



**HealthTeam Advantage Plan I (PPO)
HealthTeam Advantage Plan II (PPO)
HealthTeam Advantage Cardinal Plan (HMO)**

2024 Formulary

(List of Covered Drugs)

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

Formulary ID: 24469, Version Number 15

This formulary was updated on 07/24/2024. For more recent information or other questions, please contact HealthTeam Advantage Healthcare Concierge at 888-965-1965 (TTY users should call 711), October 1 - March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1 - September 30, 8 a.m. to 8 p.m. ET, Monday through Friday, or visit healthteamadvantage.com.

MULTI-PLAN_2431_C
Last Updated: 07/24/2024

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 Care N Care Insurance Company of North Carolina. When it refers to “plan” or “our plan,” it means HealthTeam Advantage.

This document includes a list of the drugs (formulary) for our plan which is current as of 08/01/2024. 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 HealthTeam Advantage Formulary?

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

For a complete listing of all prescription drugs covered by HealthTeam Advantage, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Can the 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 the 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 titled “How do I request an exception to the HealthTeam Advantage’s 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 the 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, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - 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 HealthTeam Advantage's 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 08/01/2024. To get updated information about the drugs covered by HealthTeam Advantage please contact us. Our contact information appears on the front and back cover pages. In addition, each month the plan posts an updated Comprehensive formulary and a Formulary Addendum that has all of the changes on the website.

How do I use the Formulary?

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

Medical Condition

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

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 95. 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?

HealthTeam Advantage 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:** HealthTeam Advantage requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from HealthTeam Advantage before you fill your prescriptions. If you don't get approval, HealthTeam Advantage may not cover the drug.
- **Quantity Limits:** For certain drugs, HealthTeam Advantage limits the amount of the drug that HealthTeam Advantage will cover. For example, HealthTeam Advantage provides 60 tablets per prescription for Entresto. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, HealthTeam Advantage 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, HealthTeam Advantage may not cover Drug B unless you try Drug A first. If Drug A does not work for you, HealthTeam Advantage will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain 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 HealthTeam Advantage 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 HealthTeam Advantage's formulary?" on page v for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact your Healthcare Concierge and ask if your drug is covered. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that HealthTeam Advantage does not cover your drug, you have two options:

- You can ask Healthcare Concierge for a list of similar drugs that are covered by HealthTeam Advantage. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by HealthTeam Advantage.
- You can ask HealthTeam Advantage 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 HealthTeam Advantage's Formulary?

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

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

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will

cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

In addition, if you experience a change in your treatment setting due to the level of care you require, we will allow an emergency transition or level of care fill. Such transitions include:

- If you are discharged from a hospital or skilled nursing facility to a home setting
- If you are admitted to a hospital or skilled nursing facility from a home setting
- If you transfer from one skilled nursing facility to another and that new facility is serviced by a different pharmacy
- If you end your skilled nursing facility Medicare Part A stay – where payments include all pharmacy charges – and now you need to use your Part D plan benefit
- If you give up Hospice status and revert back to standard Medicare Part A and B coverage

For more information

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

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

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

HealthTeam Advantage Formulary

The formulary below provides coverage information about the drugs covered by HealthTeam Advantage. If you have trouble finding your drug in the list, turn to the Index that begins on page 95.

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

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

Most drugs included in this formulary are available via mail-order benefit. Contact your Healthcare Concierge for details. Our contact information appears on the front and back cover pages.

KEY:

- **BD** = Part B versus Part D – This drug may be covered under Medicare Part B or Part D depending upon the circumstances.
- **EX** = Excluded Drugs - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
- **PA** = Prior Authorization – You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug.
- **QL** = Quantity Limits – There is a limit on the amount of drug that is covered per prescription, or within a specific time frame.
- **ST** = Step Therapy – In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Every drug on HealthTeam Advantage's Drug List is in one of five cost-sharing tiers. The second column of the Drug List contains the tier for each drug.

- **Tier 1 – Preferred Generics:** Generic drugs that are available at the lowest cost-share for this plan.
- **Tier 2 – Generics:** Generics that are available at a higher cost to you than drugs in Tier 1.
- **Tier 3 – Preferred Brands:** Generic or brand drugs that are available at a lower cost to you than drugs in Tier 4. Vaccines in this tier are available at no cost to you. In addition, you won't pay more than \$35 for a one-month supply of insulin products in this tier.
- **Tier 4 – Non-Preferred Drugs:** Generic or brand drugs that are available at a higher cost to you than drugs that are in Tier 3.
- **Tier 5 – Specialty Drugs:** This is the highest cost tier. Includes some injectables and other high-cost drugs.

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription. For more information on Copayment and Coinsurance, please review your Evidence of Coverage.

Drug Name	Tier	Restrictions/Limits
ANALGESICS		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	2	
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	2	
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr</i>	4	QL (4 EA per 28 days)
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	2	QL (60 EA per 30 days)
<i>diclofenac potassium oral tablet 50 mg</i>	3	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	3	
<i>diclofenac sodium external gel 1 %</i>	2	QL (1000 GM per 30 days)
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	2	
<i>diflunisal oral tablet 500 mg</i>	3	
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 7.5-325 MG	3	
ENDOCET ORAL TABLET 5-325 MG	2	
<i>etodolac oral capsule 200 mg, 300 mg</i>	3	
<i>etodolac oral tablet 400 mg, 500 mg</i>	3	
<i>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 400 mcg, 600 mcg, 800 mcg</i>	5	PA
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	4	PA
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	4	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	2	
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	3	
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	
<i>hydromorphone hcl injection solution 1 mg/ml, 2 mg/ml, 4 mg/ml</i>	4	
<i>hydromorphone hcl oral tablet 2 mg, 4 mg</i>	2	
<i>hydromorphone hcl oral tablet 8 mg</i>	4	
<i>hydromorphone hcl pf injection solution 1 mg/ml, 10 mg/ml, 4 mg/ml, 50 mg/5ml</i>	4	
IBU ORAL TABLET 400 MG, 600 MG, 800 MG	1	*

