

Medicare Employer Group



2024 New York State Employee Medicare

Senior Blue 699 (HMO) Plan E

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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.



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. – 4:30 p.m. EST

GROUP NAME:

GROUP NUMBER:

PLAN NAME: Senior Blue 699 (HMO) Plan E (2024)

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	2 copays for: Tier 1-2 100-day supply; Tier 3-4 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

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）。

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
- St. Vincent Hospital
- 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 [bcbswny.com/medicare](https://www.bcbswny.com/medicare) 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-resistance)

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, and copays or coinsurance to reimburse yourself if you already have dental coverage.

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., 7 days a week

April 1 – September 30, 8 a.m. – 8 p.m., 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 upgrade option on TruHearing Premium RIC Li for \$50 per 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., 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.

Manage type 2 diabetes on your own terms

Our Diabetes Management program is a no-cost* app-based virtual care program that:

- Comes with your health plan and helps you manage your care from the comfort of anywhere.
- Uses a smartphone and the app to provide access to the virtual health clinic and your care team.
- Gives you a personalized plan with ongoing, coordinated support between visits to your primary care provider.

Type 2 diabetes is manageable — especially when you have the right tools and team in your corner.

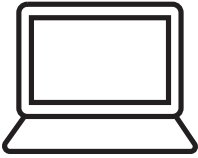
If you are eligible, you will receive an invitation to enroll. If you are not initially eligible, you may be able to enroll upon meeting eligibility criteria.

* There is no cost for most health plan members. If you have a qualified high deductible plan, you may have to pay out of pocket for some services with this solution until you meet your deductible.

To determine if you have any costs for care, you can call the Member Service team at the number on the back of your ID card.

If you are eligible, you will receive an invitation to enroll. Eligibility is determined by several factors including your medical status, health plan coverage, and historical medical claims. If you are not initially able to enroll, you may be able to upon meeting eligibility criteria.

Access your benefits wherever you go

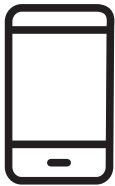


Manage your plan online

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.



My Highmark 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 My Highmark 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 mass measurement (bone density test)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings (blood tests such as cholesterol, lipids, triglycerides)
- Cervical and vaginal cancer screening
 - Pap smears and pelvic exam
- Colorectal cancer screenings
 - Barium enema
 - Colonoscopy
 - Fecal occult blood test
 - Flexible sigmoidoscopy
- CT screening for lung cancer
- COVID-19 vaccine
- Depression screening
- Diabetes screening tests
- 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 screenings
- Sexually transmitted infections (STI) screening and counseling
- Tobacco-use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare physical exam 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, social workers, 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

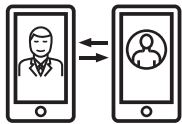
Every member is eligible for care management. If you have questions or concerns about your health care, contact Member Service to learn more.

Well360 Virtual Health



Well360 Virtual Health allows you to access medical care from your smart phone or computer. Schedule virtual visits with your health care providers at the same cost as your usual copay.

Convenient



Avoid spending time in waiting rooms. Well360 Virtual Health providers are available within minutes or by appointment. Talk with a doctor from the comfort of your own home, at your work place, or while traveling.

What's treated?

Medical care:



- Allergies
- Seasonal colds, coughs, flu
- Chronic condition management

Doctors will review symptoms and medications, perform an exam, and recommend a treatment plan.

Mental health:

- Anxiety
- Depression
- Trauma and loss

Therapists provide a safe, confidential space for you to get the treatment you need. An appointment is needed for these services.

How to get started

Download the app or visit **Well360VirtualHealth.com** to schedule an appointment.

Visit **medicare.highmark.com** for more information.

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**.

Members with certain chronic conditions have access to medical advice and urgent home visits around the clock at no cost.

Eligibility for **Care at Home** may be an option if you are living with a certain set of chronic illnesses, especially if you are managing multiple conditions. Once enrolled in **Care at Home**, you'll have access to:

- Traditional house calls* made by doctors, nurse practitioners, and physician assistants.
- A dedicated nurse care manager to advocate for you and guide you through the health system.
- Medical advice over the phone when you need it, day or night, including weekends and holidays.
- Coordinated care from pharmacists, dietitians, nurses, behavioral health specialists, and social workers.
- 24/7 medical services right in your home,* including cardiac care, administration of IV treatments, catheterization, writing prescriptions, antibiotics for infections, and help with injections

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

*Certain geographic areas are available for urgent telephonic visits only. For more details, please contact Care at Home.

In-home care

\$0 home-delivered meals



Admission to a hospital, mental health hospital, or skilled nursing facility can often be a difficult time for our members. That's why we offer a home delivered meals benefit to help ease the transition back to home life.

After discharge, our care managers will coordinate a daily meal delivered to your doorstep. Meals can be delivered nationwide and are customized to your preferences and dietary needs. You'll receive one meal per day for seven days.

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 **
- House Call Visit



\$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 chiropractic visits (see your 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.

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 100-day supply for Tiers 1 and 2.
- You pay only 1, 2, or 2.5 copays per 90-day supply for Tiers 3 and 4. 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** and register for an account.



Mail

Visit **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.

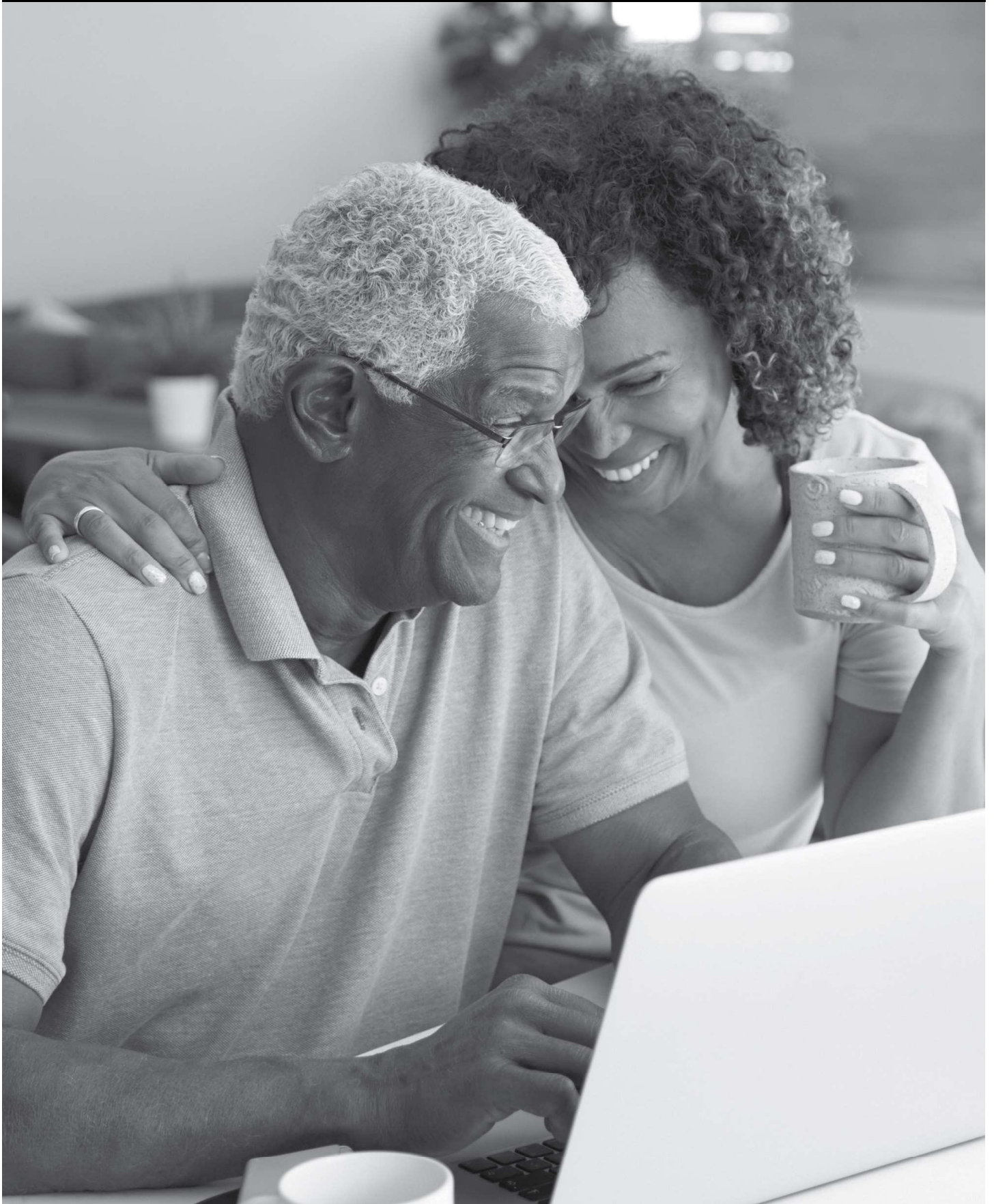
Stage 4 Catastrophic coverage

After you go through the donut hole

Once your total out-of-pocket costs reach \$8,000, your cost will not exceed your initial coverage level copay or coinsurance.

- There is \$0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.

THE CARD ACCEPTED BY OVER 90% OF DOCTORS.*



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

Understanding your prescription drug options

What is a formulary?

