)
<i>labetalol oral</i>	T2	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
LIVALO	T3	
<i>losartan oral tablet 100 mg</i>	T1	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>losartan oral tablet 25 mg</i>	T1	QL (93 EA per 31 days)
<i>losartan oral tablet 50 mg</i>	T1	QL (62 EA per 31 days)
<i>losartan-hydrochlorothiazide</i>	T1	
<i>lovastatin</i>	T1	
<i>metolazone</i>	T2	
<i>metoprolol succinate</i>	T1	
<i>metoprolol ta-hydrochlorothiaz</i>	T2	
<i>metoprolol tartrate oral</i>	T1	
<i>metyrosine</i>	T5	
<i>mexiletine</i>	T2	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
MULPLETA	T5	PA
MULTAQ	T4	
<i>nadolol</i>	T2	
<i>nebivolol oral tablet 10 mg, 2.5 mg</i>	T2	QL (93 EA per 31 days)
<i>nebivolol oral tablet 20 mg</i>	T2	QL (62 EA per 31 days)
<i>nebivolol oral tablet 5 mg</i>	T2	QL (217 EA per 31 days)
NEXLETOL	T3	PA; QL (31 EA per 31 days)
NEXLIZET	T3	PA; QL (31 EA per 31 days)
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T2	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T2	QL (31 EA per 31 days)
<i>nicardipine oral</i>	T4	
<i>nifedipine oral tablet extended release</i>	T2	
<i>nifedipine oral tablet extended release 24hr</i>	T2	
<i>nimodipine</i>	T4	
NITRO-BID	T2	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual</i>	T4	
<i>olmesartan oral tablet 20 mg, 40 mg</i>	T1	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T1	QL (93 EA per 31 days)
<i>olmesartan-amlodipin-hcthiazid</i>	T3	
<i>olmesartan-hydrochlorothiazide</i>	T1	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T2	QL (124 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
<i>pentoxifylline</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>perindopril erbumine</i>	T1	
<i>pindolol</i>	T3	
<i>prasugrel</i>	T2	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T2	
PREVALITE ORAL POWDER IN PACKET	T2	
PROMACTA ORAL POWDER IN PACKET 12.5 MG	T5	PA; QL (372 EA per 31 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	T5	PA; QL (62 EA per 31 days)
<i>propafenone oral capsule,extended release 12 hr</i>	T4	
<i>propafenone oral tablet</i>	T2	
<i>propranolol oral capsule,extended release 24 hr</i>	T2	
<i>propranolol oral solution</i>	T2	
<i>propranolol oral tablet</i>	T1	
<i>quinapril</i>	T1	
<i>quinapril-hydrochlorothiazide</i>	T1	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T2	QL (62 EA per 31 days)
REPATHA PUSHTRONEX	T3	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	T3	PA; QL (3 ML per 28 days)
REPATHA SYRINGE	T3	PA; QL (3 ML per 28 days)
<i>rosuvastatin</i>	T1	
<i>simvastatin oral tablet</i>	T1	
SORINE	T2	
SOTALOL AF	T2	
<i>sotalol oral</i>	T2	
<i>spironolactone</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T2	
TAZTIA XT	T2	
<i>telmisartan</i>	T2	
<i>telmisartan-amlodipine</i>	T2	
<i>telmisartan-hydrochlorothiazid</i>	T2	
<i>terazosin</i>	T1	
TIADYLT ER	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>timolol maleate oral</i>	T2	
<i>torseamide oral</i>	T2	
<i>trandolapril</i>	T1	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	T1	
<i>triamterene-hydrochlorothiazid oral tablet</i>	T1	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (400 EA per 365 days)
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	T1	QL (62 EA per 31 days)
<i>valsartan oral tablet 320 mg</i>	T1	QL (31 EA per 31 days)
<i>valsartan-hydrochlorothiazide</i>	T1	QL (31 EA per 31 days)
VASCEPA ORAL CAPSULE 0.5 GRAM	T3	QL (248 EA per 31 days)
VASCEPA ORAL CAPSULE 1 GRAM	T3	QL (124 EA per 31 days)
<i>verapamil oral capsule, 24 hr er pellet ct</i>	T3	
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	T2	
<i>verapamil oral tablet</i>	T2	
<i>verapamil oral tablet extended release</i>	T2	
VERQUVO	T3	PA; QL (31 EA per 31 days)
VYNDAMAX	T5	PA; QL (31 EA per 31 days)
VYNDAQEL	T5	PA; QL (124 EA per 31 days)
<i>warfarin</i>	T1	
XARELTO DVT-PE TREAT 30D START	T3	QL (51 EA per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	T3	QL (930 ML per 31 days)
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
Dermatologicals/Topical Therapy		
ACCUTANE	T4	
<i>acitretin</i>	T4	PA
<i>acyclovir topical ointment</i>	T4	QL (30 GM per 30 days)
ADBRY	T5	PA; QL (4 ML per 28 days)
ALA-CORT TOPICAL CREAM 1 %	T2	
ALA-CORT TOPICAL CREAM 2.5 %	T2	QL (30 GM per 28 days)
<i>alclometasone</i>	T2	
<i>ammonium lactate</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
AMNESTEEM	T4	
AVITA TOPICAL CREAM	T2	PA; QL (45 GM per 28 days)
<i>azelaic acid</i>	T4	QL (50 GM per 28 days)
<i>betamethasone dipropionate</i>	T2	
<i>betamethasone valerate topical cream</i>	T2	
<i>betamethasone valerate topical lotion</i>	T2	
<i>betamethasone valerate topical ointment</i>	T2	
<i>betamethasone, augmented</i>	T2	
<i>calcipotriene scalp</i>	T3	QL (60 ML per 28 days)
<i>calcipotriene topical cream</i>	T4	QL (60 GM per 28 days)
<i>calcipotriene topical ointment</i>	T3	QL (60 GM per 28 days)
<i>calcitriol topical</i>	T4	ST
CIBINQO	T5	PA; QL (31 EA per 31 days)
<i>ciclopirox topical cream</i>	T2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	T2	QL (45 GM per 28 days)
<i>ciclopirox topical shampoo</i>	T2	QL (120 ML per 28 days)
<i>ciclopirox topical solution</i>	T2	
<i>ciclopirox topical suspension</i>	T2	QL (60 ML per 28 days)
CLARAVIS	T4	
<i>clindamycin phosphate topical gel</i>	T2	QL (75 GM per 28 days)
<i>clindamycin phosphate topical lotion</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical solution</i>	T2	QL (60 ML per 28 days)
<i>clobetasol scalp</i>	T2	QL (50 ML per 28 days)
<i>clobetasol topical cream</i>	T2	QL (60 GM per 28 days)
<i>clobetasol topical foam</i>	T2	QL (100 GM per 28 days)
<i>clobetasol topical gel</i>	T2	QL (60 GM per 28 days)
<i>clobetasol topical lotion</i>	T2	QL (118 ML per 28 days)
<i>clobetasol topical ointment</i>	T2	QL (60 GM per 28 days)
<i>clobetasol topical shampoo</i>	T2	QL (118 ML per 28 days)
<i>clobetasol topical spray,non-aerosol</i>	T2	QL (125 ML per 28 days)
<i>clobetasol-emollient topical cream</i>	T2	QL (60 GM per 28 days)
<i>clotrimazole topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole topical solution</i>	T2	QL (30 ML per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	T2	QL (60 ML per 28 days)
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
CROTAN	T4	
DENAVIR	T4	QL (5 GM per 28 days)
<i>desonide topical cream</i>	T4	QL (60 GM per 28 days)
<i>desonide topical gel</i>	T4	QL (60 GM per 28 days)
<i>desonide topical lotion</i>	T4	QL (118 ML per 28 days)
<i>desonide topical ointment</i>	T4	QL (60 GM per 28 days)
<i>desoximetasone topical cream</i>	T4	QL (100 GM per 28 days)
<i>desoximetasone topical gel</i>	T4	QL (60 GM per 28 days)
<i>desoximetasone topical spray,non-aerosol</i>	T4	QL (100 ML per 28 days)
DESRX	T4	QL (60 GM per 28 days)
<i>diclofenac sodium topical gel 3 %</i>	T4	PA; QL (100 GM per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	T5	PA; QL (1.34 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
<i>econazole</i>	T2	QL (85 GM per 28 days)
ERY PADS	T2	
<i>erythromycin with ethanol topical solution</i>	T2	QL (60 ML per 28 days)
<i>fluocinolone and shower cap</i>	T2	QL (118.28 ML per 28 days)
<i>fluocinolone topical cream 0.01 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinolone topical cream 0.025 %</i>	T2	QL (120 GM per 28 days)
<i>fluocinolone topical ointment</i>	T2	QL (120 GM per 28 days)
<i>fluocinolone topical solution</i>	T2	QL (90 ML per 28 days)
<i>fluocinonide topical cream 0.05 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical gel</i>	T3	QL (60 GM per 28 days)
<i>fluocinonide topical ointment</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical solution</i>	T2	QL (60 ML per 28 days)
<i>fluocinonide-emollient</i>	T4	QL (60 GM per 28 days)
<i>fluorouracil topical cream 5 %</i>	T2	
<i>fluorouracil topical solution</i>	T2	
<i>fluticasone propionate topical cream</i>	T2	
<i>gentamicin topical</i>	T2	QL (60 GM per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>halobetasol propionate topical cream</i>	T2	QL (50 GM per 28 days)
<i>halobetasol propionate topical ointment</i>	T2	QL (50 GM per 28 days)
<i>hydrocortisone topical cream 1 %</i>	T2	
<i>hydrocortisone topical lotion 2.5 %</i>	T2	QL (118 ML per 28 days)
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	T2	
<i>imiquimod topical cream in packet 5 %</i>	T2	
<i>isotretinoin</i>	T4	
<i>ivermectin topical cream</i>	T2	
<i>ketoconazole topical cream</i>	T2	QL (60 GM per 28 days)
<i>ketoconazole topical shampoo</i>	T2	QL (120 ML per 28 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	PA; QL (50 ML per 28 days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	T2	PA; QL (93 EA per 31 days)
<i>lidocaine topical ointment</i>	T4	PA; QL (50 GM per 28 days)
LIDOCAINE VISCOUS	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	PA; QL (30 GM per 28 days)
<i>malathion</i>	T2	
<i>metronidazole topical cream</i>	T2	
<i>metronidazole topical gel</i>	T2	
<i>metronidazole topical lotion</i>	T2	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
MYORISAN	T4	
NYAMYC	T2	QL (60 GM per 28 days)
<i>nystatin topical cream</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical ointment</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical powder</i>	T2	QL (60 GM per 28 days)
<i>nystatin-triamcinolone</i>	T2	QL (60 GM per 28 days)
NYSTOP	T2	QL (60 GM per 28 days)
PANRETIN	T5	PA-NS
<i>permethrin</i>	T2	
<i>pimecrolimus</i>	T4	QL (100 GM per 28 days)
<i>podofilox</i>	T2	
REGRANEX	T5	PA
SANTYL	T3	QL (180 GM per 30 days)
<i>selenium sulfide topical lotion</i>	T2	
<i>silver sulfadiazine</i>	T2	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 84 days)