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	*
<i>indomethacin er oral capsule extended release 75 mg</i>	4	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	2	
<i>ketorolac tromethamine injection solution 15 mg/ml, 30 mg/ml</i>	4	
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	4	
<i>ketorolac tromethamine oral tablet 10 mg</i>	4	QL (20 EA per 30 days)
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	*
<i>methadone hcl oral concentrate 10 mg/ml</i>	3	
<i>methadone hcl oral solution 10 mg/5ml, 5 mg/5ml</i>	3	
<i>methadone hcl oral tablet 10 mg, 5 mg</i>	2	
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml</i>	3	
<i>morphine sulfate (pf) intravenous solution 10 mg/ml, 4 mg/ml</i>	2	
<i>morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg</i>	3	
<i>morphine sulfate intravenous solution 10 mg/ml, 4 mg/ml</i>	2	
<i>morphine sulfate oral solution 10 mg/5ml</i>	3	
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	3	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	2	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	*
<i>naproxen oral tablet delayed release 500 mg</i>	4	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	3	
<i>oxaprozin oral tablet 600 mg</i>	3	
<i>oxycodone hcl oral solution 5 mg/5ml</i>	3	
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 5 mg</i>	2	
<i>oxycodone hcl oral tablet 20 mg, 30 mg</i>	3	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg</i>	3	
<i>oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg</i>	2	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	3	
<i>sulindac oral tablet 150 mg, 200 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>tramadol hcl oral tablet 50 mg</i>	1	*
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	2	
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG	3	
ANESTHETICS		
<i>lidocaine external ointment 5 %</i>	3	PA; QL (150 GM per 30 days)
<i>lidocaine external patch 5 %</i>	4	PA
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	2	PA; QL (30 GM per 30 days)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	4	
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	2	
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 4-1 mg</i>	3	QL (60 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 8-2 mg</i>	3	QL (90 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg</i>	2	QL (360 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	2	QL (90 EA per 30 days)
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	2	QL (60 EA per 30 days)
<i>disulfiram oral tablet 250 mg, 500 mg</i>	3	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	2	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	2	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	3	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	3	
<i>naltrexone hcl oral tablet 50 mg</i>	2	
NICOTROL NS NASAL SOLUTION 10 MG/ML	4	QL (360 ML per 365 days)
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	4	QL (504 EA per 365 days)
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg, 1 mg (56 pack)</i>	4	QL (504 EA per 365 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Drug Name	Tier	Restrictions/Limits
<i>varenicline tartrate oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	4	QL (504 EA per 365 days)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	5	
ANTIBACTERIALS		
<i>amikacin sulfate injection solution 1 gm/4ml, 500 mg/2ml</i>	4	
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	*
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1	*
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	*
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	2	
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	4	
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	2	
<i>amoxicillin-pot clavulanate oral suspension reconstituted 250-62.5 mg/5ml</i>	4	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg</i>	4	
<i>amoxicillin-pot clavulanate oral tablet 500-125 mg, 875-125 mg</i>	2	
<i>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</i>	2	
<i>ampicillin oral capsule 500 mg</i>	2	
<i>ampicillin sodium injection solution reconstituted 1 gm, 125 mg</i>	3	
<i>ampicillin sodium intravenous solution reconstituted 10 gm</i>	3	
<i>ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</i>	3	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted 1.5 (1-0.5) gm, 15 (10-5) gm, 3 (2-1) gm</i>	3	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED 125-31.25 MG/5ML	4	
<i>azithromycin intravenous solution reconstituted 500 mg</i>	3	
<i>azithromycin oral packet 1 gm</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	3	
<i>azithromycin oral tablet 250 mg</i>	1	*
<i>azithromycin oral tablet 500 mg, 600 mg</i>	3	
<i>aztreonam injection solution reconstituted 1 gm, 2 gm</i>	4	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 2400000 UNIT/4ML, 600000 UNIT/ML	4	
CARETOUCH ALCOHOL PREP PAD 70 %	3	
<i>cefaclor oral capsule 250 mg, 500 mg</i>	2	
<i>cefaclor oral suspension reconstituted 250 mg/5ml</i>	4	
<i>cefadroxil oral capsule 500 mg</i>	2	
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	2	
<i>cefazolin sodium injection solution reconstituted 1 gm, 2 gm, 3 gm</i>	4	
<i>cefdinir oral capsule 300 mg</i>	2	
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	3	
<i>cefepime hcl injection solution reconstituted 1 gm</i>	4	
<i>cefepime hcl intravenous solution 1 gm/50ml</i>	4	
<i>cefepime hcl intravenous solution reconstituted 100 gm, 2 gm</i>	4	
<i>cefixime oral capsule 400 mg</i>	4	
<i>cefotetan disodium injection solution reconstituted 1 gm, 2 gm</i>	3	
<i>cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	3	
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	3	
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	4	
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	3	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	3	