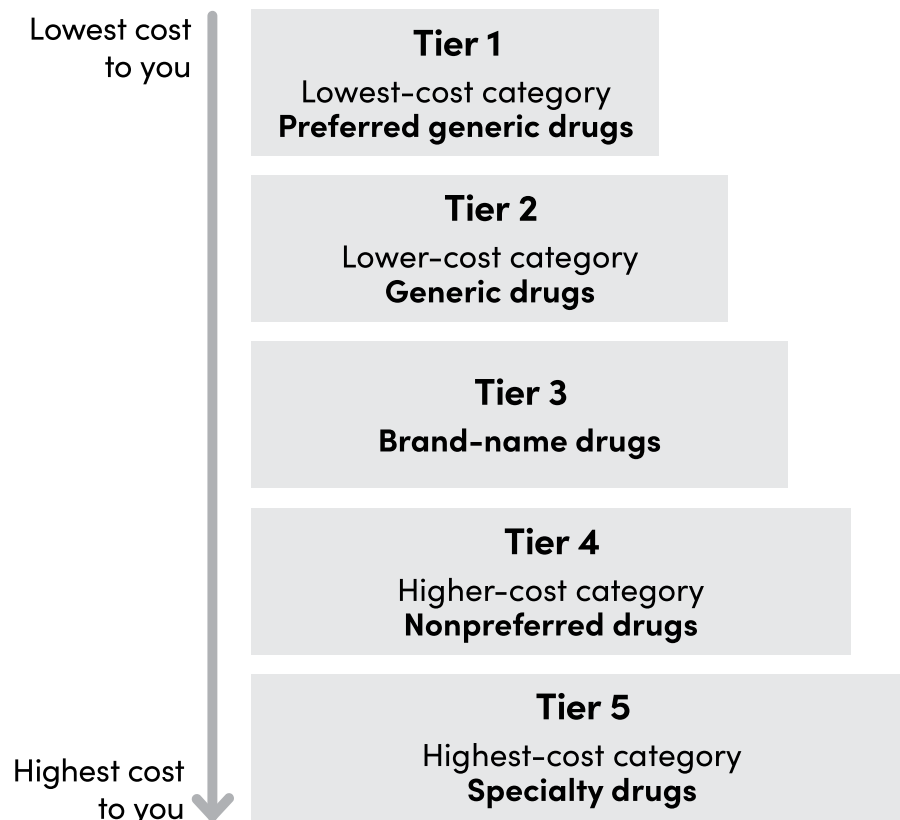
A formulary is a list of the medications that are covered under your Part D prescription drug benefit. A committee of doctors and pharmacists creates these lists by evaluating medications based on their cost, effectiveness, and availability. The formulary covers both generic and brand-name drugs.

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 bcbswny.com/medicare 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. If you cannot find your drug, please contact us at 1-800-329-2792 (TTY 711).



Senior Blue HMO, BlueSaver HMO, Employer Group PDP, Forever Blue PPO, and Freedom PPO

2024 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
Employer Group PDP

(List of Covered Drugs)

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

This formulary was updated on 8/25/2023.

For more recent information or other questions, please contact:

Senior Blue HMO, BlueSaver HMO, Employer Group PDP,
Forever Blue PPO, and Freedom PPO Pharmacy Service at 1-800-329-2792.

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

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

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.

When it refers to “plan” or “our plan,” it means Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Employer Group PDP, or Freedom PPO.

This document includes a list of the drugs (formulary) for our plan, which is current as of January 1, 2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025, and from time to time during the year.

What is the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Employer Group PDP, or Freedom PPO Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at 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, Employer Group PDP, or Freedom PPO Formulary (drug list) change?

Most changes in drug coverage happen on January 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, Employer Group PDP, 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, Employer Group PDP, 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 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of January 1, 2024. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages. 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/formulary](https://www.medicare.highmark.com/formulary).

How do I use the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Employer Group PDP, 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 plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug we will cover. For example, our plan provides 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 plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 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 plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Senior Blue HMO, BlueSaver HMO, Forever Blue PPO, Employer Group PDP, 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, Employer Group PDP, or Freedom PPO Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Pharmacy 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 Pharmacy Service for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask them 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, Employer Group PDP, 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 unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions, would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 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, Employer Group PDP, 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

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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.

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>	T4	
<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>	T4	
<i>atovaquone-proguanil</i>	T3	
<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	

Drug Name	Drug Tier	Requirements/Limits
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 600,000 UNIT/ML	T4	
BICILLIN L-A INTRAMUSCULAR SYRINGE 2,400,000 UNIT/4 ML	T5	
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>	T3	QL (50 EA per 30 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	T3	QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
<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	

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin in 5 % dextrose</i>	T4	
CLINDAMYCIN PEDIATRIC	T2	
<i>clindamycin phosphate injection</i>	T4	
<i>clindamycin phosphate intravenous</i>	T4	
<i>clotrimazole mucous membrane</i>	T2	
COARTEM	T4	
<i>colistin (colistimethate na)</i>	T4	
COMPLERA	T5	
<i>dapsone oral</i>	T2	
<i>daptomycin intravenous recon soln 350 mg</i>	T5	
<i>daptomycin intravenous recon soln 500 mg</i>	T4	
<i>darunavir ethanolate</i>	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)
DESCOVY	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 capsule, ir - delay rel, biphasic</i>	T4	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	T2	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
<i>efavirenz</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>	T3	
<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	

Drug Name	Drug Tier	Requirements/Limits
<i>entecavir</i>	T4	
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)
<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	
<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	
INTELENCE ORAL TABLET 25 MG	T4	
ISENTRESS HD	T5	
ISENTRESS ORAL POWDER IN PACKET	T5	
ISENTRESS ORAL TABLET	T5	

Drug Name	Drug Tier	Requirements/Limits
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	
KITABIS PAK	T4	PA
<i>lamivudine</i>	T3	
<i>lamivudine-zidovudine</i>	T3	
<i>ledipasvir-sofosbuvir</i>	T5	PA; QL (28 EA per 28 days)
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T3	
<i>levofloxacin oral</i>	T2	
LEXIVA ORAL SUSPENSION	T4	
<i>linezolid in dextrose 5%</i>	T4	
<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>	T4	
<i>maraviroc oral tablet 150 mg</i>	T5	
<i>maraviroc oral tablet 300 mg</i>	T4	
MAVYRET ORAL PELLETS IN PACKET	T5	PA; QL (140 EA per 28 days)
MAVYRET ORAL TABLET	T5	PA; QL (84 EA per 28 days)
<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 intravenous recon soln 100 mg</i>	T4	
<i>micafungin intravenous recon soln 50 mg</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	

Drug Name	Drug Tier	Requirements/Limits
<i>nevirapine oral suspension</i>	T4	
<i>nevirapine oral tablet</i>	T3	
<i>nevirapine oral tablet extended release 24 hr</i>	T4	
<i>nitazoxanide</i>	T4	
<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	
<i>nystatin oral</i>	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	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	
<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	PA
<i>praziquantel</i>	T4	
PREVYMIS ORAL	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 75 MG	T5	
PRIFTIN	T3	
<i>primaquine</i>	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>pyrazinamide</i>	T4	
<i>pyrimethamine</i>	T5	PA
<i>quinine sulfate</i>	T4	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
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>	T5	
<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	PA
<i>sofosbuvir-velpatasvir</i>	T5	PA; QL (28 EA per 28 days)
<i>streptomycin</i>	T5	
STRIBILD	T5	
<i>sulfadiazine</i>	T4	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	T2	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	T1	
SUNLENCA ORAL	T5	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	T4	
SYMTUZA	T5	QL (31 EA per 31 days)
TEFLARO INTRAVENOUS RECON SOLN 400 MG	T4	
TEFLARO INTRAVENOUS RECON SOLN 600 MG	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	T5	PA; QL (224 EA per 56 days)

Drug Name	Drug Tier	Requirements/Limits
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin inhalation</i>	T5	PA
<i>tobramycin sulfate injection solution</i>	T4	
TRECATOR	T4	
<i>trimethoprim</i>	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T5	QL (186 EA per 31 days)
TRIZIVIR	T5	
TYBOST	T3	
<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	
VIVJOA	T4	PA; QL (18 EA per 84 days)
<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	T4	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)
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)
<i>anastrozole</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
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)
CALQUENCE (ACALABRUTINIB MAL)	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</i>	T3	PA-BvD
<i>cyclosporine modified oral capsule</i>	T2	PA-BvD
<i>cyclosporine modified oral solution</i>	T4	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	T4	
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 ORAL TABLET 240 MG	T5	PA-NS; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
ERLEADA ORAL TABLET 60 MG	T5	PA-NS; QL (93 EA per 31 days)
<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)
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
<i>gefitinib</i>	T5	PA-NS; QL (31 EA per 31 days)
GENGRAF	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	T4	PA-NS
GLEOSTINE ORAL CAPSULE 100 MG	T5	PA-NS
<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 SUSPENSION	T5	PA-NS; QL (216 ML per 25 days)
IMBRUVICA ORAL TABLET 280 MG, 420 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)
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
JAYPIRCA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 50 MG	T5	PA-NS; QL (31 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)
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)
KOSELUGO ORAL CAPSULE 10 MG	T5	PA; QL (279 EA per 31 days)
KOSELUGO ORAL CAPSULE 25 MG	T5	PA; QL (124 EA per 31 days)
KRAZATI	T5	PA-NS; QL (186 EA per 31 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 (3 month)</i>	T4	ST
<i>leuprolide subcutaneous kit</i>	T3	
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 ORAL TABLET 120 MG	T5	PA-NS; QL (124 EA per 31 days)
LUMAKRAS ORAL TABLET 320 MG	T5	PA-NS; QL (93 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
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	T5	PA
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	T5	PA
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT	T5	PA

Drug Name	Drug Tier	Requirements/Limits
LYNPARZA	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T5	
LYTGOBI ORAL TABLET 4 MG	T5	PA-NS; QL (93 EA per 31 days)
LYTGOBI ORAL TABLET 4 MG (4X 4 MG TB)	T5	PA-NS; QL (124 EA per 31 days)
LYTGOBI ORAL TABLET 4 MG (5X 4 MG TB)	T5	PA-NS; QL (155 EA per 31 days)
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 RECON SOLN	T5	PA-NS; QL (1260 ML per 31 days)
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	T4	
<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
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, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	T4	PA
<i>octreotide acetate injection solution 500 mcg/ml</i>	T5	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)
ORSERDU ORAL TABLET 345 MG	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 86 MG	T5	PA-NS; QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
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)
REZLIDHIA	T5	PA-NS; QL (62 EA per 31 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)
<i>sunitinib malate</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 ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	T5	PA-NS; QL (930 EA per 31 days)
TAGRISSE	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
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>	T4	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	T4	ST
<i>tretinoin (antineoplastic)</i>	T5	
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 ORAL CAPSULE 125 MG	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)
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)