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE KIT	T5	PA; QL (1 EA per 84 days)
SSD	T4	
STELARA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
<i>sulfacetamide sodium (acne)</i>	T2	
SULFAMYLON TOPICAL CREAM	T3	
<i>tacrolimus topical</i>	T2	QL (100 GM per 28 days)
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
<i>tavaborole</i>	T4	
<i>tazarotene topical cream</i>	T4	PA; QL (60 GM per 28 days)
TAZORAC TOPICAL CREAM 0.05 %	T4	PA; QL (60 GM per 28 days)
TAZORAC TOPICAL GEL	T4	PA; QL (100 GM per 28 days)
<i>tretinoin topical cream</i>	T2	PA; QL (45 GM per 28 days)
<i>tretinoin topical gel</i>	T3	PA; QL (45 GM per 28 days)
<i>triamcinolone acetonide topical cream</i>	T2	
<i>triamcinolone acetonide topical lotion</i>	T2	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	T2	
TRIDERM TOPICAL CREAM	T2	
VALCHLOR	T5	PA-NS
ZENATANE	T4	
Diagnostics / Miscellaneous Agents		
<i>acamprosate</i>	T4	
<i>anagrelide</i>	T2	
<i>bupropion hcl (smoking deter)</i>	T2	QL (62 EA per 31 days)
CARBAGLU	T5	PA
<i>carglumic acid</i>	T5	PA
<i>cevimeline</i>	T2	
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
<i>d10 %-0.45 % sodium chloride</i>	T2	
<i>d2.5 %-0.45 % sodium chloride</i>	T2	
<i>d5 % and 0.9 % sodium chloride</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>d5 %-0.45 % sodium chloride</i>	T2	
<i>deferasirox oral granules in packet</i>	T5	PA
<i>deferasirox oral tablet 180 mg, 360 mg</i>	T5	PA
<i>deferasirox oral tablet 90 mg</i>	T4	PA
<i>deferasirox oral tablet, dispersible</i>	T5	PA
<i>deferiprone</i>	T5	PA
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	T2	
<i>disulfiram</i>	T2	
<i>droxidopa oral capsule 100 mg</i>	T5	PA; QL (465 EA per 31 days)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	T5	PA; QL (186 EA per 31 days)
FERRIPROX ORAL TABLET 500 MG	T5	PA
INCRELEX	T5	PA
<i>levocarnitine (with sugar)</i>	T2	PA-BvD
<i>levocarnitine oral tablet</i>	T2	PA-BvD
LOKELMA	T3	PA; QL (93 EA per 31 days)
<i>midodrine</i>	T2	
NICOTROL	T4	
NICOTROL NS	T4	
<i>nitisinone</i>	T5	
<i>pilocarpine hcl oral</i>	T3	
PROLASTIN-C INTRAVENOUS RECON SOLN	T5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	T5	PA; QL (56 EA per 28 days)
RAVICTI	T5	PA
REVCovi	T5	
<i>riluzole</i>	T3	
<i>risedronate oral tablet 30 mg</i>	T2	
<i>sevelamer carbonate oral tablet</i>	T3	
<i>sodium chloride 0.9 % intravenous piggyback</i>	T2	
<i>sodium chloride irrigation</i>	T2	
<i>sodium phenylbutyrate</i>	T5	PA
<i>sodium polystyrene sulfonate oral powder</i>	T2	
SPS (WITH SORBITOL) ORAL	T2	
<i>trientine</i>	T5	QL (248 EA per 31 days)
<i>varenicline oral tablet</i>	T4	QL (60 EA per 30 days)
<i>varenicline oral tablets,dose pack</i>	T4	QL (106 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
VELTASSA	T5	PA; QL (30 EA per 30 days)
XURIDEN	T5	PA; QL (124 EA per 31 days)
Ear, Nose / Throat Medications		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal</i>	T2	QL (30 ML per 25 days)
<i>chlorhexidine gluconate mucous membrane</i>	T1	
<i>ciprofloxacin-dexamethasone</i>	T3	
<i>fluocinolone acetonide oil</i>	T2	
<i>hydrocortisone-acetic acid</i>	T2	
<i>ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)</i>	T2	QL (30 ML per 28 days)
<i>ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)</i>	T2	QL (15 ML per 28 days)
<i>neomycin-polymyxin-hc otic (ear)</i>	T2	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T2	QL (30.5 GM per 30 days)
PERIOGARD	T1	
<i>triamcinolone acetonide dental</i>	T2	
Endocrine/Diabetes		
<i>acarbose</i>	T2	QL (93 EA per 31 days)
ALCOHOL PADS	T3	
ANDRODERM	T3	PA; QL (31 EA per 31 days)
BAQSIMI	T3	
<i>cabergoline</i>	T2	
<i>calcitonin (salmon) nasal</i>	T2	PA-BvD
<i>calcitriol oral</i>	T2	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	T4	PA-BvD; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 90 mg</i>	T4	PA-BvD; QL (124 EA per 31 days)
<i>danazol</i>	T4	
<i>desmopressin nasal spray with pump</i>	T2	
<i>desmopressin oral</i>	T2	
<i>dexamethasone oral solution</i>	T2	
<i>dexamethasone oral tablet</i>	T1	
<i>diazoxide</i>	T4	
<i>doxercalciferol oral</i>	T4	PA-BvD
EUTHYROX	T3	
<i>fludrocortisone</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<i>glimepiride</i>	T1	PA
<i>glipizide</i>	T1	
<i>glipizide-metformin</i>	T1	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
GLYXAMBI	T3	QL (31 EA per 31 days)
GVOKE	T3	
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 1-PACK SYRINGE	T3	
HUMALOG JUNIOR KWIKPEN U-100	T3	SI
HUMALOG KWIKPEN INSULIN	T3	SI
HUMALOG MIX 50-50 INSULN U-100	T3	SI
HUMALOG MIX 50-50 KWIKPEN	T3	SI
HUMALOG MIX 75-25 KWIKPEN	T3	SI
HUMALOG MIX 75-25(U-100)INSULN	T3	SI
HUMALOG U-100 INSULIN	T3	SI
HUMULIN 70/30 U-100 INSULIN	T3	SI
HUMULIN 70/30 U-100 KWIKPEN	T3	SI
HUMULIN N NPH INSULIN KWIKPEN	T3	SI
HUMULIN N NPH U-100 INSULIN	T3	SI
HUMULIN R REGULAR U-100 INSULN	T3	SI
HUMULIN R U-500 (CONC) INSULIN	T3	SI
HUMULIN R U-500 (CONC) KWIKPEN	T3	SI
<i>hydrocortisone oral</i>	T2	
INVOKAMET	T3	QL (62 EA per 31 days)
INVOKAMET XR	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T3	QL (31 EA per 31 days)
JANUMET	T3	QL (62 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T3	QL (31 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T3	QL (62 EA per 31 days)
JANUVIA ORAL TABLET 100 MG, 50 MG	T3	QL (31 EA per 31 days)
JANUVIA ORAL TABLET 25 MG	T3	QL (93 EA per 31 days)
JARDIANCE ORAL TABLET 10 MG	T3	QL (62 EA per 31 days)
JARDIANCE ORAL TABLET 25 MG	T3	QL (31 EA per 31 days)
JENTADUETO	T3	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	QL (31 EA per 31 days)
KORLYM	T5	PA; QL (124 EA per 31 days)
LANTUS SOLOSTAR U-100 INSULIN	T3	SI
LANTUS U-100 INSULIN	T3	SI
<i>levothyroxine oral tablet</i>	T1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	T3	
<i>liothyronine oral</i>	T2	
LYUMJEV KWIKPEN U-100 INSULIN	T3	SI
LYUMJEV KWIKPEN U-200 INSULIN	T3	SI
LYUMJEV U-100 INSULIN	T3	SI
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	T1	
<i>metformin oral tablet extended release 24 hr</i>	T1	
<i>metformin oral tablet extended release 24hr</i>	NF	
<i>metformin oral tablet,er gast.retention 24 hr</i>	NF	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T1	
<i>methylprednisolone</i>	T2	
<i>miglustat</i>	T5	PA; QL (93 EA per 31 days)
MOUNJARO	T3	PA; QL (2 ML per 28 days)
MYALEPT	T5	PA
<i>nateglinide</i>	T2	QL (93 EA per 31 days)
NATPARA	T5	PA; QL (31 EA per 31 days)
<i>oxandrolone oral tablet 10 mg</i>	T4	PA
<i>oxandrolone oral tablet 2.5 mg</i>	T3	PA
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	T3	PA; QL (3 ML per 28 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (15 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T5	PA; QL (4 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (90 ML per 30 days)
<i>paricalcitol oral</i>	T4	PA-BvD
<i>pioglitazone</i>	T1	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>pioglitazone-metformin</i>	T2	QL (93 EA per 31 days)
<i>prednisolone oral solution</i>	T2	
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	T2	
<i>prednisone oral solution</i>	T2	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets,dose pack</i>	T2	
<i>propylthiouracil</i>	T2	
RECORLEV	T5	PA; QL (248 EA per 31 days)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	T2	QL (124 EA per 31 days)
<i>repaglinide oral tablet 2 mg</i>	T2	QL (248 EA per 31 days)
RYBELSUS	T3	PA; QL (31 EA per 31 days)
<i>sapropterin</i>	T5	PA
SOLQUA 100/33	T3	SI; QL (18 ML per 30 days)
SOMAVERT	T5	PA
SYMLINPEN 120	T5	QL (10.8 ML per 28 days)
SYMLINPEN 60	T5	QL (6 ML per 28 days)
SYNAREL	T5	PA
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	T2	PA
<i>testosterone enanthate</i>	T3	PA
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 20.25 mg/1.25 gram (1.62 %)</i>	T2	PA
<i>testosterone transdermal gel in packet</i>	T2	PA
<i>testosterone transdermal solution in metered pump w/app</i>	T2	PA
<i>tolvaptan</i>	T5	PA
TOUJEO MAX U-300 SOLOSTAR	T3	SI
TOUJEO SOLOSTAR U-300 INSULIN	T3	SI
TRADJENTA	T3	QL (31 EA per 31 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	T3	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	T3	QL (62 EA per 31 days)
TRULICITY	T3	PA; QL (2 ML per 28 days)
UNITHROID	T3	
VICTOZA 3-PAK	T3	PA; QL (9 ML per 30 days)
XULTOPHY 100/3.6	T3	SI; QL (15 ML per 30 days)
ZEGALOGUE AUTOINJECTOR	T3	
ZEGALOGUE SYRINGE	T3	
Gastroenterology		
<i>alosetron oral tablet 0.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>alosetron oral tablet 1 mg</i>	T5	PA; QL (62 EA per 31 days)
AMITIZA	T3	QL (62 EA per 31 days)
<i>aprepitant</i>	T4	PA-BvD
<i>balsalazide</i>	T2	
<i>betaine</i>	T5	
<i>budesonide oral capsule, delayed, extend. release</i>	T4	
<i>budesonide oral tablet, delayed and ext. release</i>	T5	
CHOLBAM	T5	PA
<i>cimetidine</i>	T2	
CIMZIA	T5	PA; QL (2 EA per 28 days)
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)
CLENPIQ	T4	
COMPRO	T3	
CONSTULOSE	T2	
CREON ORAL CAPSULE, DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 3,000-9,500- 15,000 UNIT, 6,000-19,000 -30,000 UNIT	T3	
CREON ORAL CAPSULE, DELAYED RELEASE(DR/EC) 24,000-76,000 -120,000 UNIT, 36,000-114,000- 180,000 UNIT	T5	
<i>cromolyn oral</i>	T4	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
<i>diphenoxylate-atropine</i>	T2	
<i>dronabinol</i>	T4	PA-BvD
ENULOSE	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	T2	QL (31 EA per 31 days)
<i>famotidine oral suspension</i>	T2	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	
GAVILYTE-G	T2	
GENERLAC	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
<i>granisetron hcl oral</i>	T2	PA-BvD
<i>hydrocortisone rectal</i>	T4	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	T2	
IBSRELA	T5	PA; QL (62 EA per 31 days)
<i>lactulose oral solution 10 gram/15 ml</i>	T2	
<i>lansoprazole oral capsule, delayed release(dr/ec) 15 mg</i>	T2	QL (31 EA per 31 days)
<i>lansoprazole oral capsule, delayed release(dr/ec) 30 mg</i>	T2	QL (62 EA per 31 days)
LINZESS	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral capsule (with del rel tablets)</i>	T2	
<i>mesalamine oral capsule, extended release 24hr</i>	T2	
<i>mesalamine oral tablet, delayed release (dr/ec)</i>	T4	
<i>mesalamine rectal enema</i>	T4	
<i>metoclopramide hcl oral solution</i>	T2	
<i>metoclopramide hcl oral tablet</i>	T1	
<i>misoprostol</i>	T2	
MOVANTI	T3	QL (31 EA per 31 days)
OCALIVA	T5	PA; QL (31 EA per 31 days)
<i>omeprazole oral capsule, delayed release(dr/ec)</i>	T1	
<i>ondansetron</i>	T2	PA-BvD
<i>ondansetron hcl oral solution</i>	T2	PA-BvD
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	T2	PA-BvD
<i>pantoprazole oral tablet, delayed release (dr/ec)</i>	T1	
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	T2	
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>peg-electrolyte soln</i>	T2	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	T3	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	T5	
<i>prochlorperazine</i>	T2	
<i>prochlorperazine maleate</i>	T1	
PROCTO-MED HC	T2	
PROCTO-PAK	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
<i>rabeprazole oral tablet,delayed release (dr/ec)</i>	T2	QL (62 EA per 31 days)
RECTIV	T3	
<i>scopolamine base</i>	T3	QL (10 EA per 30 days)
SUCRAID	T5	
<i>sucralfate oral suspension</i>	T4	
<i>sucralfate oral tablet</i>	T2	
<i>sulfasalazine</i>	T2	
SUPREP BOWEL PREP KIT	T3	
<i>ursodiol oral capsule 300 mg</i>	T2	
<i>ursodiol oral tablet</i>	T2	
VIBERZI	T5	PA; QL (62 EA per 31 days)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 3,000-10,000 -14,000-UNIT, 5,000-17,000- 24,000 UNIT	T3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000- 105,000 UNIT, 40,000-126,000- 168,000 UNIT	T5	
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARCALYST	T5	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T3	