<i>ceftazidime and dextrose intravenous solution reconstituted 2-5 gm-%(50ml)</i>	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>ceftazidime injection solution reconstituted 1 gm, 6 gm</i>	3	
<i>ceftazidime intravenous solution reconstituted 2 gm</i>	3	
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg</i>	3	
<i>ceftriaxone sodium intravenous solution reconstituted 10 gm</i>	3	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	2	
<i>cefuroxime sodium injection solution reconstituted 750 mg</i>	3	
<i>cefuroxime sodium intravenous solution reconstituted 1.5 gm</i>	3	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	2	
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	2	
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%)	4	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	*
<i>ciprofloxacin in d5w intravenous solution 200 mg/100ml, 400 mg/200ml</i>	3	
<i>ciprofloxacin oral suspension reconstituted 250 mg/5ml (5%), 500 mg/5ml (10%)</i>	4	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	4	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	4	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	3	
CLINDACIN ETZ EXTERNAL SWAB 1 %	3	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	2	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	4	
<i>clindamycin phosphate external swab 1 %</i>	3	
<i>clindamycin phosphate injection solution 900 mg/6ml</i>	3	
<i>clindamycin phosphate vaginal cream 2 %</i>	4	
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	5	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>daptomycin intravenous solution reconstituted 350 mg, 500 mg</i>	5	
<i>daptomycin-sodium chloride intravenous solution 1000-0.9 mg/100ml-%, 350-0.9 mg/50ml-%, 500-0.9 mg/50ml-%, 700-0.9 mg/100ml-%</i>	4	
<i>demeclocycline hcl oral tablet 150 mg, 300 mg</i>	4	
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	2	
DIFICID ORAL TABLET 200 MG	5	
DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	4	
<i>doxycycline hyclate intravenous solution reconstituted 100 mg</i>	4	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline hyclate oral tablet 100 mg</i>	2	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	3	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i>	2	
<i>ertapenem sodium injection solution reconstituted 1 gm</i>	4	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml</i>	4	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	4	
<i>gentamicin sulfate external cream 0.1 %</i>	3	
<i>gentamicin sulfate external ointment 0.1 %</i>	3	
<i>gentamicin sulfate injection solution 10 mg/ml, 40 mg/ml</i>	3	
HUMATIN ORAL CAPSULE 250 MG	5	
<i>imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg</i>	4	
IMPAVIDO ORAL CAPSULE 50 MG	5	
<i>levofloxacin in d5w intravenous solution 250 mg/50ml, 500 mg/100ml, 750 mg/150ml</i>	4	
<i>levofloxacin intravenous solution 25 mg/ml</i>	4	
<i>levofloxacin oral solution 25 mg/ml</i>	4	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>linezolid intravenous solution 600 mg/300ml</i>	4	
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	5	QL (1800 ML per 28 days)
<i>linezolid oral tablet 600 mg</i>	4	QL (56 EA per 28 days)
<i>meropenem intravenous solution reconstituted 1 gm, 500 mg</i>	4	
<i>methenamine hippurate oral tablet 1 gm</i>	4	
<i>metronidazole intravenous solution 500 mg/100ml</i>	2	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	*
<i>metronidazole vaginal gel 0.75 %</i>	3	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	3	
MONDOXYNE NL ORAL CAPSULE 100 MG	2	
<i>moxifloxacin hcl in nacl intravenous solution 400 mg/250ml</i>	4	
<i>moxifloxacin hcl oral tablet 400 mg</i>	3	
<i>nafcillin sodium injection solution reconstituted 1 gm, 2 gm</i>	4	
<i>nafcillin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	4	
<i>neomycin sulfate oral tablet 500 mg</i>	2	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	4	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	2	
<i>oxacillin sodium injection solution reconstituted 1 gm, 2 gm</i>	4	
<i>oxacillin sodium intravenous solution reconstituted 10 gm</i>	4	
<i>penicillin g sodium injection solution reconstituted 5000000 unit</i>	5	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	2	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	2	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm</i>	4	
<i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i>	5	
<i>sulfadiazine oral tablet 500 mg</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	3	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	*
TAZICEF INJECTION SOLUTION RECONSTITUTED 1 GM	3	
TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED 1 GM, 2 GM, 6 GM	3	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	5	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	3	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	3	
<i>tobramycin sulfate injection solution 1.2 gm/30ml, 10 mg/ml, 2 gm/50ml, 80 mg/2ml</i>	3	
<i>tobramycin sulfate injection solution reconstituted 1.2 gm</i>	3	
<i>trimethoprim oral tablet 100 mg</i>	2	
<i>vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 500 mg, 750 mg</i>	3	
<i>vancomycin hcl oral capsule 125 mg</i>	4	QL (120 EA per 30 days)
<i>vancomycin hcl oral capsule 250 mg</i>	4	QL (240 EA per 30 days)
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG	5	
BRIVIACT ORAL SOLUTION 10 MG/ML	5	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	5	PA
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	4	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	3	
<i>carbamazepine oral suspension 100 mg/5ml</i>	3	
<i>carbamazepine oral tablet 200 mg</i>	3	
<i>carbamazepine oral tablet chewable 100 mg</i>	2	
<i>clobazam oral suspension 2.5 mg/ml</i>	4	
<i>clobazam oral tablet 10 mg, 20 mg</i>	4	
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	1	QL (90 EA per 30 days); *