Drug Name	Drug Tier	Requirements/Limits
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 ORAL CAPSULE	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS; QL (248 EA per 31 days)
ZOLINZA	T5	PA-NS
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA	T5	PA-NS; QL (93 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	T2	PA; QL (5167 ML per 31 days)
<i>acetaminophen-codeine oral tablet</i>	T2	PA; QL (403 EA per 31 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	T3	PA; QL (1 ML per 28 days)
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>	T4	PA-NS
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>asenapine maleate</i>	T4	PA-NS; QL (62 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T4	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<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)
AUVELITY	T4	PA-NS; QL (62 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, 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>buprenorphine-naloxone sublingual tablet</i>	T4	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T2	QL (31 EA per 31 days)
<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	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)
<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)

Drug Name	Drug Tier	Requirements/Limits
<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	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet 2 mg</i>	T2	PA-NS; QL (310 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet,disintegrating 2 mg</i>	T2	PA-NS; 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	PA-NS; QL (186 EA per 31 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	T2	PA-NS; 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)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
<i>cyclobenzaprine oral tablet 10 mg</i>	T2	QL (93 EA per 31 days)
<i>cyclobenzaprine oral tablet 5 mg</i>	T2	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)

Drug Name	Drug Tier	Requirements/Limits
<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	PA-NS; QL (248 ML per 31 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	PA-NS; QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	PA-NS; 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>diflunisal</i>	T2	
<i>dihydroergotamine nasal</i>	T4	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>	T3	QL (31 EA per 31 days)
<i>donepezil oral tablet, disintegrating</i>	T2	
<i>doxepin oral capsule</i>	T2	PA-NS
<i>doxepin oral concentrate</i>	T2	PA-NS
<i>doxepin oral tablet</i>	T2	PA
<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)

Drug Name	Drug Tier	Requirements/Limits
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET	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	
EVRYSDI	T5	PA; QL (240 ML per 31 days)
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	
<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>	T5	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>	T4	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T4	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 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>	T4	PA; QL (12 EA per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	T3	PA-NS; QL (56 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
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)
<i>fingolimod</i>	T5	PA; QL (31 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 (pmdd)</i>	T2	
<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)
<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	
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	T5	PA; QL (31 ML per 31 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	T5	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T3	PA; QL (155 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	T4	PA; QL (31 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T4	PA; QL (93 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 750 MG, 900 MG	T4	PA; QL (62 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 2 mg, 4 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>hydromorphone oral tablet 8 mg</i>	T3	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</i>	T2	
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	T5	QL (3.5 ML per 180 days)
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)

Drug Name	Drug Tier	Requirements/Limits
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)
KESIMPTA PEN	T5	PA; QL (0.4 ML per 28 days)
KLOXXADO	T3	
<i>lacosamide oral</i>	T4	
<i>lamotrigine oral tablet</i>	T1	
<i>lamotrigine oral tablet extended release 24hr</i>	T4	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
<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	PA; QL (155 ML per 31 days)
<i>lorazepam oral tablet 0.5 mg</i>	T2	PA; QL (124 EA per 31 days)
<i>lorazepam oral tablet 1 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>lorazepam oral tablet 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>loxapine succinate</i>	T2	
LUCEMYRA	T5	
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>lurasidone oral tablet 80 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
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>methsuximide</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
<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 15 mg, 30 mg, 45 mg</i>	T1	
<i>mirtazapine oral tablet 7.5 mg</i>	T2	
<i>mirtazapine oral tablet,disintegrating</i>	T2	
<i>modafinil</i>	T3	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	
<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>	T3	QL (20 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>naratriptan oral tablet 2.5 mg</i>	T3	QL (9 EA per 28 days)
NAYZILAM	T4	PA-NS; QL (10 EA per 30 days)
<i>nefazodone</i>	T2	
NEUPRO	T4	
<i>nortriptyline</i>	T2	
NOURIANZ	T5	PA; QL (31 EA per 31 days)
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 tablet</i>	T2	QL (31 EA per 31 days)
<i>olanzapine oral tablet,disintegrating</i>	T4	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	
<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	

Drug Name	Drug Tier	Requirements/Limits
<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 oral tablet 125 mg</i>	T4	
<i>primidone oral tablet 250 mg, 50 mg</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 150 mg</i>	T3	QL (62 EA per 31 days)
<i>quetiapine oral tablet extended release 24 hr</i>	T2	QL (62 EA per 31 days)
QULIPTA	T5	PA; QL (31 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	
RELYVRIO	T5	PA; QL (62 EA per 31 days)
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	T4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 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)
<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)

Drug Name	Drug Tier	Requirements/Limits
<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
RYTARY	T3	ST
SECUADO	T5	PA-NS; QL (31 EA per 31 days)
<i>selegiline hcl</i>	T2	
<i>sertraline oral concentrate</i>	T2	
<i>sertraline oral tablet</i>	T1	
SKYCLARYS	T5	PA; QL (93 EA per 31 days)
<i>sodium oxybate</i>	T5	PA; QL (540 ML per 30 days)
SPRITAM	T4	
SUBVENITE	T2	
<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)
TASCENSO ODT	T5	PA; QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>tasimelteon</i>	T5	PA; QL (31 EA per 31 days)
<i>teriflunomide</i>	T5	PA; QL (31 EA per 31 days)
<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 oral tablet</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 oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trifluoperazine</i>	T2	
<i>trimipramine</i>	T4	PA-NS
TRINTELLIX	T3	
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 NASAL SPRAY, NON-AEROSOL 10 MG/SPRAY (0.1 ML), 5 MG/SPRAY (0.1 ML)	T4	PA-NS; QL (10 EA per 30 days)
VALTOCO NASAL SPRAY, NON-AEROSOL 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2)	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	
VERSACLOZ	T5	QL (558 ML per 31 days)
<i>vigabatrin</i>	T5	PA-NS
VIGADRONE ORAL POWDER IN PACKET	T5	PA-NS
<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)

Drug Name	Drug Tier	Requirements/Limits
VUMERITY	T5	PA; QL (124 EA per 31 days)
XCOPRI	T5	PA-NS
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1)	T4	PA-NS
XCOPRI MAINTENANCE PACK ORAL TABLET 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)
ZAVZPRET	T5	PA; QL (8 EA per 30 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER PACK (7-DAY)	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>zolpidem oral tablet</i>	T2	PA; QL (31 EA per 31 days)
ZONISADE	T5	PA-NS; QL (930 ML per 31 days)
<i>zonisamide</i>	T2	
ZTALMY	T5	PA-NS; QL (1100 ML per 30 days)
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	

Drug Name	Drug Tier	Requirements/Limits
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-atorvastatin</i>	T2	
<i>amlodipine-benazepril</i>	T1	
<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	
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>	T4	
<i>colestipol oral tablet</i>	T3	
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)
<i>digoxin oral solution</i>	T3	QL (155 ML per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<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</i> 360 mg, 420 mg	T2	
<i>diltiazem hcl oral capsule,extended release 24hr</i> 120 mg, 180 mg, 240 mg, 300 mg	T2	
<i>diltiazem hcl oral tablet</i>	T1	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	T2	
DILT-XR	T2	
<i>dofetilide</i>	T4	
DOPTLET (10 TAB PACK)	T5	PA
DOPTLET (15 TAB PACK)	T5	PA
DOPTLET (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	QL (31 EA per 31 days)
<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	
FILSPARI	T5	PA; QL (31 EA per 31 days)
<i>flecainide</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<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	
FUROSCIX	T5	PA; QL (8 EA per 30 days)
<i>furosemide injection solution</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 oral capsule 0.5 gram</i>	T2	QL (248 EA per 31 days)
<i>icosapent ethyl oral capsule 1 gram</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)
<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	

Drug Name	Drug Tier	Requirements/Limits
<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	PA
<i>mexiletine</i>	T3	
<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	T4	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	
<i>perindopril erbumine</i>	T1	
<i>pindolol</i>	T3	
<i>prasugrel</i>	T2	
<i>pravastatin</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<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>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T4	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</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	
TIADYL T ER	T2	
<i>timolol maleate oral</i>	T2	
<i>torse mide oral</i>	T2	
<i>trandolapril</i>	T1	
<i>triamterene-hydrochlorothiazid</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
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)
<i>verapamil oral capsule, 24 hr er pellet ct</i>	T4	
<i>verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg</i>	T2	
<i>verapamil oral capsule,ext rel. pellets 24 hr 360 mg</i>	T4	
<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		
AC CUTANE	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	
AMNESTEEM	T4	
<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	

Drug Name	Drug Tier	Requirements/Limits
<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-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>	T3	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)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
CROTAN	T4	
<i>desoximetasone topical cream</i>	T4	QL (100 GM per 28 days)
<i>desoximetasone topical gel</i>	T4	QL (60 GM 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)

Drug Name	Drug Tier	Requirements/Limits
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)
<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>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	

Drug Name	Drug Tier	Requirements/Limits
<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	
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>penciclovir</i>	T4	QL (5 GM per 28 days)
<i>permethrin</i>	T2	
<i>pimecrolimus</i>	T4	QL (100 GM per 28 days)
<i>podofilox</i>	T2	
REGRANEX	T5	PA
SANTYL	T4	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)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (1 ML 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>tazarotene topical cream</i>	T4	PA; QL (60 GM per 28 days)
<i>tazarotene topical gel</i>	T4	PA; QL (100 GM per 28 days)