Drug Name	Drug Tier	Requirements/Limits
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	QL (14 EA per 28 days)
BEXSERO	T3	
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
FULPHILA	T5	
GARDASIL 9 (PF)	T3	
HAVRIX (PF)	T3	
HIBERIX (PF)	T3	
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	T3	
INTRON A INJECTION RECON SOLN	T5	PA-NS
IPOL	T3	
IXIARO (PF)	T3	
KINRIX (PF) INTRAMUSCULAR SYRINGE	T3	
LEUKINE INJECTION RECON SOLN	T5	PA
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENQUADFI (PF)	T3	
MENVEO A-C-Y-W-135-DIP (PF)	T3	
M-M-R II (PF)	T3	
NIVESTYM	T5	
NYVEPRIA	T5	
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	T3	
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)
PREHEVBRIO (PF)	T3	PA-BvD
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION	T3	
RABAVERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
RETACRIT	T3	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SHINGRIX (PF)	T3	QL (2 EA per 999 days)
TDVAX	T3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T3	
<i>tetanus,diphtheria tox ped(pf)</i>	T3	
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	T3	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI	T3	
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
Miscellaneous Supplies		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T3	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>pen needle, diabetic needle 29 gauge x 1/2"</i>	T3	
Musculoskeletal / Rheumatology		
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
<i>alendronate oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>allopurinol</i>	T1	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
<i>colchicine oral tablet</i>	T2	QL (62 EA per 31 days)
ENBREL MINI	T5	PA; QL (7.84 ML per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
<i>febuxostat</i>	T2	PA
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN CROHNS-UC-HS START	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS	T5	PA; QL (4 EA per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF)	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (3 EA per 28 days)
<i>ibandronate oral</i>	T2	
<i>leflunomide</i>	T2	
OLUMIANT ORAL TABLET 1 MG, 2 MG	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
<i>penicillamine oral tablet</i>	T5	
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
PROLIA	T3	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T2	
RIDAURA	T5	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	T5	PA; QL (31 EA per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	T5	PA; QL (112 EA per 365 days)
<i>risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	T2	
<i>risedronate oral tablet,delayed release (dr/ec)</i>	T4	
SAVELLA	T3	PA
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
<i>teriparatide</i>	T5	PA; QL (2.48 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 30 days)
XELJANZ ORAL SOLUTION	T5	PA; QL (310 ML per 31 days)
XELJANZ ORAL TABLET	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
Obstetrics / Gynecology		
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
AMABELZ	T2	
APRI	T2	
ARANELLE (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
AVIANE	T2	
CAMILA	T2	
CAZIAN (28)	T2	
<i>clindamycin phosphate vaginal</i>	T2	
CRYSELLE (28)	T2	
CYRED EQ	T2	
<i>desogestrel-ethinyl estradiol</i>	T2	
DOTTI	T2	
<i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)</i>	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
ELURYNG	T4	
EMOQUETTE	T2	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
<i>estradiol oral</i>	T2	
<i>estradiol transdermal</i>	T2	
<i>estradiol vaginal</i>	T2	
<i>estradiol-norethindrone acet</i>	T2	
<i>ethynodiol diac-eth estradiol</i>	T2	
<i>etonogestrel-ethinyl estradiol</i>	T4	
FEMYNOR	T2	
INCASSIA	T2	
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T4	
JULEBER	T2	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1-50 (28)	T2	
KURVELO (28)	T2	
<i>l norgest/e.estradiol-e.estrad</i>	T2	
LARISSIA	T2	
LESSINA	T2	
LEVONEST (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
LEVORA-28	T2	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYLEQ	T2	
LYLLANA	T2	
LYZA	T2	
MARLISSA (28)	T2	
<i>medroxyprogesterone</i>	T2	
<i>metronidazole vaginal</i>	T2	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
MIMVEY	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	T4	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	T2	
<i>norgestimate-ethinyl estradiol</i>	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
PIMTREA (28)	T2	
PIRMELLA ORAL TABLET 1-35 MG-MCG	T2	
PORTIA 28	T2	
PREMARIN ORAL	T3	
PREMARIN VAGINAL	T3	
PREMPRO	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>progesterone micronized</i>	T2	
RECLIPSEN (28)	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
<i>terconazole</i>	T2	
TILIA FE	T2	
<i>tranexamic acid oral</i>	T3	
TRI-ESTARYLLA	T2	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
VANDAZOLE	T3	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VESTURA (28)	T2	
VIENVA	T2	
YUVAFEM	T2	
ZAFEMY	T4	
ZOVIA 1-35 (28)	T2	
Ophthalmology		
<i>acetazolamide</i>	T2	
ALOMIDE	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
<i>apraclonidine</i>	T2	
<i>atropine ophthalmic (eye) drops</i>	T2	
<i>azelastine ophthalmic (eye)</i>	T2	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b</i>	T2	
<i>bepotastine besilate</i>	T3	
BESIVANCE	T3	
<i>betaxolol ophthalmic (eye)</i>	T2	
<i>bimatoprost ophthalmic (eye)</i>	T2	
BLEPHAMIDE S.O.P.	T4	
<i>brimonidine</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>brimonidine-timolol</i>	T3	
<i>brinzolamide</i>	T4	
<i>bromfenac</i>	T2	
BROMSITE	T3	
<i>carteolol</i>	T2	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T2	
COMBIGAN	T3	
<i>cromolyn ophthalmic (eye)</i>	T2	
<i>cyclosporine ophthalmic (eye)</i>	T3	QL (60 EA per 30 days)
CYSTARAN	T5	PA; QL (60 ML per 28 days)
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	
<i>diclofenac sodium ophthalmic (eye)</i>	T2	
<i>difluprednate</i>	T3	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
EYSUVIS	T3	QL (8.3 ML per 30 days)
<i>fluorometholone</i>	T2	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T2	
GENTAK OPHTHALMIC (EYE) OINTMENT	T2	
<i>gentamicin ophthalmic (eye) drops</i>	T2	
ILEVRO	T3	
<i>ketorolac ophthalmic (eye)</i>	T2	
<i>latanoprost</i>	T1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T2	
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	T3	
<i>loteprednol etabonate ophthalmic (eye) drops,gel</i>	T3	
<i>loteprednol etabonate ophthalmic (eye) drops,suspension</i>	T2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
<i>methazolamide</i>	T4	
<i>moxifloxacin ophthalmic (eye) drops</i>	T2	
NATACYN	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>neomycin-bacitracin-poly-hc</i>	T2	
<i>neomycin-bacitracin-polymyxin</i>	T2	
<i>neomycin-polymyxin b-dexameth</i>	T2	
<i>neomycin-polymyxin-gramicidin</i>	T2	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T3	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>olopatadine ophthalmic (eye)</i>	T2	
OXERVATE	T5	PA; QL (112 ML per 56 days)
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
<i>polymyxin b sulf-trimethoprim</i>	T2	
<i>prednisolone acetate</i>	T2	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
PROLENSA	T3	
RESTASIS	T3	QL (60 EA per 30 days)
RESTASIS MULTIDOSE	T3	QL (5.5 ML per 27 days)
RHOPRESSA	T3	ST
ROCKLATAN	T3	ST
SIMBRINZA	T4	
<i>sulfacetamide sodium ophthalmic (eye)</i>	T2	
<i>sulfacetamide-prednisolone</i>	T2	
<i>timolol maleate ophthalmic (eye) drops</i>	T1	
<i>timolol maleate ophthalmic (eye) drops, once daily</i>	T2	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	T3	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
<i>tobramycin ophthalmic (eye)</i>	T2	
<i>tobramycin-dexamethasone</i>	T3	
<i>travoprost</i>	T3	
<i>trifluridine</i>	T3	
XIIDRA	T3	QL (60 EA per 30 days)
ZIRGAN	T4	ST
Respiratory And Allergy		
<i>acetylcysteine</i>	T2	PA-BvD
ADEMPAS	T5	PA; QL (93 EA per 31 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	T2	QL (17 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	T2	QL (13.4 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)</i>	NF	
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	T2	PA-BvD
<i>albuterol sulfate oral syrup</i>	T2	
<i>albuterol sulfate oral tablet</i>	T4	
ALYQ	T5	PA; QL (62 EA per 31 days)
<i>ambrisentan</i>	T5	PA; QL (31 EA per 31 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
<i>arformoterol</i>	T3	PA-BvD
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
<i>azelastine-fluticasone</i>	T2	QL (23 GM per 30 days)
<i>bosentan</i>	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BREZTRI AEROSPHERE	T3	QL (10.7 GM per 30 days)
<i>budesonide inhalation</i>	T4	PA-BvD
<i>cetirizine oral solution 1 mg/ml</i>	T2	QL (310 ML per 31 days)
CINRYZE	T5	PA; QL (20 EA per 28 days)
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T5	PA-BvD
DALIRESP	T4	QL (31 EA per 31 days)
<i>desloratadine oral tablet</i>	T2	QL (31 EA per 31 days)
<i>desloratadine oral tablet,disintegrating</i>	T3	QL (31 EA per 31 days)
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	T3	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 267 MG	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 801 MG	T5	PA; QL (93 EA per 31 days)
FASENRA	T5	PA; QL (1 ML per 56 days)
FASENRA PEN	T5	PA; QL (1 ML per 56 days)