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>clonazepam oral tablet 2 mg</i>	1	QL (300 EA per 30 days); *
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	4	QL (90 EA per 30 days)
<i>clonazepam oral tablet dispersible 2 mg</i>	4	QL (300 EA per 30 days)
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	5	PA
DIACOMIT ORAL PACKET 250 MG, 500 MG	5	PA
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	4	
DILANTIN ORAL CAPSULE 30 MG	4	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	2	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	2	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	2	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	5	PA
EPITOL ORAL TABLET 200 MG	3	
EPRONTIA ORAL SOLUTION 25 MG/ML	4	
<i>ethosuximide oral capsule 250 mg</i>	3	
<i>ethosuximide oral solution 250 mg/5ml</i>	3	
<i>felbamate oral suspension 600 mg/5ml</i>	5	
<i>felbamate oral tablet 400 mg, 600 mg</i>	4	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	5	PA
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	5	
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	5	
FYCOMPA ORAL TABLET 2 MG	4	
<i>gabapentin oral capsule 100 mg, 300 mg</i>	1	QL (360 EA per 30 days); *
<i>gabapentin oral capsule 400 mg</i>	2	QL (270 EA per 30 days)
<i>gabapentin oral solution 250 mg/5ml</i>	4	QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	2	QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	2	QL (150 EA per 30 days)
<i>lacosamide oral solution 10 mg/ml</i>	3	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	4	
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 42 x 50 mg & 14x100 mg</i>	4	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	*
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	2	
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	4	
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	4	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg</i>	4	
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg</i>	4	
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	3	
<i>levetiracetam oral solution 100 mg/ml</i>	2	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	2	
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG	4	QL (10 EA per 30 days)
<i>methsuximide oral capsule 300 mg</i>	4	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	4	QL (10 EA per 30 days)
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	4	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	2	
<i>phenobarbital oral elixir 20 mg/5ml</i>	4	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	4	
PHENYTEK ORAL CAPSULE 200 MG, 300 MG	2	
<i>phenytoin oral suspension 125 mg/5ml</i>	2	
<i>phenytoin oral tablet chewable 50 mg</i>	2	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	2	
<i>primidone oral tablet 125 mg, 250 mg, 50 mg</i>	2	
ROWEEPRA ORAL TABLET 500 MG	2	
<i>rufinamide oral suspension 40 mg/ml</i>	5	
<i>rufinamide oral tablet 200 mg</i>	4	
<i>rufinamide oral tablet 400 mg</i>	5	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG	4	
SUBVENITE ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG	1	
SUBVENITE STARTER KIT-BLUE ORAL KIT 35 X 25 MG	4	
SUBVENITE STARTER KIT-GREEN ORAL KIT 84 X 25 MG & 14X100 MG	4	
SUBVENITE STARTER KIT-ORANGE ORAL KIT 42 X 25 MG & 7 X 100 MG	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	
SYMPAZAN ORAL FILM 5 MG	4	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	4	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	3	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	*
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	5	QL (10 EA per 30 days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML	5	QL (10 EA per 30 days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML	5	QL (10 EA per 30 days)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	5	QL (10 EA per 30 days)
<i>vigabatrin oral packet 500 mg</i>	5	PA
<i>vigabatrin oral tablet 500 mg</i>	5	PA
VIGADRONE ORAL PACKET 500 MG	5	PA
VIGADRONE ORAL TABLET 500 MG	5	PA
VIGPODER ORAL PACKET 500 MG	5	PA
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG	5	PA
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG	5	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG	5	PA
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG	4	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
XCOPRI ORAL TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG	5	PA
ZONISADE ORAL SUSPENSION 100 MG/5ML	4	ST
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	2	
ANTIDEMENTIA AGENTS		
<i>donepezil hcl oral tablet 10 mg, 5 mg</i>	1	*
<i>donepezil hcl oral tablet 23 mg</i>	4	
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	2	
<i>ergoloid mesylates oral tablet 1 mg</i>	4	
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	4	
<i>galantamine hydrobromide oral solution 4 mg/ml</i>	4	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	4	
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	4	QL (30 EA per 30 days)
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg</i>	2	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	4	QL (30 EA per 30 days); ST
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	2	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	4	
ANTIDEPRESSANTS		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	3	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	4	
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG	4	QL (60 EA per 30 days); ST
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg</i>	2	QL (90 EA per 30 days)
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg, 200 mg</i>	2	QL (60 EA per 30 days)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg</i>	2	QL (90 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg</i>	2	QL (30 EA per 30 days)
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	2	
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	4	
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg</i>	1	*
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	4	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	4	
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg</i>	2	QL (120 EA per 30 days)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg</i>	2	QL (30 EA per 30 days)