Drug Name	Drug Tier	Requirements/Limits
TAZORAC TOPICAL CREAM 0.05 %	T4	PA; QL (60 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	T4	
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	
<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 125 mg</i>	T4	PA
<i>deferasirox oral tablet, dispersible 250 mg, 500 mg</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)
INCRELEX	T5	PA
<i>levocarnitine (with sugar)</i>	T2	PA-BvD
<i>levocarnitine oral tablet</i>	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
LOKELMA	T3	PA; QL (93 EA per 31 days)
<i>midodrine</i>	T2	
NICOTROL	T4	
NICOTROL NS	T5	
<i>nitisinone</i>	T5	PA
PHEBURANE	T5	PA; QL (620 GM per 31 days)
<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>	T4	
<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)
XURIDEN	T5	PA; QL (124 EA per 31 days)
ZOKINVY	T5	PA
Ear, Nose / Throat Medications		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal aerosol,spray</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	

Drug Name	Drug Tier	Requirements/Limits
<i>olopatadine nasal</i>	T3	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	T2	
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	
<i>glimepiride</i>	T1	
<i>glipizide</i>	T1	
<i>glipizide-metformin</i>	T1	
GLUCAGEN HYPOKIT	T3	
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	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 INSULN U-100	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMALOG MIX 75-25(U-100)INSULN	T3	

Drug Name	Drug Tier	Requirements/Limits
HUMALOG TEMPO PEN(U-100)INSULN	T3	
HUMALOG U-100 INSULIN	T3	
HUMULIN 70/30 U-100 INSULIN	T3	
HUMULIN 70/30 U-100 KWIKPEN	T3	
HUMULIN N NPH INSULIN KWIKPEN	T3	
HUMULIN N NPH U-100 INSULIN	T3	
HUMULIN R REGULAR U-100 INSULN	T3	
HUMULIN R U-500 (CONC) INSULIN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
<i>hydrocortisone oral</i>	T2	
<i>insulin lispro</i>	T3	
<i>insulin lispro protamin-lispro</i>	T3	
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)
JAVYGTOR	T5	PA
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG	T3	QL (62 EA per 31 days)
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	
LANTUS U-100 INSULIN	T3	
<i>levothyroxine oral tablet</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
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>lithyronine oral</i>	T2	
<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)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 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)
<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>	T3	
<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

Drug Name	Drug Tier	Requirements/Limits
SOLQUA 100/33	T3	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</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	
TOUJEO SOLOSTAR U-300 INSULIN	T3	
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)
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	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)
<i>aprepitant</i>	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
<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	T4	
CONSTULOSE	T2	
CREON	T3	
<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 oral liquid</i>	T4	
<i>diphenoxylate-atropine oral tablet</i>	T2	
<i>dronabinol</i>	T4	PA-BvD
ENULOSE	T2	
<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)

Drug Name	Drug Tier	Requirements/Limits
LINZESS	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	
<i>lubiprostone</i>	T3	QL (62 EA per 31 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral capsule (with del rel tablets)</i>	T2	QL (186 EA per 31 days)
<i>mesalamine oral capsule, extended release</i>	T4	QL (248 EA per 31 days)
<i>mesalamine oral capsule,extended release 24hr</i>	T2	QL (124 EA per 31 days)
<i>mesalamine oral tablet,delayed release (dr/ec) 1.2 gram</i>	T4	QL (124 EA per 31 days)
<i>mesalamine rectal enema</i>	T4	QL (1860 ML per 31 days)
<i>metoclopramide hcl oral solution</i>	T2	
<i>metoclopramide hcl oral tablet</i>	T1	
<i>misoprostol</i>	T2	
MOVANTIK	T3	QL (31 EA per 31 days)
OICALIVA	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</i>	T2	
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	T4	
<i>peg-electrolyte soln</i>	T2	
<i>prochlorperazine</i>	T4	
<i>prochlorperazine maleate</i>	T1	
PROCTO-MED HC	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)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	T5	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	T5	PA; QL (2.4 ML per 56 days)
<i>sodium,potassium,mag sulfates</i>	T3	
SUCRAID	T5	PA
<i>sucralfate oral suspension</i>	T4	
<i>sucralfate oral tablet</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>sulfasalazine</i>	T2	
<i>ursodiol oral capsule 300 mg</i>	T2	
<i>ursodiol oral tablet</i>	T2	
VIBERZI	T5	PA; QL (62 EA per 31 days)
VOWST	T5	PA; QL (12 EA per 14 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, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT	T3	
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARCALYST	T5	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	PA; QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (4 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T3	
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	PA; QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
ENGRIX-B (PF)	T3	PA-BvD
ENGRIX-B PEDIATRIC (PF)	T3	PA-BvD
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	T5	PA
FULPHILA	T5	
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA

Drug Name	Drug Tier	Requirements/Limits
GARDASIL 9 (PF)	T3	
HAVRIX (PF)	T3	
HEPLISAV-B (PF)	T3	PA-BvD
HIBERIX (PF)	T3	
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	T3	
IPOL	T3	
IXIARO (PF)	T3	
JYNNEOS (PF)(STOCKPILE)	T3	PA-BvD
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) INTRAMUSCULAR KIT	T3	
M-M-R II (PF)	T3	
NEULASTA	T5	
NIVESTYM	T5	
NORDITROPIN FLEXPOR	T5	PA
OCTAGAM	T5	PA
PANZYGA	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	PA; QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	PA; QL (1 ML per 28 days)
PREHEVBRIO (PF)	T3	PA-BvD
PRIORIX (PF)	T3	
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

Drug Name	Drug Tier	Requirements/Limits
PROQUAD (PF)	T3	
QUADRACEL (PF)	T3	
RABAVERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF)	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)	T3	
<i>tetanus, diphtheria tox ped(pf)</i>	T3	
TICOVAC	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	
<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 oral tablet 100 mg, 300 mg</i>	T1	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
<i>colchicine (gout) oral tablet</i>	T2	QL (62 EA per 31 days)
ENBREL MINI	T5	PA; QL (8 ML 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)

Drug Name	Drug Tier	Requirements/Limits
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (8 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (8 ML per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 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	
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
<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)
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)

Drug Name	Drug Tier	Requirements/Limits
<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 (168 EA per 365 days)
<i>risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	T4	
<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	
APRI	T2	
ARANELLE (28)	T2	
AVIANE	T2	
CAMILA	T2	
<i>clindamycin phosphate vaginal</i>	T2	
CRYSELLE (28)	T2	
CYRED EQ	T2	
DEPO-SUBQ PROVERA 104	T4	
<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	

Drug Name	Drug Tier	Requirements/Limits
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
<i>estradiol oral</i>	T2	
<i>estradiol transdermal patch semiweekly</i>	T2	
<i>estradiol transdermal patch weekly</i>	T2	
<i>estradiol vaginal cream</i>	T3	
<i>estradiol vaginal tablet</i>	T2	
<i>estradiol-norethindrone acet</i>	T2	
<i>ethynodiol diac-eth estradiol</i>	T2	
<i>etonogestrel-ethinyl estradiol</i>	T4	
IMVEXXY MAINTENANCE PACK	T3	
IMVEXXY STARTER PACK	T3	
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	
LESSINA	T2	
LEVONEST (28)	T2	
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
LEVORA-28	T2	
LILETTA	T4	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYLEQ	T2	
LYLLANA	T2	
LYZA	T2	
MARLISSA (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
<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	
<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), 1-20(5)/1-30(7) /1mg-35mcg (9)</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	
PORTIA 28	T2	
PREMARIN ORAL	T3	
PREMARIN VAGINAL	T3	
PREMPRO	T3	
<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	

Drug Name	Drug Tier	Requirements/Limits
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	T3	
ZAFEMY	T4	
ZOVIA 1-35 (28)	T2	
Ophthalmology		
<i>acetazolamide</i>	T2	
ALOMIDE	T4	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
<i>apraclonidine</i>	T3	
<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	
<i>brimonidine ophthalmic (eye)</i>	T2	
<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	

Drug Name	Drug Tier	Requirements/Limits
<i>difluprednate</i>	T4	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
<i>fluorometholone</i>	T2	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T3	
<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	
<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	
NEO-POLYCIN	T2	
NEO-POLYCIN HC	T2	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>olopatadine ophthalmic (eye) drops 0.1 %</i>	T2	
OXERVATE	T5	PA; QL (112 ML per 56 days)
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
POLYCIN	T2	
<i>polymyxin b sulf-trimethoprim</i>	T2	
<i>prednisolone acetate</i>	T2	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
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) gel forming solution</i>	T3	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	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)
<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)