Drug Name	Drug Tier	Requirements/Limits
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	T4	QL (12 GM per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	T4	QL (24 GM per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	T4	QL (10.6 GM per 30 days)
<i>flunisolide</i>	T2	QL (50 ML per 25 days)
<i>fluticasone propionate nasal</i>	T2	QL (16 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	T3	QL (1 EA per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	T1	QL (60 EA per 30 days)
<i>formoterol fumarate</i>	T3	PA-BvD
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>icatibant</i>	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T3	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation</i>	T2	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
<i>levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml</i>	T2	PA-BvD
<i>levalbuterol hcl inhalation solution for nebulization 1.25 mg/3 ml</i>	T3	PA-BvD
<i>levalbuterol tartrate</i>	T3	QL (30 GM per 30 days)
<i>levocetirizine oral solution</i>	T2	QL (310 ML per 31 days)
<i>levocetirizine oral tablet</i>	T2	QL (31 EA per 31 days)
<i>mometasone nasal</i>	T2	QL (34 GM per 30 days)
<i>montelukast oral tablet</i>	T2	QL (31 EA per 31 days)
<i>montelukast oral tablet,chewable</i>	T2	QL (31 EA per 31 days)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	T5	PA; QL (3 EA per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (3 ML per 28 days)
OFEV	T5	PA; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
OPSUMIT	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
ORLADEYO	T5	PA; QL (31 EA per 31 days)
<i>pirfenidone oral tablet 267 mg</i>	T5	PA; QL (279 EA per 31 days)
<i>pirfenidone oral tablet 801 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>promethazine oral</i>	T4	PA
PULMOZYME	T5	PA
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
SAJAZIR	T5	PA; QL (18 ML per 30 days)
SEREVENT DISKUS	T3	QL (60 EA per 30 days)
<i>sildenafil (pulm.hypertension) oral tablet</i>	T3	PA; QL (93 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T3	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
SYMJEPI	T4	
<i>tadalafil (pulm. hypertension) oral tablet</i>	T5	PA; QL (62 EA per 31 days)
<i>terbutaline oral</i>	T4	
THEO-24	T3	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
TRELEGY ELLIPTA	T3	QL (60 EA per 30 days)
TRIKAFTA	T5	PA; QL (84 EA per 28 days)
WIXELA INHUB	T1	QL (60 EA per 30 days)
XOLAIR	T5	PA
<i>zafirlukast oral tablet 10 mg</i>	T2	QL (93 EA per 31 days)
<i>zafirlukast oral tablet 20 mg</i>	T2	QL (62 EA per 31 days)
Urologicals		
<i>alfuzosin</i>	T2	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg</i>	T2	
<i>bethanechol chloride oral tablet 50 mg</i>	T3	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T4	
<i>dutasteride</i>	T2	QL (31 EA per 31 days)
<i>dutasteride-tamsulosin</i>	T2	QL (31 EA per 31 days)
ELMIRON	T5	
<i>finasteride oral tablet 5 mg</i>	T2	
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	T3	QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral syrup</i>	T3	
<i>oxybutynin chloride oral tablet</i>	T3	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg</i>	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral tablet extended release 24hr 15 mg</i>	T3	QL (62 EA per 31 days)
<i>potassium citrate oral tablet extended release</i>	T2	
<i>silodosin</i>	T2	
<i>tadalafil oral tablet 2.5 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>tadalafil oral tablet 5 mg</i>	T4	PA; QL (31 EA per 31 days)
<i>tamsulosin</i>	T1	
<i>tolterodine oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>tolterodine oral tablet</i>	T2	QL (62 EA per 31 days)
<i>trospium oral capsule,extended release 24hr</i>	T3	QL (31 EA per 31 days)
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Vitamins, Hematinics / Electrolytes		
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CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
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Drug Name	Drug Tier	Requirements/Limits
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<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	T2	
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<i>fluconazole</i>	8	<i>glimepiride</i>	44	UV-ADOL HS	52
<i>fluconazole in nacl (iso-osm)</i>	8	<i>glipizide</i>	44	HUMULIN 70/30 U-100	
<i>flucytosine</i>	8	<i>glipizide-metformin</i>	44	INSULIN	44
<i>fludrocortisone</i>	43	GLUCAGON EMERGENCY		HUMULIN 70/30 U-100	
<i>flunisolide</i>	60	KIT (HUMAN)	44	KWIKPEN	44
<i>fluocinolone</i>	39	<i>glycopyrrolate</i>	48	HUMULIN N NPH INSULIN	
<i>fluocinolone acetonide oil</i>	43	GLYXAMBI	44	KWIKPEN	44
<i>fluocinolone and shower cap</i>	39	GRALISE	24	HUMULIN N NPH U-100	
<i>fluocinonide</i>	39	<i>granisetron hcl</i>	48	INSULIN	44
<i>fluocinonide-emollient</i>	39	<i>griseofulvin microsize</i>	8	HUMULIN R REGULAR U-	
<i>fluoride (sodium)</i>	62	<i>griseofulvin ultramicrosize</i>	8	100 INSULN	44
<i>fluorometholone</i>	57	GVOKE	44	HUMULIN R U-500 (CONC)	
<i>fluorouracil</i>	39	GVOKE HYPOPEN 2-PACK ..	44	INSULIN	44
<i>fluoxetine</i>	23	GVOKE PFS 1-PACK		HUMULIN R U-500 (CONC)	
<i>fluphenazine decanoate</i>	23	SYRINGE	44	KWIKPEN	44
<i>fluphenazine hcl</i>	23	<i>halobetasol propionate</i>	40	<i>hydralazine</i>	34
<i>flurbiprofen</i>	23	<i>haloperidol</i>	24	<i>hydrochlorothiazide</i>	34
<i>flurbiprofen sodium</i>	57	<i>haloperidol decanoate</i>	24	<i>hydrocodone-acetaminophen</i>	24
<i>fluticasone propionate</i>	39, 60	<i>haloperidol lactate</i>	24	<i>hydrocodone-ibuprofen</i>	24
<i>fluticasone propion-salmeterol</i> ..	60	HARVONI	8	<i>hydrocortisone</i>	40, 44, 48
<i>fluvastatin</i>	34	HAVRIX (PF)	50	<i>hydrocortisone-acetic acid</i>	43