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	3	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	4	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 60 MG	4	QL (60 EA per 30 days)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 30 MG, 40 MG	4	QL (90 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 60 mg</i>	2	QL (60 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 30 mg</i>	2	QL (90 EA per 30 days)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	5	QL (30 EA per 30 days); ST
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	2	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	1	*
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG	4	QL (30 EA per 30 days); ST
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	4	QL (56 EA per 365 days); ST
<i>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</i>	1	*
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	4	
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	4	
MARPLAN ORAL TABLET 10 MG	4	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	2	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	3	
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	4	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	4	
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	4	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
<i>phenelzine sulfate oral tablet 15 mg</i>	3	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	4	
<i>sertraline hcl oral concentrate 20 mg/ml</i>	3	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	1	*
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	5	PA
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	5	PA
<i>tranlycypromine sulfate oral tablet 10 mg</i>	4	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg</i>	1	*
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	4	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	4	QL (30 EA per 30 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	2	
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	4	QL (30 EA per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	5	PA; QL (28 EA per 14 days)
ZURZUVAE ORAL CAPSULE 30 MG	5	PA; QL (14 EA per 14 days)
ANTIEMETICS		
<i>aprepitant oral capsule 125 mg</i>	4	BD; QL (2 EA per 30 days)
<i>aprepitant oral capsule 40 mg</i>	4	BD; QL (1 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>aprepitant oral capsule 80 & 125 mg</i>	4	BD; QL (6 EA per 30 days)
<i>aprepitant oral capsule 80 mg</i>	4	BD; QL (8 EA per 30 days)
COMPRO RECTAL SUPPOSITORY 25 MG	4	
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	4	PA; QL (60 EA per 30 days)
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	4	
<i>ondansetron hcl injection solution prefilled syringe 4 mg/2ml</i>	4	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	4	BD; QL (450 ML per 30 days)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	BD; *
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	2	BD
<i>prochlorperazine edisylate injection solution 10 mg/2ml</i>	4	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	2	
<i>prochlorperazine rectal suppository 25 mg</i>	4	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	3	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	3	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	2	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	4	
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG	4	
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	4	
ANTIFUNGALS		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	4	BD
<i>amphotericin b intravenous solution reconstituted 50 mg</i>	4	BD
<i>amphotericin b liposome intravenous suspension reconstituted 50 mg</i>	5	BD
<i>caspofungin acetate intravenous solution reconstituted 50 mg</i>	5	
<i>caspofungin acetate intravenous solution reconstituted 70 mg</i>	4	
<i>clotrimazole external cream 1 %</i>	2	
<i>clotrimazole mouth/throat troche 10 mg</i>	3	
<i>econazole nitrate external cream 1 %</i>	2	
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%</i>	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	3	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	5	
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	4	
<i>griseofulvin microsize oral tablet 500 mg</i>	4	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	4	
<i>itraconazole oral capsule 100 mg</i>	4	PA
JUBLIA EXTERNAL SOLUTION 10 %	5	
<i>ketoconazole external cream 2 %</i>	2	QL (90 GM per 30 days)
<i>ketoconazole external shampoo 2 %</i>	2	
<i>ketoconazole oral tablet 200 mg</i>	2	
KLAYESTA EXTERNAL POWDER 100000 UNIT/GM	2	QL (120 GM per 30 days)
NYAMYC EXTERNAL POWDER 100000 UNIT/GM	2	QL (120 GM per 30 days)
<i>nystatin external cream 100000 unit/gm</i>	2	
<i>nystatin external ointment 100000 unit/gm</i>	2	
<i>nystatin external powder 100000 unit/gm</i>	2	QL (120 GM per 30 days)
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	2	
<i>nystatin oral tablet 500000 unit</i>	3	
NYSTOP EXTERNAL POWDER 100000 UNIT/GM	2	QL (120 GM per 30 days)
<i>posaconazole oral suspension 40 mg/ml</i>	5	PA
<i>posaconazole oral tablet delayed release 100 mg</i>	5	PA
<i>terbinafine hcl oral tablet 250 mg</i>	2	QL (84 EA per 180 days)
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	3	
<i>voriconazole intravenous solution reconstituted 200 mg</i>	5	PA
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	5	
<i>voriconazole oral tablet 200 mg, 50 mg</i>	4	
ANTIGOUT AGENTS		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	*
<i>colchicine oral tablet 0.6 mg</i>	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	2	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	4	
<i>probenecid oral tablet 500 mg</i>	2	
ANTIMIGRAINE AGENTS		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	4	PA; QL (1 ML per 28 days)
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML	4	PA; QL (2 ML per 28 days)
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	4	PA; QL (8 ML per 30 days)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA; QL (3 ML per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	4	PA; QL (2 ML per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	4	PA; QL (2 ML per 28 days)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	3	QL (24 EA per 28 days)
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	3	QL (9 EA per 30 days)