Drug Name	Drug Tier	Requirements/Limits
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>	T4	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>budesonide-formoterol</i>	T3	QL (10.2 GM per 30 days)
<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
<i>desloratadine oral tablet</i>	T2	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	
FASENRA	T5	PA; QL (1 ML per 56 days)
FASENRA PEN	T5	PA; QL (1 ML per 56 days)
<i>flunisolide</i>	T2	QL (50 ML per 25 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	T3	QL (12 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	T3	QL (24 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	T3	QL (10.6 GM per 30 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>	T3	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)
<i>ipratropium bromide inhalation</i>	T2	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 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)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.4 ML per 28 days)
OFEV	T5	PA; QL (62 EA per 31 days)
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 capsule</i>	T5	PA; QL (279 EA per 31 days)
<i>pirfenidone oral tablet</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)
<i>roflumilast</i>	T4	QL (31 EA per 31 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 (372 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
SYMJEPI	T4	
<i>tadalafil (pulm. hypertension)</i>	T5	PA; QL (62 EA per 31 days)
TADLIQ	T5	PA; QL (310 ML 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 ORAL GRANULES IN PACKET, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	T5	PA; QL (84 EA per 28 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG (112)- 32 MCG (84)	T5	PA; QL (392 EA per 365 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG	T5	PA
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG	T5	PA; QL (504 EA per 365 days)
VENTOLIN HFA	T3	QL (36 GM per 30 days)
WIXELA INHUB	T3	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)
<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)
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Drug Name	Drug Tier	Requirements/Limits
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<i>dutasteride-tamsulosin</i>	T3	QL (31 EA per 31 days)
ELMIRON	T4	
<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 5 mg</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)
<i>trospium oral tablet</i>	T2	QL (93 EA per 31 days)
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CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
<i>fluoride (sodium) oral tablet</i>	T2	
INTRALIPID INTRAVENOUS EMULSION 20 %	T4	PA-BvD
ISOLYTE S PH 7.4	T3	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T4	PA-BvD
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KLOR-CON M15	T2	
KLOR-CON M20	T1	
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Drug Name	Drug Tier	Requirements/Limits
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<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	T2	
<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	
<i>potassium chloride intravenous</i>	T2	
<i>potassium chloride oral capsule, extended release</i>	T1	
<i>potassium chloride oral liquid</i>	T2	
<i>potassium chloride oral packet</i>	T2	
<i>potassium chloride oral tablet extended release</i>	T1	
<i>potassium chloride oral tablet,er particles/crystals 10 meq, 20 meq</i>	T1	
<i>potassium chloride oral tablet,er particles/crystals 15 meq</i>	T2	
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<i>fluphenazine decanoate</i>	24	GLUCAGON EMERGENCY		HUMIRA(CF) PEN PSOR-	
<i>fluphenazine hcl</i>	24	KIT (HUMAN)	44	UV-ADOL HS	53
<i>flurbiprofen</i>	24	<i>glycopyrrolate</i>	48	HUMULIN 70/30 U-100	
<i>flurbiprofen sodium</i>	58	GLYXAMBI	44	INSULIN	45
<i>fluticasone propionate</i>	40, 60	GRALISE	24, 25	HUMULIN 70/30 U-100	
<i>fluticasone propion-salmeterol</i> ...	60	<i>granisetron hcl</i>	48	KWIKPEN	45
<i>fluvastatin</i>	35	<i>griseofulvin microsize</i>	8	HUMULIN N NPH INSULIN	
<i>fluvoxamine</i>	24	<i>griseofulvin ultramicrosize</i>	8	KWIKPEN	45
<i>fondaparinux</i>	35	GVOKE	44	HUMULIN N NPH U-100	
<i>formoterol fumarate</i>	60	GVOKE HYPOPEN 2-PACK ..	44	INSULIN	45
<i>fosamprenavir</i>	8	GVOKE PFS 1-PACK		HUMULIN R REGULAR U-	
<i>fosinopril</i>	35	SYRINGE	44	100 INSULN	45
<i>fosinopril-hydrochlorothiazide</i> ...	35	<i>halobetasol propionate</i>	40	HUMULIN R U-500 (CONC)	
FOTIVDA	14	<i>haloperidol</i>	25	INSULIN	45
FULPHILA	50	<i>haloperidol decanoate</i>	25	HUMULIN R U-500 (CONC)	
FUROSCIX	35	<i>haloperidol lactate</i>	25	KWIKPEN	45
<i>furosemide</i>	35	HARVONI	8	<i>hydralazine</i>	35
FUZEON	8	HAVRIX (PF)	51	<i>hydrochlorothiazide</i>	35
FYCOMPA	24	<i>heparin (porcine)</i>	35	<i>hydrocodone-acetaminophen</i>	25
<i>gabapentin</i>	24	HEPLISAV-B (PF)	51	<i>hydrocodone-ibuprofen</i>	25
<i>galantamine</i>	24	HETLIOZ	25	<i>hydrocortisone</i>	40, 45, 48
GAMMAGARD LIQUID	50	HIBERIX (PF)	51	<i>hydrocortisone-acetic acid</i>	43
				<i>hydromorphone</i>	25

<i>hydroxychloroquine</i>	8	ISOLYTE-P IN 5 %		<i>labetalol</i>	35
<i>hydroxyurea</i>	14	DEXTROSE	63	<i>lacosamide</i>	26
<i>hydroxyzine hcl</i>	60	<i>isoniazid</i>	9	<i>lactulose</i>	48
<i>ibandronate</i>	53	<i>isosorbide dinitrate</i>	35	<i>lamivudine</i>	9
IBRANCE	14	<i>isosorbide mononitrate</i>	35	<i>lamivudine-zidovudine</i>	9
IBSRELA	48	<i>isotretinoin</i>	40	<i>lamotrigine</i>	26
IBU	25	<i>isradipine</i>	35	<i>lansoprazole</i>	48
<i>ibuprofen</i>	25	<i>itraconazole</i>	9	LANTUS SOLOSTAR U-100	
<i>icatibant</i>	60	<i>ivermectin</i>	9	INSULIN	45
ICLUSIG	14	IXIARO (PF)	51	LANTUS U-100 INSULIN	45
<i>icosapent ethyl</i>	35	JAKAFI	14	<i>lapatinib</i>	15
IDHIFA	14	JANTOVEN	35	<i>latanoprost</i>	58
ILEVRO	58	JANUMET	45	<i>ledipasvir-sofosbuvir</i>	9
<i>imatinib</i>	14	JANUMET XR	45	<i>leflunomide</i>	53
IMBRUVICA	14	JANUVIA	45	<i>lenalidomide</i>	15
<i>imipenem-cilastatin</i>	8	JARDIANCE	45	LENVIMA	15
<i>imipramine hcl</i>	25	JASMIEL (28)	55	LESSINA	55
<i>imiquimod</i>	40	JAVYGTOR	45	<i>letrozole</i>	15
IMOVAX RABIES		JAYPIRCA	15	<i>leucovorin calcium</i>	15
VACCINE (PF)	51	JENTADUETO	45	LEUKERAN	15
IMVEXXY MAINTENANCE		JENTADUETO XR	45	LEUKINE	51
PACK	55	JINTELI	55	<i>leuprolide</i>	15
IMVEXXY STARTER PACK	55	JULEBER	55	<i>leuprolide (3 month)</i>	15
INCASSIA	55	JULUCA	9	<i>levalbuterol hcl</i>	61
INCRELEX	42	JUXTAPID	35	<i>levalbuterol tartrate</i>	61
<i>indapamide</i>	35	JYNNEOS		<i>levetiracetam</i>	26
<i>indomethacin</i>	25	(PF)(STOCKPILE)	51	<i>levobunolol</i>	58
INFANRIX (DTAP) (PF)	51	KALYDECO	60, 61	<i>levocarnitine</i>	42
INLYTA	14	KARIVA (28)	55	<i>levocarnitine (with sugar)</i>	42
INQOVI	14	KELNOR 1/35 (28)	55	<i>levocetirizine</i>	61
INREBIC	14	KELNOR 1-50 (28)	55	<i>levofloxacin</i>	9, 58
<i>insulin lispro</i>	45	KERENDIA	35	<i>levofloxacin in d5w</i>	9
<i>insulin lispro protamin-lispro</i>	45	KESIMPTA PEN	26	LEVONEST (28)	55
<i>insulin syringe-needle u-100</i>	52	<i>ketoconazole</i>	9, 40	<i>levonorgestrel-ethinyl estrad</i>	55
INTELENCE	8	<i>ketorolac</i>	58	<i>levonorg-eth estrad triphasic</i>	55
INTRALIPID	63	KEVZARA	53	LEVORA-28	55
INTROVALE	55	KINERET	53	<i>levothyroxine</i>	45
INVEGA HAFYERA	25	KINRIX (PF)	51	LEVOXYL	46
INVEGA SUSTENNA	25	KISQALI	15	LEXIVA	9
INVEGA TRINZA	26	KISQALI FEMARA CO-		<i>lidocaine</i>	40
INVOKAMET	45	PACK	15	<i>lidocaine hcl</i>	40
INVOKAMET XR	45	KITABIS PAK	9	LIDOCAINE VISCOUS	40
INVOKANA	45	KLOR-CON	63	<i>lidocaine-prilocaine</i>	41
IPOL	51	KLOR-CON M10	63	LILETTA	55
<i>ipratropium bromide</i>	43, 60	KLOR-CON M15	63	<i>linezolid</i>	9
<i>ipratropium-albuterol</i>	60	KLOR-CON M20	63	<i>linezolid in dextrose 5%</i>	9
<i>irbesartan</i>	35	KLOXXADO	26	LINZESS	49
<i>irbesartan-hydrochlorothiazide</i>	35	KORLYM	45	<i>liothyronine</i>	46
ISENTRESS	8, 9	KOSELUGO	15	<i>lisinopril</i>	35
ISENTRESS HD	8	KRAZATI	15	<i>lisinopril-hydrochlorothiazide</i>	35
ISIBLOOM	55	KURVELO (28)	55	<i>lithium carbonate</i>	26
ISOLYTE S PH 7.4	63	<i>l norgest/e.estradiol-e.estrad</i>	55	LIVALO	35