<i>hydromorphone</i>	24	ISOLYTE-P IN 5 %		LANTUS U-100 INSULIN	45
<i>hydroxychloroquine</i>	8	DEXTROSE	62	<i>lapatinib</i>	15
<i>hydroxyurea</i>	14	<i>isoniazid</i>	9	LARISSIA	54
<i>hydroxyzine hcl</i>	60	<i>isosorbide dinitrate</i>	34	<i>latanoprost</i>	57
<i>ibandronate</i>	52	<i>isosorbide mononitrate</i>	34	LATUDA	25
IBRANCE	14	<i>isotretinoin</i>	40	<i>leflunomide</i>	52
IBSRELA	48	<i>isradipine</i>	34	<i>lenalidomide</i>	15
IBU	24	<i>itraconazole</i>	9	LENVIMA	15
<i>ibuprofen</i>	24	<i>ivermectin</i>	9, 40	LESSINA	54
<i>icatibant</i>	60	IXIARO (PF)	50	<i>letrozole</i>	15
ICLUSIG	14	JAKAFI	14	<i>leucovorin calcium</i>	15
<i>icosapent ethyl</i>	34	JANTOVEN	34	LEUKERAN	15
IDHIFA	14	JANUMET	44	LEUKINE	50
ILEVRO	57	JANUMET XR	44	<i>leuprolide</i>	15
<i>imatinib</i>	14	JANUVIA	44	<i>levalbuterol hcl</i>	60
IMBRUVICA	14	JARDIANCE	44	<i>levalbuterol tartrate</i>	60
<i>imipenem-cilastatin</i>	8	JASMIEL (28)	54	<i>levetiracetam</i>	25
<i>imipramine hcl</i>	24	JENTADUETO	44	<i>levobunolol</i>	57
<i>imiquimod</i>	40	JENTADUETO XR	45	<i>levocarnitine</i>	42
IMOVAX RABIES		JINTELI	54	<i>levocarnitine (with sugar)</i>	42
VACCINE (PF)	50	JULEBER	54	<i>levocetirizine</i>	60
IMPAVIDO	8	JULUCA	9	<i>levofloxacin</i>	9, 57
INCASSIA	54	JUXTAPID	34	<i>levofloxacin in d5w</i>	9
INCRELEX	42	KALYDECO	60	LEVONEST (28)	54
INCRUSE ELLIPTA	60	KARIVA (28)	54	<i>levonorgestrel-ethinyl estrad</i>	55
<i>indapamide</i>	34	KELNOR 1/35 (28)	54	<i>levonorg-eth estrad triphasic</i>	55
<i>indomethacin</i>	24	KELNOR 1-50 (28)	54	LEVORA-28	55
INFANRIX (DTAP) (PF)	50	KERENDIA	34	<i>levothyroxine</i>	45
INLYTA	14	<i>ketoconazole</i>	9, 40	LEVOXYL	45
INQOVI	14	<i>ketorolac</i>	57	LEXIVA	9
INREBIC	14	KINRIX (PF)	50	<i>lidocaine</i>	40
<i>insulin syringe-needle u-100</i>	51	KISQALI	14, 15	<i>lidocaine hcl</i>	40
INTELENCE	8	KISQALI FEMARA CO-		LIDOCAINE VISCOUS	40
INTRALIPID	62	PACK	14	<i>lidocaine-prilocaine</i>	40
INTRON A	50	KLOR-CON	63	<i>linezolid</i>	9
INTROVALE	54	KLOR-CON M10	63	<i>linezolid in dextrose 5%</i>	9
INVEGA HAFYERA	24, 25	KLOR-CON M15	63	LINZESS	48
INVEGA SUSTENNA	25	KLOR-CON M20	63	<i>liothyronine</i>	45
INVEGA TRINZA	25	KLOXXADO	25	<i>lisinopril</i>	34
INVOKAMET	44	KORLYM	45	<i>lisinopril-hydrochlorothiazide</i>	34
INVOKAMET XR	44	KURVELO (28)	54	<i>lithium carbonate</i>	25
INVOKANA	44	KYNMOBI	25	LIVALO	34
IPOL	50	<i>l norgest/e.estradiol-e.estrad</i>	54	LOKELMA	42
<i>ipratropium bromide</i>	43, 60	<i>labetalol</i>	34	LONSURF	15
<i>ipratropium-albuterol</i>	60	<i>lacosamide</i>	25	<i>loperamide</i>	48
<i>irbesartan</i>	34	<i>lactulose</i>	48	<i>lopinavir-ritonavir</i>	9
<i>irbesartan-hydrochlorothiazide</i> ..	34	<i>lamivudine</i>	9	<i>lorazepam</i>	25, 26
IRESSA	14	<i>lamivudine-zidovudine</i>	9	LORAZEPAM INTENSOL	25
ISENTRESS	9	<i>lamotrigine</i>	25	LORBRENA	15
ISENTRESS HD	8	<i>lansoprazole</i>	48	LORYNA (28)	55
ISIBLOOM	54	LANTUS SOLOSTAR U-100		<i>losartan</i>	34, 35
ISOLYTE S PH 7.4	62	INSULIN	45	<i>losartan-hydrochlorothiazide</i>	35

loteprednol etabonate	57	methotrexate sodium (pf)	15	naproxen	27
lovastatin	35	methylphenidate hcl	26	naproxen sodium	27
LOW-OGESTREL (28)	55	methylprednisolone	45	naratriptan	27
loxapine succinate	26	metoclopramide hcl	48	NARCAN	27
LUMAKRAS	15	metolazone	35	NATACYN	57
LUMIGAN	57	metoprolol succinate	35	nateglinide	45
LUPRON DEPOT	15	metoprolol ta-hydrochlorothiaz ..	35	NATPARA	45
LUPRON DEPOT (3		metoprolol tartrate	35	NAYZILAM	27
MONTH)	15	metronidazole	9, 40, 55	nebivolol	35
LUPRON DEPOT (4		metronidazole in nacl (iso-os)	9	nefazodone	27
MONTH)	15	metyrosine	35	neomycin	9
LUPRON DEPOT (6		mexiletine	35	neomycin-bacitracin-poly-hc	58
MONTH)	15	miconazole	9	neomycin-bacitracin-polymyxin ..	58
LUTERA (28)	55	MICONAZOLE-3	55	neomycin-polymyxin b-	
LYLEQ	55	MICROGESTIN 1.5/30 (21)	55	dexameth	58
LYLLANA	55	MICROGESTIN 1/20 (21)	55	neomycin-polymyxin-gramicidin ..	58
LYNPARZA	15	MICROGESTIN FE 1.5/30		neomycin-polymyxin-hc	43, 58
LYSODREN	15	(28)	55	NERLYNX	16
LYUMJEV KWIKPEN U-100		MICROGESTIN FE 1/20 (28) ..	55	NEUPRO	27
INSULIN	45	midodrine	42	nevirapine	9, 10
LYUMJEV KWIKPEN U-200		miglustat	45	NEXLETOL	35
INSULIN	45	MILI	55	NEXLIZET	35
LYUMJEV U-100 INSULIN ..	45	MIMVEY	55	niacin	35
LYZA	55	minocycline	9	nicardipine	35
magnesium sulfate	63	minoxidil	35	NICOTROL	42
malathion	40	mirtazapine	26	NICOTROL NS	42
maraviroc	9	misoprostol	48	nifedipine	35
MARLISSA (28)	55	M-M-R II (PF)	50	nilutamide	16
MARPLAN	26	modafinil	26	nimodipine	35
MATULANE	15	moexipril	35	NINLARO	16
meclizine	48	molindone	26	nitazoxanide	10
medroxyprogesterone	55	mometasone	40, 60	nitisinone	42
mefloquine	9	montelukast	60	NITRO-BID	35
megestrol	15	morphine	26	nitrofurantoin	10
MEKINIST	15	morphine concentrate	26	nitrofurantoin macrocrystal	10
MEKTOVI	15	MOUNJARO	45	nitrofurantoin monohyd/m-cryst ..	10
meloxicam	26	MOVANTIK	48	nitroglycerin	35
memantine	26	moxifloxacin	9, 57	NIVESTYM	50
MENACTRA (PF)	50	MULPLETA	35	norethindrone (contraceptive)	55
MENQUADFI (PF)	50	MULTAQ	35	norethindrone acetate	55
MENVEO A-C-Y-W-135-DIP		mupirocin	40	norethindrone ac-eth estradiol ...	55
(PF)	50	MYALEPT	45	norethindrone-e.estradiol-iron ...	55
mercaptopurine	15	mycophenolate mofetil	15	norgestimate-ethinyl estradiol ...	55
meropenem	9	mycophenolate sodium	15	NORTREL 0.5/35 (28)	55
mesalamine	48	MYORISAN	40	NORTREL 1/35 (21)	55
MESNEX	15	MYRBETRIQ	62	NORTREL 1/35 (28)	55
metformin	45	nabumetone	26	NORTREL 7/7/7 (28)	55
methadone	26	nadolol	35	nortriptyline	27
methazolamide	57	nafcillin	9	NORVIR	10
methenamine hippurate	9	naloxone	26, 27	NUBEQA	16
methimazole	45	naltrexone	27	NUCALA	60
methotrexate sodium	15	NAMZARIC	27	NUEDEXTA	27