NURTEC ORAL TABLET DISPERSIBLE 75 MG	5	PA; QL (18 EA per 30 days)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG	5	PA; QL (30 EA per 30 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	2	QL (18 EA per 30 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	3	QL (18 EA per 30 days)
<i>sumatriptan nasal solution 20 mg/lact, 5 mg/lact</i>	4	QL (12 EA per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (9 EA per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml</i>	4	QL (5 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	4	QL (5 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	4	QL (5 ML per 30 days)
UBRELVY ORAL TABLET 100 MG, 50 MG	5	PA; QL (16 EA per 30 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	3	QL (12 EA per 30 days)
ANTIMYASTHENIC AGENTS		
<i>pyridostigmine bromide oral tablet 60 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
ANTIMYCOBACTERIALS		
<i>cycloserine oral capsule 250 mg</i>	5	
<i>dapsone oral tablet 100 mg, 25 mg</i>	3	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	2	
<i>isoniazid injection solution 100 mg/ml</i>	4	
<i>isoniazid oral syrup 50 mg/5ml</i>	3	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	1	*
PASER ORAL PACKET 4 GM	4	
PRIFTIN ORAL TABLET 150 MG	4	
<i>pyrazinamide oral tablet 500 mg</i>	3	
<i>rifabutin oral capsule 150 mg</i>	4	
<i>rifampin intravenous solution reconstituted 600 mg</i>	4	
<i>rifampin oral capsule 150 mg, 300 mg</i>	3	
SIRTURO ORAL TABLET 100 MG, 20 MG	5	
TRECTOR ORAL TABLET 250 MG	4	
ANTINEOPLASTICS		
<i>abiraterone acetate oral tablet 250 mg</i>	4	PA
<i>abiraterone acetate oral tablet 500 mg</i>	5	PA
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	5	PA
ALECENSA ORAL CAPSULE 150 MG	5	PA
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PA; QL (30 EA per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PA; QL (120 EA per 30 days)
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5	PA; QL (60 EA per 365 days)
<i>anastrozole oral tablet 1 mg</i>	1	*
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	5	PA; QL (30 EA per 30 days)
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	5	PA
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML	5	PA
<i>bexarotene external gel 1%</i>	5	PA
<i>bexarotene oral capsule 75 mg</i>	5	PA
<i>bicalutamide oral tablet 50 mg</i>	2	
BOSULIF ORAL CAPSULE 100 MG, 50 MG	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Drug Name	Tier	Restrictions/Limits
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG	5	PA
BRAFTOVI ORAL CAPSULE 75 MG	5	PA
BRUKINSA ORAL CAPSULE 80 MG	5	PA
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5	PA
CALQUENCE ORAL CAPSULE 100 MG	5	PA
CALQUENCE ORAL TABLET 100 MG	5	PA
CAPRELSA ORAL TABLET 100 MG	5	PA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA
<i>cisplatin intravenous solution 100 mg/100ml</i>	4	
COLUMVI INTRAVENOUS SOLUTION 10 MG/10ML, 2.5 MG/2.5ML	5	PA
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5	PA
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5	PA
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5	PA
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA
COTELLIC ORAL TABLET 20 MG	5	PA
<i>cyclophosphamide intravenous solution 500 mg/ml</i>	5	
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	3	BD
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1800-30000 MG-UT/15ML	5	PA
DAURISMO ORAL TABLET 100 MG, 25 MG	5	PA
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	4	
EPKINLY SUBCUTANEOUS SOLUTION 4 MG/0.8ML, 48 MG/0.8ML	5	PA
ERIVEDGE ORAL CAPSULE 150 MG	5	PA
ERLEADA ORAL TABLET 240 MG, 60 MG	5	PA
<i>erlotinib hcl oral tablet 100 mg, 25 mg</i>	4	PA
<i>erlotinib hcl oral tablet 150 mg</i>	5	PA
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	5	PA; QL (30 EA per 30 days)
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	5	PA
<i>exemestane oral tablet 25 mg</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>flutamide oral capsule 125 mg</i>	3	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	5	PA
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG	5	PA
GAVRETO ORAL CAPSULE 100 MG	5	PA
<i>gefitinib oral tablet 250 mg</i>	5	PA
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA; QL (30 EA per 30 days)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	4	
<i>hydroxyurea oral capsule 500 mg</i>	2	
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA
ICLUSIG ORAL TABLET 10 MG, 15 MG	5	PA; QL (30 EA per 30 days)
ICLUSIG ORAL TABLET 30 MG, 45 MG	5	PA
IDHIFA ORAL TABLET 100 MG, 50 MG	5	PA; QL (30 EA per 30 days)
<i>imatinib mesylate oral tablet 100 mg</i>	2	PA
<i>imatinib mesylate oral tablet 400 mg</i>	4	PA
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	5	PA
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG	5	PA
INLYTA ORAL TABLET 1 MG, 5 MG	5	PA
INQOVI ORAL TABLET 35-100 MG	5	PA
INREBIC ORAL CAPSULE 100 MG	5	PA
IWILFIN ORAL TABLET 192 MG	5	PA
JAKAFI ORAL TABLET 10 MG	5	PA; QL (60 EA per 30 days)
JAKAFI ORAL TABLET 15 MG, 20 MG, 25 MG, 5 MG	5	PA
JAYPIRCA ORAL TABLET 100 MG	5	PA
JAYPIRCA ORAL TABLET 50 MG	5	PA; QL (30 EA per 30 days)
KANJINTI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	5	PA
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	5	PA
KRAZATI ORAL TABLET 200 MG	5	PA
<i>lapatinib ditosylate oral tablet 250 mg</i>	5	PA
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	5	PA
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5	PA
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	5	PA
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	5	PA
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	5	PA
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	5	PA
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	5	PA
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5	PA
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	5	PA
<i>letrozole oral tablet 2.5 mg</i>	2	
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	3	
LEUKERAN ORAL TABLET 2 MG	5	
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
LOQTORZI INTRAVENOUS SOLUTION 240 MG/6ML	5	PA
LORBRENA ORAL TABLET 100 MG, 25 MG	5	PA
LUMAKRAS ORAL TABLET 120 MG, 320 MG	5	PA
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5	PA
MATULANE ORAL CAPSULE 50 MG	5	
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML	5	PA
MEKINIST ORAL TABLET 0.5 MG, 2 MG	5	PA
MEKTOVI ORAL TABLET 15 MG	5	PA