LOKELMA	43	MENQUADFI (PF)	51	MULTAQ	36
LONSURF	15	MENVEO A-C-Y-W-135-DIP		<i>mupirocin</i>	41
<i>loperamide</i>	49	(PF)	51	MYALEPT	46
<i>lopinavir-ritonavir</i>	9	<i>mercaptopurine</i>	16	<i>mycophenolate mofetil</i>	16
<i>lorazepam</i>	26	<i>meropenem</i>	9	<i>mycophenolate sodium</i>	16
LORAZEPAM INTENSOL	26	<i>mesalamine</i>	49	MYRBETRIQ	63
LORBRENA	15	MESNEX	16	<i>nabumetone</i>	27
LORYNA (28)	55	<i>metformin</i>	46	<i>nadolol</i>	36
<i>losartan</i>	35	<i>methadone</i>	26	<i>nafcilin</i>	9
<i>losartan-hydrochlorothiazide</i>	35	<i>methazolamide</i>	58	<i>naloxone</i>	27
<i>loteprednol etabonate</i>	58	<i>methenamine hippurate</i>	9	<i>naltrexone</i>	27
<i>lovastatin</i>	35	<i>methimazole</i>	46	NAMZARIC	27
LOW-OGESTREL (28)	55	<i>methotrexate sodium</i>	16	<i>naproxen</i>	27
<i>loxapine succinate</i>	26	<i>methotrexate sodium (pf)</i>	16	<i>naproxen sodium</i>	27
<i>lubiprostone</i>	49	<i>methsuximide</i>	26	<i>naratriptan</i>	27, 28
LUCEMYRA	26	<i>methylphenidate hcl</i>	27	NATACYN	58
LUMAKRAS	15	<i>methylprednisolone</i>	46	<i>nateglinide</i>	46
LUMIGAN	58	<i>metoclopramide hcl</i>	49	NATPARA	46
LUPRON DEPOT	15	<i>metolazone</i>	36	NAYZILAM	28
LUPRON DEPOT (3		<i>metoprolol succinate</i>	36	<i>nebivolol</i>	36
MONTH)	15	<i>metoprolol ta-hydrochlorothiaz</i> ..	36	<i>nefazodone</i>	28
LUPRON DEPOT (4		<i>metoprolol tartrate</i>	36	<i>neomycin</i>	9
MONTH)	15	<i>metronidazole</i>	9, 41, 56	<i>neomycin-bacitracin-poly-hc</i>	58
LUPRON DEPOT (6		<i>metronidazole in nacl (iso-os)</i>	9	<i>neomycin-bacitracin-polymyxin</i> ..	58
MONTH)	15	<i>metyrosine</i>	36	<i>neomycin-polymyxin b-</i>	
LUPRON DEPOT-PED	15	<i>mexiletine</i>	36	<i>dexameth</i>	58
LUPRON DEPOT-PED (3		<i>micafungin</i>	9	<i>neomycin-polymyxin-gramicidin</i>	58
MONTH)	15	MICONAZOLE-3	56	<i>neomycin-polymyxin-hc</i>	43, 58
<i>lurasidone</i>	26	MICROGESTIN 1.5/30 (21)	56	NEO-POLYCIN	58
LUTERA (28)	55	MICROGESTIN 1/20 (21)	56	NEO-POLYCIN HC	58
LYLEQ	55	MICROGESTIN FE 1.5/30		NERLYNX	16
LYLLANA	55	(28)	56	NEULASTA	51
LYNPARZA	16	MICROGESTIN FE 1/20 (28) ..	56	NEUPRO	28
LYSODREN	16	<i>midodrine</i>	43	<i>nevirapine</i>	10
LYTGOBI	16	<i>miglustat</i>	46	NEXLETOL	36
LYZA	55	MILI	56	NEXLIZET	36
<i>magnesium sulfate</i>	63	<i>minocycline</i>	9	<i>niacin</i>	36
<i>malathion</i>	41	<i>minoxidil</i>	36	<i>nicardipine</i>	36
<i>maraviroc</i>	9	<i>mirtazapine</i>	27	NICOTROL	43
MARLISSA (28)	55	<i>misoprostol</i>	49	NICOTROL NS	43
MARPLAN	26	M-M-R II (PF)	51	<i>nifedipine</i>	36
MATULANE	16	<i>modafinil</i>	27	<i>nilutamide</i>	16
MAVYRET	9	<i>moexipril</i>	36	<i>nimodipine</i>	36
<i>meclizine</i>	49	<i>molindone</i>	27	NINLARO	16
<i>medroxyprogesterone</i>	56	<i>mometasone</i>	41, 61	<i>nitazoxanide</i>	10
<i>mefloquine</i>	9	<i>montelukast</i>	61	<i>nitisinone</i>	43
<i>megestrol</i>	16	<i>morphine</i>	27	NITRO-BID	36
MEKINIST	16	<i>morphine concentrate</i>	27	<i>nitrofurantoin</i>	10
MEKTOVI	16	MOUNJARO	46	<i>nitrofurantoin macrocrystal</i>	10
<i>meloxicam</i>	26	MOVANTIK	49	<i>nitrofurantoin monohyd/m-cryst</i> ..	10
<i>memantine</i>	26	<i>moxifloxacin</i>	9, 58	<i>nitroglycerin</i>	36
MENACTRA (PF)	51	MULPLETA	36	NIVESTYM	51

NORDITROPIN FLEXP	51	<i>oxaprozin</i>	28	<i>piperacillin-tazobactam</i>	10
<i>norethindrone (contraceptive)</i>	56	<i>oxcarbazepine</i>	28	PIQRAY	17
<i>norethindrone acetate</i>	56	OXERVATE	58	<i>pirfenidone</i>	61
<i>norethindrone ac-eth estradiol</i>	56	<i>oxybutynin chloride</i>	63	<i>piroxicam</i>	28
<i>norethindrone-e.estradiol-iron</i>	56	<i>oxycodone</i>	28	PLEGRIDY	51
<i>norgestimate-ethinyl estradiol</i>	56	<i>oxycodone-acetaminophen</i>	28	PLENAMINE	64
NORTREL 0.5/35 (28)	56	OZEMPIC	46	<i>podofilox</i>	41
NORTREL 1/35 (21)	56	PACERONE	36	POLYCIN	58
NORTREL 1/35 (28)	56	<i>paliperidone</i>	28	<i>polymyxin b sulf-trimethoprim</i>	58
NORTREL 7/7/7 (28)	56	PALYNZIQ	46	POMALYST	17
<i>nortriptyline</i>	28	PANRETIN	41	PORTIA 28	56
NORVIR	10	<i>pantoprazole</i>	49	<i>posaconazole</i>	10
NOURIANZ	28	PANZYGA	51	<i>potassium chlorid-d5-</i>	
NUBEQA	16	<i>paricalcitol</i>	46	<i>0.45%nacl</i>	64
NUCALA	61	<i>paromomycin</i>	10	<i>potassium chloride</i>	64
NUDEXTA	28	<i>paroxetine hcl</i>	28	<i>potassium chloride in 0.9%nacl</i>	64
NUPLAZID	28	PAXIL	28	<i>potassium chloride in 5 % dex</i>	64
NURTEC ODT	28	PEDIARIX (PF)	51	<i>potassium chloride in lr-d5</i>	64
NYAMYC	41	PEDVAX HIB (PF)	51	<i>potassium chloride in water</i>	64
<i>nystatin</i>	10, 41	<i>peg 3350-electrolytes</i>	49	<i>potassium chloride-0.45 % nacl</i>	64
<i>nystatin-triamcinolone</i>	41	<i>peg3350-sod sul-nacl-kcl-asb-c</i>	49	<i>potassium chloride-d5-</i>	
NYSTOP	41	PEGASYS	51	<i>0.2%nacl</i>	64
OCALIVA	49	<i>peg-electrolyte soln</i>	49	<i>potassium chloride-d5-</i>	
OCTAGAM	51	PEMAZYRE	17	<i>0.9%nacl</i>	64
<i>octreotide acetate</i>	16	<i>pen needle, diabetic</i>	52	<i>potassium citrate</i>	63
ODEFSEY	10	<i>penciclovir</i>	41	<i>pramipexole</i>	28
ODOMZO	16	<i>penicillamine</i>	53	<i>prasugrel</i>	36
OFEV	61	<i>penicillin g pot in dextrose</i>	10	<i>pravastatin</i>	36
<i>ofloxacin</i>	10, 43, 58	<i>penicillin g potassium</i>	10	<i>praziquantel</i>	10
<i>olanzapine</i>	28	<i>penicillin g procaine</i>	10	<i>prazosin</i>	37
<i>olmesartan</i>	36	<i>penicillin v potassium</i>	10	<i>prednisolone</i>	46
<i>olmesartan-amlodipin-hcthiiazid</i>	36	PENTACEL (PF)	51	<i>prednisolone acetate</i>	58
<i>olmesartan-hydrochlorothiazide</i>	36	<i>pentamidine</i>	10	<i>prednisolone sodium phosphate</i>	
<i>olopatadine</i>	44, 58	<i>pentoxifylline</i>	36		46, 58
OLUMIANT	53	<i>perindopril erbumine</i>	36	<i>prednisone</i>	46
<i>omega-3 acid ethyl esters</i>	36	PERIOGARD	44	<i>pregabalin</i>	29
<i>omeprazole</i>	49	<i>permethrin</i>	41	PREHEVBRIO (PF)	51
<i>ondansetron</i>	49	<i>perphenazine</i>	28	PREMARIN	56
<i>ondansetron hcl</i>	49	PERSERIS	28	PREMPRO	56
ONUREG	16	PHEBURANE	43	PRENATAL VITAMIN	
OPSUMIT	61	<i>phenelzine</i>	28	PLUS LOW IRON	64
ORENCIA	53	<i>phenobarbital</i>	28	PREVALITE	37
ORENCIA CLICKJECT	53	<i>phenytoin</i>	28	PREVYMIS	10
ORGOVYX	16	<i>phenytoin sodium extended</i>	28	PREZCOBIX	10
ORKAMBI	61	PIFELTRO	10	PREZISTA	10
ORLADEYO	61	<i>pilocarpine hcl</i>	43, 58	PRIFTIN	10
ORSERDU	16	<i>pimecrolimus</i>	41	<i>primaquine</i>	10
<i>oseltamivir</i>	10	<i>pimozide</i>	28	<i>primidone</i>	29
OTEZLA	53	PIMTREA (28)	56	PRIORIX (PF)	51
OTEZLA STARTER	53	<i>pindolol</i>	36	PRIVIGEN	51
<i>oxacillin</i>	10	<i>pioglitazone</i>	46	<i>probenecid</i>	53
<i>oxacillin in dextrose(iso-osm)</i>	10	<i>pioglitazone-metformin</i>	46	<i>probenecid-colchicine</i>	53