NUPLAZID	27	<i>paroxetine hcl</i>	27	<i>potassium chloride in 0.9%nacl</i>	63
NURTEC ODT	27	PASER	10	<i>potassium chloride in 5 % dex</i>	63
NYAMYC	40	PAXIL	27	<i>potassium chloride in lr-d5</i>	63
<i>nystatin</i>	10, 40	PEDIARIX (PF)	50	<i>potassium chloride in water</i>	63
<i>nystatin-triamcinolone</i>	40	PEDVAX HIB (PF)	50	<i>potassium chloride-0.45 % nacl</i>	63
NYSTOP	40	<i>peg 3350-electrolytes</i>	48	<i>potassium chloride-d5-</i>	
NYVEPRIA	50	<i>peg3350-sod sul-nacl-kcl-asb-c</i> ..	48	<i>0.2%nacl</i>	63
OALIVA	48	PEGASYS	50	<i>potassium chloride-d5-</i>	
<i>octreotide acetate</i>	16	<i>peg-electrolyte soln</i>	49	<i>0.9%nacl</i>	63
ODEFSEY	10	PEMAZYRE	16	<i>potassium citrate</i>	62
ODOMZO	16	<i>pen needle, diabetic</i>	52	<i>pramipexole</i>	28
OFEV	60	<i>penicillamine</i>	53	<i>prasugrel</i>	36
<i>ofloxacin</i>	10, 43, 58	<i>penicillin g pot in dextrose</i>	10	<i>pravastatin</i>	36
<i>olanzapine</i>	27	<i>penicillin g potassium</i>	10	<i>praziquantel</i>	10
<i>olmesartan</i>	35	<i>penicillin g procaine</i>	10	<i>prazosin</i>	36
<i>olmesartan-amlodipin-hcthiazid</i>	35	<i>penicillin v potassium</i>	10	<i>prednisolone</i>	46
<i>olmesartan-hydrochlorothiazide</i>	35	PENTACEL (PF)	50	<i>prednisolone acetate</i>	58
<i>olopatadine</i>	43, 58	<i>pentamidine</i>	10	<i>prednisolone sodium phosphate</i>	
OLUMIANT	52	PENTASA	49		46, 58
<i>omega-3 acid ethyl esters</i>	35	<i>pentoxifylline</i>	35	<i>prednisone</i>	46
<i>omeprazole</i>	48	<i>perindopril erbumine</i>	36	<i>pregabalin</i>	28
OMNITROPE	50	PERIOGARD	43	PREHEVBRIO (PF)	51
<i>ondansetron</i>	48	<i>permethrin</i>	40	PREMARIN	55
<i>ondansetron hcl</i>	48	<i>perphenazine</i>	28	PREMPRO	55
ONUREG	16	PERSERIS	28	PRENATAL VITAMIN	
OPSUMIT	61	<i>phenelzine</i>	28	PLUS LOW IRON	63
ORACEA	10	<i>phenobarbital</i>	28	PREVALITE	36
ORENCIA	52, 53	<i>phenytoin</i>	28	PREVYMIS	10
ORENCIA CLICKJECT	52	<i>phenytoin sodium extended</i>	28	PREZCOBIX	10
ORGOVYX	16	PIFELTRO	10	PREZISTA	10
ORKAMBI	61	<i>pilocarpine hcl</i>	42, 58	PRIFTIN	10
ORLADEYO	61	<i>pimecrolimus</i>	40	<i>primaquine</i>	11
<i>oseltamivir</i>	10	<i>pimozide</i>	28	<i>primidone</i>	28
OTEZLA	53	PIMTREA (28)	55	PRIVIGEN	51
OTEZLA STARTER	53	<i>pindolol</i>	36	<i>probenecid</i>	53
<i>oxacillin</i>	10	<i>pioglitazone</i>	45	<i>probenecid-colchicine</i>	53
<i>oxacillin in dextrose(iso-osm)</i>	10	<i>pioglitazone-metformin</i>	46	<i>prochlorperazine</i>	49
<i>oxandrolone</i>	45	<i>piperacillin-tazobactam</i>	10	<i>prochlorperazine maleate</i>	49
<i>oxaprozin</i>	27	PIQRAY	16	PROCRIT	51
<i>oxcarbazepine</i>	27	<i>pirfenidone</i>	61	PROCTO-MED HC	49
OXERVATE	58	PIRMELLA	55	PROCTO-PAK	49
<i>oxybutynin chloride</i>	62	<i>piroxicam</i>	28	PROCTOSOL HC	49
<i>oxycodone</i>	27	PLEGRIDY	50, 51	PROCTOZONE-HC	49
<i>oxycodone-acetaminophen</i>	27	PLENAMINE	63	<i>progesterone micronized</i>	56
OZEMPIC	45	<i>podofilox</i>	40	PROGRAF	16
PACERONE	35	<i>polymyxin b sulf-trimethoprim</i>	58	PROLASTIN-C	42
<i>paliperidone</i>	27	POMALYST	16	PROLENSA	58
PALYNZIQ	45	PORTIA 28	55	PROLIA	53
PANRETIN	40	<i>posaconazole</i>	10	PROMACTA	36
<i>pantoprazole</i>	48	<i>potassium chlorid-d5-</i>		<i>promethazine</i>	61
<i>paricalcitol</i>	45	<i>0.45%nacl</i>	63	<i>propafenone</i>	36
<i>paromomycin</i>	10	<i>potassium chloride</i>	63	<i>propranolol</i>	36

<i>propylthiouracil</i>	46	<i>rimantadine</i>	11	<i>sodium phenylbutyrate</i>	42
PROQUAD (PF)	51	RINVOQ	53	<i>sodium polystyrene sulfonate</i>	42
<i>protriptyline</i>	28	<i>risedronate</i>	42, 53	SOLQUA 100/33	46
PULMOZYME	61	RISPERDAL CONSTA	28	SOLTAMOX	16
PURIXAN	16	<i>risperidone</i>	28, 29	SOMAVERT	46
<i>pyrazinamide</i>	11	<i>ritonavir</i>	11	<i>sorafenib</i>	16
<i>pyridostigmine bromide</i>	28	<i>rivastigmine</i>	29	SORINE	36
<i>pyrimethamine</i>	11	<i>rivastigmine tartrate</i>	29	<i>sotalol</i>	36
PYRUKYND	42	<i>rizatriptan</i>	29	SOTALOL AF	36
QINLOCK	16	ROCKLATAN	58	SPIRIVA RESPIMAT	61
QUADRACEL (PF)	51	<i>ropinirole</i>	29	SPIRIVA WITH	
<i>quetiapine</i>	28	<i>rosuvastatin</i>	36	HANDIHALER	61
<i>quinapril</i>	36	ROTARIX	51	<i>spironolactone</i>	36
<i>quinapril-hydrochlorothiazide</i>	36	ROTATEQ VACCINE	51	<i>spironolacton-hydrochlorothiaz.</i>	36
<i>quinidine sulfate</i>	36	ROWEEPRA	29	SPRINTEC (28)	56
<i>quinine sulfate</i>	11	ROZLYTREK	16	SPRITAM	29
QVAR REDHALER	61	RUBRACA	16	SPRYCEL	16
RABAVERT (PF)	51	<i>rufinamide</i>	29	SPS (WITH SORBITOL)	42
<i>rabeprazole</i>	49	RUKOBIA	11	SRONYX	56
RADICAVA ORS STARTER		RYBELSUS	46	SSD	41
KIT SUSP	28	RYDAPT	16	STELARA	41
<i>raloxifene</i>	53	SAJAZIR	61	STIOLTO RESPIMAT	61
<i>ramelteon</i>	28	SANDIMMUNE	16	STIVARGA	16
<i>ramipril</i>	36	SANTYL	40	<i>streptomycin</i>	11
<i>ranolazine</i>	36	<i>sapropterin</i>	46	STRIBILD	11
<i>rasagiline</i>	28	SAVELLA	53	STRIVERDI RESPIMAT	61
RAVICTI	42	SCSEMBLIX	16	SUCRAID	49
RECLIPSEN (28)	56	<i>scopolamine base</i>	49	<i>sucralfate</i>	49
RECOMBIVAX HB (PF)	51	SECUADO	29	<i>sulfacetamide sodium</i>	58
RECORLEV	46	<i>selegiline hcl</i>	29	<i>sulfacetamide sodium (acne)</i>	41
RECTIV	49	<i>selenium sulfide</i>	40	<i>sulfacetamide-prednisolone</i>	58
REGRANEX	40	SELZENTRY	11	<i>sulfadiazine</i>	11
RELENZA DISKHALER	11	SEREVENT DISKUS	61	<i>sulfamethoxazole-trimethoprim</i> ..	11
<i>repaglinide</i>	46	<i>sertraline</i>	29	SULFAMYLON	41
REPATHA PUSHTRONEX	36	SETLAKIN	56	<i>sulfasalazine</i>	49
REPATHA SURECLICK	36	<i>sevelamer carbonate</i>	42	<i>sulindac</i>	29
REPATHA SYRINGE	36	SHINGRIX (PF)	51	<i>sumatriptan</i>	29
RESTASIS	58	SIGNIFOR	16	<i>sumatriptan succinate</i>	29
RESTASIS MULTIDOSE	58	<i>sildenafil (pulm.hypertension)</i>	61	<i>sunitinib</i>	17
RETACRIT	51	<i>silodosin</i>	62	SUPRAX	11
RETEVMO	16	<i>silver sulfadiazine</i>	40	SUPREP BOWEL PREP KIT	49
REVCovi	42	SIMBRINZA	58	SYEDA	56
REVLIMID	16	SIMPONI	53	SYMBICORT	61
REXULTI	28	<i>simvastatin</i>	36	SYMDEKO	61
REYATAZ	11	<i>sirolimus</i>	16	SYMJEPI	61
REYVOW	28	SIRTURO	11	SYMLINPEN 120	46
RHOPRESSA	58	SKYRIZI	40, 41	SYMLINPEN 60	46
<i>ribavirin</i>	11	<i>sodium chloride</i>	42	SYMPAZAN	29
RIDAURA	53	<i>sodium chloride 0.45 %</i>	63	SYMTUZA	11
<i>rifabutin</i>	11	<i>sodium chloride 0.9 %</i>	42	SYNAREL	46
<i>rifampin</i>	11	<i>sodium chloride 3 % hypertonic</i>	63	SYNJARDY	46
<i>riluzole</i>	42	<i>sodium chloride 5 % hypertonic</i>	63	SYNJARDY XR	46