<i>mercaptopurine oral tablet 50 mg</i>	3	
MESNEX ORAL TABLET 400 MG	5	
NERLYNX ORAL TABLET 40 MG	5	PA; QL (180 EA per 30 days)
<i>nilutamide oral tablet 150 mg</i>	5	
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA
NUBEQA ORAL TABLET 300 MG	5	PA
ODOMZO ORAL CAPSULE 200 MG	5	PA
OGSIVEO ORAL TABLET 50 MG	5	PA
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML	5	PA
OJEMDA ORAL TABLET 100 MG	5	PA
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	5	PA
ONUREG ORAL TABLET 200 MG, 300 MG	5	PA
OPDUALAG INTRAVENOUS SOLUTION 240-80 MG/20ML	5	PA
ORSERDU ORAL TABLET 345 MG, 86 MG	5	PA
PANRETIN EXTERNAL GEL 0.1 %	5	
<i>pazopanib hcl oral tablet 200 mg</i>	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA; QL (30 EA per 30 days)
PHESGO SUBCUTANEOUS SOLUTION 60-60-2000 MG-MG-U/ML, 80-40-2000 MG-MG-U/ML	5	PA
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5	PA
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	5	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML	5	
QINLOCK ORAL TABLET 50 MG	5	PA
RETEVMO ORAL CAPSULE 40 MG, 80 MG	5	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	5	PA
REZLIDHIA ORAL CAPSULE 150 MG	5	PA
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	5	PA
ROZLYTREK ORAL PACKET 50 MG	5	PA
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	5	PA
RYDAPT ORAL CAPSULE 25 MG	5	PA
SCEMBLIX ORAL TABLET 100 MG	5	PA; QL (120 EA per 30 days)
SCEMBLIX ORAL TABLET 20 MG	5	PA; QL (60 EA per 30 days)
SCEMBLIX ORAL TABLET 40 MG	5	PA
SOLTAMOX ORAL SOLUTION 10 MG/5ML	5	
<i>sorafenib tosylate oral tablet 200 mg</i>	5	PA
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG	5	PA
STIVARGA ORAL TABLET 40 MG	5	PA
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG	5	PA
TABLOID ORAL TABLET 40 MG	4	
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA; QL (120 EA per 30 days)
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA
TAFINLAR ORAL TABLET SOLUBLE 10 MG	5	PA
TAGRISSO ORAL TABLET 40 MG	5	PA; QL (30 EA per 30 days)
TAGRISSO ORAL TABLET 80 MG	5	PA
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	2	
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG	5	PA
TAZVERIK ORAL TABLET 200 MG	5	PA
TEPMETKO ORAL TABLET 225 MG	5	PA
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	5	PA
TIBSOVO ORAL TABLET 250 MG	5	PA
<i>toremifene citrate oral tablet 60 mg</i>	5	
TORPENZ ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	5	PA; QL (30 EA per 30 days)
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	5	PA
<i>tretinoin oral capsule 10 mg</i>	5	
TRUQAP ORAL TABLET 160 MG, 200 MG	5	PA
TUKYSA ORAL TABLET 150 MG, 50 MG	5	PA
TURALIO ORAL CAPSULE 125 MG, 200 MG	5	PA
VALCHLOR EXTERNAL GEL 0.016 %	5	PA
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	5	PA
VENCLEXTA ORAL TABLET 10 MG	3	PA
VENCLEXTA ORAL TABLET 100 MG, 50 MG	5	PA
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	5	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA
VONJO ORAL CAPSULE 100 MG	5	PA
VOTRIENT ORAL TABLET 200 MG	5	PA
WELIREG ORAL TABLET 40 MG	5	PA
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA
XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG	5	PA
XOSPATA ORAL TABLET 40 MG	5	PA
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5	PA
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	5	PA
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA
XTANDI ORAL CAPSULE 40 MG	5	PA
XTANDI ORAL TABLET 40 MG, 80 MG	5	PA
ZEJULA ORAL CAPSULE 100 MG	5	PA
ZEJULA ORAL TABLET 100 MG	5	PA; QL (30 EA per 30 days)
ZEJULA ORAL TABLET 200 MG, 300 MG	5	PA
ZELBORAF ORAL TABLET 240 MG	5	PA
ZOLINZA ORAL CAPSULE 100 MG	5	PA
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA
ZYKADIA ORAL TABLET 150 MG	5	PA
ANTIPARASITICS		
<i>albendazole oral tablet 200 mg</i>	4	
<i>atovaquone oral suspension 750 mg/5ml</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	3	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	3	
COARTEM ORAL TABLET 20-120 MG	4	
<i>hydroxychloroquine sulfate oral tablet 100 mg, 200 mg</i>	2	
<i>ivermectin oral tablet 3 mg</i>	2	PA
<i>mefloquine hcl oral tablet 250 mg</i>	2	
<i>nitazoxanide oral tablet 500 mg</i>	4	
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	3	BD
<i>pentamidine isethionate injection solution reconstituted 300 mg</i>	3	
<i>praziquantel oral tablet 600 mg</i>	4	
<i>primaquine phosphate oral tablet 26.3 (15 base) mg</i>	3	
<i>pyrimethamine oral tablet 25 mg</i>	5	PA
<i>quinine sulfate oral capsule 324 mg</i>	3	PA
ANTIPARKINSON AGENTS		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>bromocriptine mesylate oral capsule 5 mg</i>	4	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	4	
<i>carbidopa oral tablet 25 mg</i>	4	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	3	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	2	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	4	
<i>entacapone oral tablet 200 mg</i>	3	
INBRIJA INHALATION CAPSULE 42 MG	5	PA
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA; QL (150 EA per 30 days)
KYNMOBI TITRATION KIT SUBLINGUAL KIT 10&15&20&25	5	PA; QL (20 EA per 365 days)
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
OSMOLEX ER ORAL TABLET ER 24 HOUR THERAPY PACK 129 & 193 MG	4	PA
OSMOLEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR 129 MG, 193 MG	4	PA
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	2	
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	4	
<i>ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	4	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	2	
RYTARY ORAL CAPSULE EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG	4	ST
<i>selegiline hcl oral capsule 5 mg</i>	3	
<i>selegiline hcl oral tablet 5 mg</i>	3	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	4	
ANTIPSYCHOTICS		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	5	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	5	
<i>aripiprazole oral solution 1 mg/ml</i>	4	QL (750 ML per 30 days)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	2	QL (30 EA per 30 days)
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	5	QL (60 EA per 30 days)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML	5	
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML	5	
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	4	QL (60 EA per 30 days)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	5	PA; QL (30 EA per 30 days)