<i>prochlorperazine</i>	49	REPATHA SYRINGE	37	SETLAKIN	56
<i>prochlorperazine maleate</i>	49	RESTASIS	59	<i>sevelamer carbonate</i>	43
PROCRIPT	51	RESTASIS MULTIDOSE	59	SHINGRIX (PF)	52
PROCTO-MED HC	49	RETACRIT	52	SIGNIFOR	17
PROCTOSOL HC	49	RETEVMO	17	<i>sildenafil (pulm.hypertension)</i>	61
PROCTOZONE-HC	49	REVCIVI	43	<i>silodosin</i>	63
<i>progesterone micronized</i>	56	REXULTI	29	<i>silver sulfadiazine</i>	41
PROGRAF	17	REYATAZ	11	SIMBRINZA	59
PROLASTIN-C	43	REYVOW	29	SIMPONI	54
PROLENSA	59	REZLIDHIA	17	<i>simvastatin</i>	37
PROLIA	53	RHOPRESSA	59	<i>sirolimus</i>	17
PROMACTA	37	<i>ribavirin</i>	11	SIRTURO	11
<i>promethazine</i>	61	RIDAURA	54	SKYCLARYS	30
<i>propafenone</i>	37	<i>rifabutin</i>	11	SKYRIZI	41, 49
<i>propranolol</i>	37	<i>rifampin</i>	11	<i>sodium chloride</i>	43
<i>propylthiouracil</i>	46	<i>riluzole</i>	43	<i>sodium chloride 0.45 %</i>	64
PROQUAD (PF)	52	<i>rimantadine</i>	11	<i>sodium chloride 0.9 %</i>	43
<i>protriptyline</i>	29	RINVOQ	54	<i>sodium chloride 3 % hypertonic</i> ..	64
PULMOZYME	61	<i>risedronate</i>	43, 54	<i>sodium chloride 5 % hypertonic</i> ..	64
PURIXAN	17	RISPERDAL CONSTA	29	<i>sodium oxybate</i>	30
<i>pyrazinamide</i>	11	<i>risperidone</i>	29	<i>sodium phenylbutyrate</i>	43
<i>pyridostigmine bromide</i>	29	<i>ritonavir</i>	11	<i>sodium polystyrene sulfonate</i>	43
<i>pyrimethamine</i>	11	<i>rivastigmine</i>	29	<i>sodium,potassium,mag sulfates</i> ..	49
PYRUKYND	43	<i>rivastigmine tartrate</i>	30	<i>sofosbuvir-velpatasvir</i>	11
QINLOCK	17	<i>rizatriptan</i>	30	SOLQUA 100/33	47
QUADRACEL (PF)	52	ROCKLATAN	59	SOLTAMOX	17
<i>quetiapine</i>	29	<i>roflumilast</i>	61	SOMAVERT	47
<i>quinapril</i>	37	<i>ropinirole</i>	30	<i>sorafenib</i>	17
<i>quinidine sulfate</i>	37	<i>rosuvastatin</i>	37	SORINE	37
<i>quinine sulfate</i>	11	ROTARIX	52	<i>sotalol</i>	37
QULIPTA	29	ROTATEQ VACCINE	52	SOTALOL AF	37
QVAR REDHALER	61	ROWEEPR	30	SPIRIVA RESPIMAT	61
RABAVERT (PF)	52	ROZLYTREK	17	SPIRIVA WITH	
<i>rabeprazole</i>	49	RUBRACA	17	HANDHALER	62
RADICAVA ORS STARTER		<i>rufinamide</i>	30	<i>spironolactone</i>	37
KIT SUSP	29	RUKOBIA	11	<i>spironolacton-hydrochlorothiaz</i> ..	37
<i>raloxifene</i>	54	RYBELSUS	46	SPRINTEC (28)	56
<i>ramelteon</i>	29	RYDAPT	17	SPRITAM	30
<i>ramipril</i>	37	RYTARY	30	SPRYCEL	17
<i>ranolazine</i>	37	SAJAZIR	61	SPS (WITH SORBITOL)	43
<i>rasagiline</i>	29	SANDIMMUNE	17	SRONYX	56
RAVICTI	43	SANTYL	41	SSD	41
RECLIPSEN (28)	56	<i>sapropterin</i>	46	STELARA	41
RECOMBIVAX HB (PF)	52	SAVELLA	54	STIOLTO RESPIMAT	62
RECORLEV	46	SCEMBLIX	17	STIVARGA	17
RECTIV	49	<i>scopolamine base</i>	49	<i>streptomycin</i>	11
REGRANEX	41	SECUADO	30	STRIBILD	11
RELENZA DISKHALER	11	<i>selegiline hcl</i>	30	STRIVERDI RESPIMAT	62
RELYVRIO	29	<i>selenium sulfide</i>	41	SUBVENITE	30
<i>repaglinide</i>	46	SELZENTRY	11	SUCRAID	49
REPATHA PUSHTRONEX	37	SEREVENT DISKUS	61	<i>sucralfate</i>	49
REPATHA SURECLICK	37	<i>sertraline</i>	30	<i>sulfacetamide sodium</i>	59

<i>sulfacetamide sodium (acne)</i>	41	<i>terazosin</i>	37	TRECATOR	12
<i>sulfacetamide-prednisolone</i>	59	<i>terbinafine hcl</i>	11	TRELEGY ELLIPTA	62
<i>sulfadiazine</i>	11	<i>terbutaline</i>	62	TRELSTAR	18
<i>sulfamethoxazole-trimethoprim</i> ..	11	<i>terconazole</i>	56	<i>tretinoin</i>	42
SULFAMYLON	41	<i>teriflunomide</i>	31	<i>tretinoin (antineoplastic)</i>	18
<i>sulfasalazine</i>	50	<i>teriparatide</i>	54	<i>triamcinolone acetonide</i>	42, 44
<i>sulindac</i>	30	<i>testosterone</i>	47	<i>triamterene-hydrochlorothiazid</i> ..	37
<i>sumatriptan</i>	30	<i>testosterone cypionate</i>	47	TRIDERM	42
<i>sumatriptan succinate</i>	30	<i>testosterone enanthate</i>	47	<i>trientine</i>	43
<i>sunitinib malate</i>	17	<i>tetanus,diphtheria tox ped(pf)</i>	52	TRI-ESTARYLLA	56
SUNLENCA	11	<i>tetrabenazine</i>	31	<i>trifluoperazine</i>	31
SUPRAX	11	<i>tetracycline</i>	11	<i>trifluridine</i>	59
SYEDA	56	THALOMID	18	TRIJARDY XR	47
SYMDEKO	62	THEO-24	62	TRIKAFTA	62
SYMJEPI	62	<i>theophylline</i>	62	TRI-LEGEST FE	56
SYMLINPEN 120	47	<i>thioridazine</i>	31	TRI-LO-ESTARYLLA	57
SYMLINPEN 60	47	<i>thiothixene</i>	31	TRI-LO-SPRINTEC	57
SYMPAZAN	30	TIADYLT ER	37	<i>trimethoprim</i>	12
SYMTUZA	11	<i>tiagabine</i>	31	<i>trimipramine</i>	31
SYNAREL	47	TIBSOVO	18	TRINTELLIX	31
SYNJARDY	47	TICOVAC	52	TRI-SPRINTEC (28)	57
SYNJARDY XR	47	<i>tigecycline</i>	11	TRIUMEQ	12
SYNRIBO	17	TILIA FE	56	TRIUMEQ PD	12
SYNTHROID	47	<i>timolol maleate</i>	37, 59	TRIVORA (28)	57
TABLOID	17	TIVICAY	11	TRIZIVIR	12
TABRECTA	17	TIVICAY PD	11	TROPHAMINE 10 %	64
<i>tacrolimus</i>	17, 41	<i>tizanidine</i>	31	<i>trospium</i>	63
<i>tadalafil</i>	63	TOBI PODHALER	11	TRULICITY	47
<i>tadalafil (pulm. hypertension)</i>	62	TOBRADEX	59	TRUMENBA	52
TADLIQ	62	TOBRADEX ST	59	TUKYSA	18
TAFINLAR	17	<i>tobramycin</i>	12, 59	TURALIO	18
TAGRISSO	17	<i>tobramycin in 0.225 % nacl</i>	12	TWINRIX (PF)	52
TALTZ AUTOINJECTOR	41	<i>tobramycin sulfate</i>	12	TYBOST	12
TALTZ SYRINGE	41	<i>tobramycin-dexamethasone</i>	59	TYMLOS	54
TALZENNA	17	<i>tolterodine</i>	63	TYPHIM VI	52
<i>tamoxifen</i>	17	<i>tolvaptan</i>	47	TYVASO DPI	62
<i>tamsulosin</i>	63	<i>topiramate</i>	31	UBRELVY	31
TASCENSO ODT	30	<i>toremifene</i>	18	UNITHROID	47
TASIGNA	18	<i>torseamide</i>	37	UPTRAVI	38
<i>tasimelteon</i>	31	TOUJEO MAX U-300		<i>ursodiol</i>	50
<i>tazarotene</i>	41	SOLOSTAR	47	<i>valacyclovir</i>	12
TAZORAC	42	TOUJEO SOLOSTAR U-300		VALCHLOR	42
TAZTIA XT	37	INSULIN	47	<i>valganciclovir</i>	12
TAZVERIK	18	TRADJENTA	47	<i>valproic acid</i>	31
TDVAX	52	<i>tramadol</i>	31	<i>valproic acid (as sodium salt)</i>	31
TEFLARO	11	<i>tramadol-acetaminophen</i>	31	<i>valsartan</i>	38
<i>telmisartan</i>	37	<i>trandolapril</i>	37	<i>valsartan-hydrochlorothiazide</i> ...	38
<i>telmisartan-amlodipine</i>	37	<i>tranexamic acid</i>	56	VALTOCO	31
<i>telmisartan-hydrochlorothiazid</i> ..	37	<i>tranylcypromine</i>	31	<i>vancomycin</i>	12
TENIVAC (PF)	52	TRAVASOL 10 %	64	VANDAZOLE	57
<i>tenofovir disoproxil fumarate</i>	11	<i>travoprost</i>	59	VAQTA (PF)	52
TEPMETKO	18	<i>trazodone</i>	31	<i>varenicline</i>	43