SYNRIBO	17	TIVICAY PD	11	<i>trospium</i>	62
SYNTHROID	46	<i>tizanidine</i>	30	TRUDHESA	30
TABLOID	17	TOBI PODHALER	11	TRULICITY	47
TABRECTA	17	TOBRADEX	58	TRUMENBA	51
<i>tacrolimus</i>	17, 41	<i>tobramycin</i>	11, 58	TRUSELTIQ	17
<i>tadalafil</i>	62	<i>tobramycin in 0.225 % nacl</i>	11	TUKYSA	17
<i>tadalafil (pulm. hypertension)</i>	61	<i>tobramycin sulfate</i>	11, 12	TURALIO	17
TAFINLAR	17	<i>tobramycin-dexamethasone</i>	58	TWINRIX (PF)	51
TAGRISSO	17	<i>tolterodine</i>	62	TYMLOS	53
TALTZ AUTOINJECTOR	41	<i>tolvaptan</i>	46	TYPHIM VI	51
TALTZ SYRINGE	41	<i>topiramate</i>	30	UBRELVY	30
TALZENNA	17	<i>toremifene</i>	17	UNITHROID	47
<i>tamoxifen</i>	17	<i>torse mide</i>	37	UPTRAVI	37
<i>tamsulosin</i>	62	TOUJEO MAX U-300		<i>ursodiol</i>	49
TASIGNA	17	SOLOSTAR	46	<i>valacyclovir</i>	12
<i>tavaborole</i>	41	TOUJEO SOLOSTAR U-300		VALCHLOR	41
<i>tazarotene</i>	41	INSULIN	46	<i>valganciclovir</i>	12
TAZORAC	41	TRADJENTA	46	<i>valproic acid</i>	30
TAZTIA XT	36	<i>tramadol</i>	30	<i>valproic acid (as sodium salt)</i>	30
TAZVERIK	17	<i>tramadol-acetaminophen</i>	30	<i>valsartan</i>	37
TDVAX	51	<i>trandolapril</i>	37	<i>valsartan-hydrochlorothiazide</i> ...	37
TEFLARO	11	<i>tranexamic acid</i>	56	VALTOCO	30
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This formulary was updated on 9/1/2022.

For more recent information or other questions, please contact:

Highmark Blue Cross Blue Shield of Western New York Customer Service
at 1-800-329-2792.

For TTY users, 711 National Relay Service, Oct. 1 – March 31, 8 a.m. – 8 p.m. EST,
seven days a week, and April 1 – Aug. 30, 8 a.m. – 8 p.m. EST, Monday – Friday,
or visit **medicare.highmark.com**.

The Formulary may change at any time. You will receive notice when necessary.

Highmark Blue Cross Blue Shield of Western New York is a trade name of
Highmark Western and Northeastern New York Inc., an independent licensee
of the Blue Cross Blue Shield Association.

Highmark Blue Cross Blue Shield of Western New York is a Medicare Advantage
plan with a Medicare contract and enrollment depends on contract renewal.
Highmark Blue Cross Blue Shield of Western New York complies with applicable
Federal civil rights laws and does not discriminate on the basis of race, color,
national origin, age, disability, or sex.

Additional information

About our benefits and premiums

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help program, call one of the following:

- 1-800-MEDICARE (1-800-633-4227) (TTY 711), 24 hours a day, seven days a week.
- The Social Security office at 1-800-772-1213 (TTY 711), between 7 a.m. and 7 p.m., Monday through Friday.
- Your state Medicaid office.

About us

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

Highmark BCBSWNY is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal.

Highmark Blue Cross Blue Shield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Dental coverage is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company that administers Highmark dental services

About our partners

Express Scripts® is a separate company.

Onduo is an independent company that provides a diabetes management program on behalf of Highmark.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.

SilverSneakers® is a registered trademark of Tivity Health, Inc. Tivity Health is an independent company that administers the SilverSneakers gym benefit.

Amwell is an independent company that provides telemedicine services. Amwell does not provide Blue Cross and/or Blue Shield products or services and it is solely responsible for its telemedicine services.

Care at HomeSM is a program for Highmark BCBSWNY members and is administered by Landmark Health, a separate company.

Mom's Meals, an independent company, administers meal benefits on behalf of Highmark BCBSWNY.

Davis Vision, a subsidiary of Versant Health, administers vision benefits on behalf of Highmark BCBSWNY.

Other pharmacies/physicians/providers are available in our network. Out of network/noncontracted providers are under no obligation to treat Highmark BCBSWNY members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out of network services.

Notice of Nondiscrimination

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

The plan 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)
- 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, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan 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: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لیے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

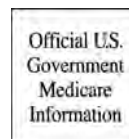
Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k'éhjí yá'áti'bee shíká adoowot nohsingo naaltsoos nihaa halne'go nidaahtinígíí bine'dée' Customer Service bibéesh bee hane' é biká'ígíí bich'j' dahodootnih.

IMPORTANT INFORMATION:

2022 Medicare Star Ratings



Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York - H3384

For 2022, Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York - H3384 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★

Health Services Rating: ★★★★★

Drug Services Rating: ★★★★★

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

The number of stars show how well a plan performs.

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online

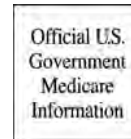
Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 800-248-9296 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 800-329-2792 (toll-free) or 711 (TTY).

IMPORTANT INFORMATION:

2022 Medicare Star Ratings



Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York - H5526

For 2022 Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York - H5526 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★
Health Services Rating: ★★★★★
Drug Services Rating: ★★★★★

Due to a Medicare error, plans based on a 3-star rating are

Why Star Ratings Are Important

Medicare rates plans on their health and drug services

This lets you easily compare plans based on quality and performance

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan for everyone who may get better care and better customer service



The number of stars show how well a plan performs

- ★★★★★ D5 CD . DNT
- ★★★★☆ ABOXD AXDRAL D
- ★★★☆☆ AXDRAL D
- ★★☆☆☆ BD. OW AXDRAL D
- ★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare)

Questions about this plan?

Contact Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Shield of Northeastern New York weekdays a week from 9:00 a.m. to 5:00 p.m. Eastern time at 1-800-272-9298 toll-free (or call 616-444-1000 from October 1 to March 1). Our hours of operation from April 1 to September 10 are Monday through Friday from 9:00 a.m. to 5:00 p.m. Eastern time. Current members please call 1-800-272-9292 toll-free (or call 616-444-1000).



HIGHMARK
WESTERN NEW YORK

2023 Summary of Benefits

Buffalo Medicare portfolio/11448675
Senior Blue 699 (HMO) Plan E (2023)
HMO-H3384 806

This is a summary of drug and health services covered by Senior Blue 699 (HMO) Plan E (2023)

January 1, 2023 – December 31, 2023

Senior Blue 699 (HMO) Plan E (2023) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

The benefit information provided does not list every service that we cover, limitation, or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage".

To join **Senior Blue 699 (HMO) Plan E (2023)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New York State: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services. You must receive all care from plan providers, with limited exceptions.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This document is also available in large print.

Please call us at 1-855-215-9237 (TTY 711) or visit us at **[bcbwny.com/medicare](https://www.bcbwny.com/medicare)**.

Our office hours are:
Monday-Friday: 8 a.m. - 5 p.m.

Premiums and Benefits	Senior Blue 699 (HMO) Plan E (2023)
Monthly plan premium	*If you currently pay a premium for your coverage please reach out to your Group Benefit Administrator to find out your cost.
Deductible	This plan does not have a medical deductible
Maximum out-of-pocket responsibility (does not include prescription drugs)	You pay no more than \$3,000 annually Includes copays and other costs for medical services for the year.
Inpatient hospital	You pay \$0 per stay Services may require a prior authorization
Outpatient hospital	You pay \$75 Services may require a prior authorization

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Premiums and Benefits	Senior Blue 699 (HMO) Plan E (2023)
Doctor visit Primary Specialist	You pay \$10 You pay \$30
Preventive care (e.g. flu vaccine, diabetic screenings)	You pay \$0
Emergency care	You pay \$65 If you are admitted to the hospital within 1 day, then you do not have to pay \$65
Surgery - ambulatory center	You pay \$75 Services may require a prior authorization
Urgently needed services	You pay \$35 If you are admitted to the hospital within 1 day, then you do not have to pay \$35
Diagnostic services/labs/imaging Diagnostic tests and procedures Lab services Advanced radiology — MRI, MRA, PET, and CT Outpatient X-Rays Therapeutic radiology services (such as radiation treatment for cancer)	You pay \$30 You pay \$0 You pay \$30 You pay \$30 You pay \$30 Services may require a prior authorization
Hearing services Diagnostic hearing exam Routine hearing exam — TruHearing™ Hearing aid benefit — TruHearing™	You pay \$30 You pay \$45, one routine hearing exam allowed annually \$699/\$999, one aid per ear per year
Dental services Medicare covered dental services Dental allowance	You pay \$0 You pay \$200 annual allowance

Premiums and Benefits		Senior Blue 699 (HMO) Plan E (2023)	
Vision services Routine eye exam* Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) Annual screening for diabetic retinopathy (for people with diabetes) Eyeglass or contact lenses after cataract surgery* Eyewear allowance* *A Davis Vision provider must be used to be considered in-network	You pay \$0 You pay \$30 You pay \$0 You pay \$0 \$200 annual allowance		
Mental health services Mental health (inpatient, 190-day lifetime limit) Outpatient group therapy/ individual therapy visit	You pay \$0 per stay You pay \$40 Services may require a prior authorization		
Skilled nursing facility	You pay \$0 per stay Services may require a prior authorization		
Physical therapy	You pay \$20		
Ambulance	You pay \$100 Services may require a prior authorization		
Transportation	Not covered		
Medicare Part B drugs Immunosuppressive drugs Oral chemotherapy drugs Physician administered injectables Nebulizer drugs other Part B drugs	You pay \$0 You pay \$0 You pay \$0 You pay \$0 You pay \$0 Services may require a prior authorization		
Outpatient Prescription Drugs			
Deductible	You pay \$0		
	Retail Rx-30 day supply	Mail Order 90-day supply	

Outpatient Prescription Drugs**		
Initial coverage		
Tier 1: Preferred generic	You pay \$0	You pay \$0
Tier 2: Generic	You pay \$15	You pay \$30
Tier 3: Preferred brand	You pay \$30	You pay \$60
Tier 4: Non-preferred drug	You pay \$50	You pay \$100
Tier 5: Specialty tier	You pay \$50	You pay \$100
Coverage gap or donut hole	No Coverage Gap	
Cost-sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.		
Additional Benefits		
Other rehabilitation services		
Occupational therapy	You pay \$20	
Speech therapy	You pay \$20	
Cardiac rehab	You pay \$20	
Chiropractor	You pay \$20	
	Services may require a prior authorization	
Supplies, equipment and devices		
Durable medical equipment	You pay \$0 compression stockings; 20% all other items	
Prosthetics	You pay \$0 diabetic shoes/inserts; 20% all other items	
Diabetic supplies - Part B	You pay \$0	
	Services may require a prior authorization	
Fitness program - Silver Sneakers®	Covered in full	
Hospital observation	You pay \$65	
Dialysis	You pay \$0	
Shingles	\$0	
Telemedicine		
Amwell	You pay \$0	
Your health provider	Your regular copay (Primary = \$10, Specialist = \$30, Mental health professional = \$40, Mental health psychiatrist = \$40, Alcohol & Substance Abuse = \$40)	
Home health care	You pay \$0	

****Important Message:** If you have prescription cost sharing more than \$35/month - What You Pay for Insulin – The maximum copayment for a one-month supply of covered insulin products is \$35, no matter what cost-sharing tier it is on or if you have not met your Rx deductible (if applicable).



HIGHMARK
WESTERN NEW YORK

2023 Summary of Benefits

Buffalo Medicare portfolio/11448675
Senior Blue 699 (HMO) Plan E1 (2023)
HMO-H3384 805

This is a summary of drug and health services covered by Senior Blue 699 (HMO) Plan E1 (2023)

January 1, 2023 – December 31, 2023

Senior Blue 699 (HMO) Plan E1 (2023) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

The benefit information provided does not list every service that we cover, limitation, or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage".

To join **Senior Blue 699 (HMO) Plan E1 (2023)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New York State: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services. You must receive all care from plan providers, with limited exceptions.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This document is also available in large print.

Please call us at 1-855-215-9237 (TTY 711) or visit us at [bcbwny.com/medicare](https://www.bcbwny.com/medicare).

Our office hours are:
Monday-Friday: 8 a.m. - 5 p.m.

Premiums and Benefits	Senior Blue 699 (HMO) Plan E1 (2023)
Monthly plan premium	*If you currently pay a premium for your coverage please reach out to your Group Benefit Administrator to find out your cost.
Deductible	This plan does not have a medical deductible
Maximum out-of-pocket responsibility (does not include prescription drugs)	You pay no more than \$3,000 annually Includes copays and other costs for medical services for the year.
Inpatient hospital	You pay \$0 per stay Services may require a prior authorization
Outpatient hospital	You pay \$75 Services may require a prior authorization

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Premiums and Benefits	Senior Blue 699 (HMO) Plan E1 (2023)
Doctor visit Primary Specialist	You pay \$10 You pay \$30
Preventive care (e.g. flu vaccine, diabetic screenings)	You pay \$0
Emergency care	You pay \$65 If you are admitted to the hospital within 1 day, then you do not have to pay \$65
Surgery - ambulatory center	You pay \$75 Services may require a prior authorization
Urgently needed services	You pay \$35 If you are admitted to the hospital within 1 day, then you do not have to pay \$35
Diagnostic services/labs/imaging Diagnostic tests and procedures Lab services Advanced radiology — MRI, MRA, PET, and CT Outpatient X-Rays Therapeutic radiology services (such as radiation treatment for cancer)	You pay \$30 You pay \$0 You pay \$30 You pay \$30 You pay \$30 Services may require a prior authorization
Hearing services Diagnostic hearing exam Routine hearing exam — TruHearing™ Hearing aid benefit — TruHearing™	You pay \$30 You pay \$45, one routine hearing exam allowed annually \$699/\$999, one aid per ear per year
Dental services Medicare covered dental services Dental allowance	You pay \$0 You pay \$200 annual allowance

Premiums and Benefits	Senior Blue 699 (HMO) Plan E1 (2023)
Vision services Routine eye exam* Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) Annual screening for diabetic retinopathy (for people with diabetes) Eyeglass or contact lenses after cataract surgery* Eyewear allowance* *A Davis Vision provider must be used to be considered in-network	You pay \$0 You pay \$30 You pay \$0 You pay \$0 \$200 annual allowance
Mental health services Mental health (inpatient, 190-day lifetime limit) Outpatient group therapy/ individual therapy visit	You pay \$0 per stay You pay \$40 Services may require a prior authorization
Skilled nursing facility	You pay \$0 per stay Services may require a prior authorization
Physical therapy	You pay \$20
Ambulance	You pay \$100 Services may require a prior authorization
Transportation	Not covered
Medicare Part B drugs Immunosuppressive drugs Oral chemotherapy drugs Physician administered injectables Nebulizer drugs other Part B drugs	You pay \$0 You pay \$0 You pay \$0 You pay \$0 You pay \$0 Services may require a prior authorization
Additional Benefits	

Additional Benefits	
Other rehabilitation services Occupational therapy Speech therapy Cardiac rehab Chiropractor	You pay \$20 You pay \$20 You pay \$20 You pay \$20 Services may require a prior authorization
Supplies, equipment and devices Durable medical equipment Prosthetics Diabetic supplies - Part B	You pay \$0 compression stockings; 20% all other items You pay \$0 diabetic shoes/inserts; 20% all other items You pay \$0 Services may require a prior authorization
Fitness program - Silver Sneakers®	Covered in full
Hospital observation	You pay \$65
Dialysis	You pay \$0
Shingles	Not Covered
Telemedicine Amwell Your health provider	You pay \$0 Your regular copay (Primary = \$10, Specialist = \$30, Mental health professional = \$40, Mental health psychiatrist = \$40, Alcohol & Substance Abuse = \$40)
Home health care	You pay \$0

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Amwell is a separate company that provides telemedicine services to Highmark BCBSWNY members. TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the hearing-aid benefit. Davis Vision, a subsidiary of Versant Health, administers vision benefits. SilverSneakers® is a registered trademark of Tivity Health, Inc. Tivity Health is an independent company that administers the SilverSneakers gym benefit. Other pharmacies/physicians/providers are available in our network. Out-of-network/non-contracted providers are under no obligation to treat Highmark BCBSWNY members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Highmark BCBSWNY complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-735-4515. (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 1-833-735-4515 (TTY 711)。

Medicare Advantage Acupuncture/ Massage Therapy Receipt Reimbursement

Please attach a copy of your itemized bill and paid receipt. Please keep a copy of all documents for your records, as copies submitted with your request will not be returned. The available allowance amount can be found on your plan's Evidence of Coverage. You must submit your claim to us within 12 months of the date you received the service.

Date	
Name	
Address	
Date of birth	
Subscriber ID	
Group number	
Service received ☐ Acupuncture ☐ Massage therapy (Please provide CPT code)	
Diagnosis for treatment (Description and/or Dx code)	
Provider's name	
Provider's address	
Provider's phone number	
Provider's verification (NPI# or tax ID)	

Please mail to:

Medicare Advantage Customer Service
PO Box 15013
Albany, NY 12212-5013

Allow four to six weeks for reimbursement. If you have any questions, feel free to contact customer service at 1-800-329-2792 (TTY 711).

We're available 8 a.m. – 8 p.m. EST, Monday – Friday.

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The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。



Medicare Advantage Dental Receipt Reimbursement

Please attach a copy of your itemized bill and paid receipt. Keep a copy of all documents for your records, as copies submitted with your request will not be returned. Not all plans include dental coverage or dental allowances. If your plan does not include dental coverage or dental allowances, disregard this form. You must submit your claim to us within 12 months of the date you received the service.

Date	
Name	
Address	
Date of birth	
Subscriber ID	
Dental provider's national provider identifier (NPI)/taxpayer identification number (TIN)	
Dental provider's name	
Dental provider's address	

Please mail to:

Dental Claims Administrator
P.O. Box 69421
Harrisburg, PA 17106-9421

Allow four to six weeks for reimbursement. If you have any questions, feel free to contact customer service at 1-800-329-2792 (TTY 711), Monday – Friday, 8 a.m. – 8 p.m. EST.

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[medicare.highmark.com](https://www.medicare.highmark.com)

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