VARIVAX (PF)	52	XIFAXAN	12
VELIVET TRIPHASIC		XIIDRA	59
REGIMEN (28)	57	XOFLUZA	12
VEMLIDY	12	XOLAIR	62
VENCLEXTA	18	XOSPATA	18
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PACK	18	XTANDI	19
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<i>verapamil</i>	38	XYREM	32
VERQUVO	38	YF-VAX (PF)	52
VERSACLOZ	31	YONSA	19
VERZENIO	18	YUVAFEM	57
VESTURA (28)	57	ZAFEMY	57
VIBERZI	50	<i>zafirlukast</i>	62
VICTOZA 3-PAK	47	<i>zaleplon</i>	32
VIENVA	57	ZARXIO	52
<i>vigabatrin</i>	31	ZAVZPRET	32
VIGADRONE	31	ZEGALOGUE	
VIJOICE	18	AUTOINJECTOR	47
<i>vilazodone</i>	31	ZEGALOGUE SYRINGE	47
VIRACEPT	12	ZEJULA	19
VIREAD	12	ZELBORAF	19
VITRAKVI	18	ZENATANE	42
VIVITROL	31	ZENPEP	50
VIVJOA	12	ZEPOSIA	32
VIZIMPRO	18	ZEPOSIA STARTER PACK	
VONJO	18	(7-DAY)	32
<i>voriconazole</i>	12	<i>zidovudine</i>	12
VOSEVI	12	ZIEXTENZO	52
VOTRIENT	18	<i>ziprasidone hcl</i>	32
VOWST	50	<i>ziprasidone mesylate</i>	32
VRAYLAR	31	ZIRGAN	59
VUMERITY	32	ZOKINVY	43
VYNDAMAX	38	ZOLINZA	19
VYNDAQEL	38	<i>zolpidem</i>	32
<i>warfarin</i>	38	ZONISADE	32
WELIREG	18	<i>zonisamide</i>	32
WIXELA INHUB	62	ZOVIA 1-35 (28)	57
XALKORI	18	ZTALMY	32
XARELTO	38	ZUBSOLV	32
XARELTO DVT-PE TREAT		ZYDELIG	19
30D START	38	ZYKADIA	19
XATMEP	18	ZYPREXA RELPREVV	32
XCOPRI	32		
XCOPRI MAINTENANCE			
PACK	32		
XCOPRI TITRATION PACK	32		
XELJANZ	54		
XELJANZ XR	54		
XERMELO	18		
XGEVA	18		

This formulary was updated on 8/25/2023.

For more recent information or other questions, please contact:

Senior Blue HMO, BlueSaver HMO, Employer Group PDP, Forever Blue PPO,
and Freedom PPO Pharmacy Service at 1-800-329-2792.

For TTY users, 711 National Relay Service, Oct. 1 – March 31, 8 a.m. – 8 p.m. ET,
seven days a week, and April 1 – Sept. 30, 8 a.m. – 8 p.m. ET, Monday – Friday, or
visit **[medicare.highmark.com/formulary](https://www.medicare.highmark.com/formulary)**.

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

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D
plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue
Shield is an independent licensee of the Blue Cross Blue Shield Association.

All references to “Highmark” in this document are references to the Highmark
company that is providing the member’s health benefits or health benefit
administration and/or to one or more of its affiliated Blue companies.



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 BCBSWNY 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.

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.

Well360 Virtual Health is powered by Amwell. Amwell is an independent company that provides telemedicine services and does not provide Highmark BCBSWNY products or services. Amwell is solely responsible for their telemedicine services.

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

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.

Discrimination is Against the Law

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, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. 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 formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact 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, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call the number provided for your state of residence. Someone who speaks English can help you. This is a free service.

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

我們免費提供口譯服務，為您解答有關我們健康計畫或藥物計畫的任何疑問。若要獲得口譯服務，只需撥打您所在州的電話號碼即可。講漢語的工作人員可為您提供協助。此項服務免費。

Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na posibleng mayroon ka tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang ang numerong ibinigay para sa estadong tinitirhan mo. May taong nagsasalita ng Tagalog na makakatulong sa iyo. Isa itong libreng serbisyo.

Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous vous posez sur notre régime d'assurance maladie ou d'assurance médicaments. Pour obtenir les services d'un interprète, il vous suffit d'appeler le numéro correspondant à votre État de résidence. Une personne parlant français pourra vous aider. Ce service est gratuit.

Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc của quý vị về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi số được cung cấp cho tiểu bang cư trú của quý vị. Ai đó nói Tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

Wir verfügen über kostenlose Dolmetschdienste, damit Sie alle eventuellen Fragen zu unserer Krankenversicherung oder zur Medikamenten-Zusatzversicherung klären können. Rufen Sie hierzu einfach die Nummer für den Bundesstaat an, in dem Sie Ihren Wohnsitz haben. Jemand, der Deutsch spricht, wird Ihnen behilflich sein. Dies ist ein kostenloser Service.

لدينا خدمات ترجمة فورية مجانية للإجابة عن أي أسئلة قد تراودك حول خطتنا الصحية أو الدوائية. للحصول على مترجم فوري، فقط اتصل بالرقم المقدم للولاية التي تقيم فيها. ويمكن لشخص يتحدث العربية مساعدتك. هذه خدمة مجانية.

건강 또는 약물 플랜에 대한 귀하의 질문에 답변해 드릴 수 있는 무료 통역 서비스를 제공해 드립니다. 통역사를 구하려면 거주하시는 주의 전화 번호로 문의하십시오. 한국어(를) 말할 수 있는 직원이 도와드릴 수 있습니다. 이 서비스는 무료로 제공됩니다.

Мы предоставляем бесплатные услуги устного перевода, чтобы помочь вам получить ответы на любые вопросы, которые могут у вас возникнуть в отношении нашего медицинского плана или плана лекарственных препаратов. Чтобы заказать услуги переводчика, просто позвоните по номеру, указанному для штата, в котором вы проживаете. Один из наших переводчиков, специализацией которого является русский язык, поможет вам. Эта услуга предоставляется бесплатно.

हमारे पास हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए मुफ्त दुभाषिया सेवाएँ हैं। एक दुभाषिया प्राप्त करने के लिए, बस अपने निवास स्थान की स्टेट के लिए दिए गए नंबर पर कॉल करें। हिंदी बोलने वाला कोई व्यक्ति आपकी सहायता कर सकता है। यह एक निःशुल्क सेवा है।

Disponiamo di servizi di interpretariato gratuiti per rispondere a ogni sua domanda riguardo al suo piano sanitario o farmaceutico. Per ottenere l'assistenza di un interprete, chiami il numero fornito per il suo stato di residenza. Qualcuno che parla italiano la aiuterà. Il servizio è gratuito.

Temos serviços de interpretação gratuitos para esclarecer suas dúvidas sobre nosso plano de saúde ou de medicamentos. Para contar com um intérprete, ligue para o número fornecido para o seu estado de residência. Alguém que fale Português pode ajudar você. Este é um serviço gratuito.

Nou gen sèvis entèpretasyon gratis pou reponn ak nenpòt kesyon ou ta ka genyen sou plan asirans sante oswa medikaman nou an. Pou jwenn yon entèprèt ede w, senpleman rele nimewo ki koresponn ak Eta kote w rete a. Yon moun ki pale Kreyòl Ayisyenap ede w. Sèvis sa a gratis.

Dysponujemy darmowymi usługami tłumaczeniowymi, dzięki którym może Pan/Pani uzyskać odpowiedzi na pytania dotyczące naszego planu zdrowia lub leków. Aby uzyskać pomoc tłumacza, wystarczy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka. Ktoś, kto zna język polsku, może Panu/Pani pomóc. Ta usługa jest darmowa.

当院では、無料の通訳サービスを用意し、治療や投薬計画に関するご質問にお答えしています。通訳を手配したい場合は、お住まいの州で指定された番号までお電話でご連絡ください。日本語話せる者が対応をお手伝いします。サービスは無料でご利用いただけます。

IMPORTANT INFORMATION:

2023 Medicare Star Ratings



Highmark BCBS of WNY and Highmark BS of NENY - H3384

For 2023, Highmark BCBS of WNY and Highmark BS of NENY - 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 BCBS of WNY and Highmark BS of NENY 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:

2023 Medicare Star Ratings



Highmark BCBS of WNY and Highmark BS of NENY - H5526

For 2023, Highmark BCBS of WNY and Highmark BS of NENY - H5526 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

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



The number of stars show how well a plan performs.

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ 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 BCBS of WNY and Highmark BS of NENY 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).



Highmark Blue Cross Blue Shield of Western New York (Highmark BCBS of WNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Highmark BCBS of WNY is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. Highmark BCBS of WNY complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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HIGHMARK
WESTERN NEW YORK

2024 Summary of Benefits

Buffalo Medicare portfolio/11448675
Senior Blue 699 (HMO) Plan E (2024)
HMO-H3384 806

This is a summary of drug and health services covered by Senior Blue 699 (HMO) Plan E (2024)

January 1, 2024 – December 31, 2024

Senior Blue 699 (HMO) Plan E (2024) 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 (2024)**, 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, 24 hours a day, seven days a week. 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. - 4:30 p.m.

Premiums and Benefits	Senior Blue 699 (HMO) Plan E (2024)
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

Premiums and Benefits	Senior Blue 699 (HMO) Plan E (2024)
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 (2024)	
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-31 day supply	Mail Order 100-day supply-Tier 1&2 90-day supply-Tier 3&4

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 \$75	
Dialysis	You pay \$0	
Shingles	\$0	
Telemedicine Service - Vendor	You pay the cost sharing that applies to the type of service received.	
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).

THE CARD ACCEPTED BY OVER 90% OF DOCTORS.*



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

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
P.O. Box 15112
Albany, NY 12212

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 October 1 - March 31, 8 a.m. - 8 p.m. seven days a week; April 1 - September 30, 8 a.m. - 8 p.m., Monday - Friday.

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.

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）。



Y0037_22_4011_C 01/23

MX2206803WNY



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

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), October 1 - March 31, 8 a.m. - 8 p.m., seven days a week; April 1 - September 30, 8 a.m. - 8 p.m., Monday - Friday.

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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)。

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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	
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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	

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