<i>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	4	
<i>clozapine oral tablet 100 mg</i>	4	QL (270 EA per 30 days)
<i>clozapine oral tablet 200 mg</i>	4	QL (120 EA per 30 days)
<i>clozapine oral tablet 25 mg</i>	3	QL (270 EA per 30 days)
<i>clozapine oral tablet 50 mg</i>	3	QL (180 EA per 30 days)
<i>clozapine oral tablet dispersible 100 mg, 25 mg</i>	4	QL (270 EA per 30 days)
<i>clozapine oral tablet dispersible 12.5 mg</i>	4	QL (90 EA per 30 days)
<i>clozapine oral tablet dispersible 150 mg</i>	4	QL (180 EA per 30 days)
<i>clozapine oral tablet dispersible 200 mg</i>	5	QL (120 EA per 30 days)
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5	QL (60 EA per 30 days); ST
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	4	QL (8 EA per 180 days); ST
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	4	
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	4	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	4	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	4	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	4	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml 1 ml, 50 mg/ml, 50 mg/ml(1ml)</i>	3	
<i>haloperidol lactate injection solution 5 mg/ml</i>	3	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	2	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
<i>haloperidol oral tablet 20 mg</i>	3	
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML	5	ST
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 78 MG/0.5ML	5	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML	5	
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	4	QL (30 EA per 30 days)
<i>lurasidone hcl oral tablet 80 mg</i>	4	QL (60 EA per 30 days)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	5	QL (30 EA per 30 days); ST
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	4	
NUPLAZID ORAL CAPSULE 34 MG	5	PA
NUPLAZID ORAL TABLET 10 MG	5	PA
<i>olanzapine intramuscular solution reconstituted 10 mg</i>	4	
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	2	QL (30 EA per 30 days)
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	3	QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	4	QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	4	QL (60 EA per 30 days)
<i>perphenazine oral tablet 16 mg, 8 mg</i>	4	
<i>perphenazine oral tablet 2 mg, 4 mg</i>	3	
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG	5	
<i>pimozide oral tablet 1 mg, 2 mg</i>	4	
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 300 mg, 400 mg, 50 mg</i>	2	QL (60 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 200 mg</i>	2	QL (90 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 50 mg</i>	2	QL (90 EA per 30 days)
<i>quetiapine fumarate oral tablet 300 mg, 400 mg</i>	2	QL (60 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5	QL (30 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG	4	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG	5	
<i>risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg</i>	4	
<i>risperidone microspheres er intramuscular suspension reconstituted er 25 mg, 37.5 mg, 50 mg</i>	5	
<i>risperidone oral solution 1 mg/ml</i>	2	QL (240 ML per 30 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	1	QL (60 EA per 30 days); *
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	4	QL (60 EA per 30 days)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR	5	QL (30 EA per 30 days); ST
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	3	
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	3	
<i>trifluoperazine hcl oral tablet 1 mg, 2 mg, 5 mg</i>	3	
<i>trifluoperazine hcl oral tablet 10 mg</i>	4	
VERSACLOZ ORAL SUSPENSION 50 MG/ML	5	QL (540 ML per 30 days)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	5	QL (30 EA per 30 days)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	3	QL (60 EA per 30 days)
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	4	QL (60 EA per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG	4	
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 300 MG, 405 MG	5	
ANTISPASTICITY AGENTS		
<i>baclofen oral tablet 10 mg, 20 mg</i>	2	
<i>baclofen oral tablet 5 mg</i>	3	
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	2	
ANTIVIRALS		
<i>abacavir sulfate oral solution 20 mg/ml</i>	4	
<i>abacavir sulfate oral tablet 300 mg</i>	4	
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	4	QL (30 EA per 30 days)
<i>acyclovir oral capsule 200 mg</i>	2	
<i>acyclovir oral suspension 200 mg/5ml</i>	4	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	2	
<i>acyclovir sodium intravenous solution 50 mg/ml</i>	4	BD
<i>adefovir dipivoxil oral tablet 10 mg</i>	4	
<i>amantadine hcl oral capsule 100 mg</i>	2	
<i>amantadine hcl oral solution 50 mg/5ml</i>	2	
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML	5	
APTIVUS ORAL CAPSULE 250 MG	5	
<i>atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg</i>	4	
BARACLUDGE ORAL SOLUTION 0.05 MG/ML	4	QL (600 ML per 30 days)
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5	QL (30 EA per 30 days)
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML	5	
<i>cidofovir intravenous solution 75 mg/ml</i>	5	
CIMDUO ORAL TABLET 300-300 MG	5	QL (30 EA per 30 days)
COMPLERA ORAL TABLET 200-25-300 MG	5	QL (30 EA per 30 days)
<i>darunavir oral tablet 600 mg, 800 mg</i>	5	
DELSTRIGO ORAL TABLET 100-300-300 MG	5	QL (30 EA per 30 days)
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	5	QL (30 EA per 30 days)
DOVATO ORAL TABLET 50-300 MG	5	QL (30 EA per 30 days)
EDURANT ORAL TABLET 25 MG	5	
<i>efavirenz oral capsule 200 mg, 50 mg</i>	4	
<i>efavirenz oral tablet 600 mg</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	4	QL (30 EA per 30 days)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	5	QL (30 EA per 30 days)
<i>emtricitabine oral capsule 200 mg</i>	2	
<i>emtricitabine-tenofovir df oral tablet 100-150 mg</i>	4	QL (30 EA per 30 days)
<i>emtricitabine-tenofovir df oral tablet 133-200 mg, 167-250 mg</i>	5	QL (30 EA per 30 days)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	2	QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	4	
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	4	QL (30 EA per 30 days)
<i>etravirine oral tablet 100 mg</i>	4	
<i>etravirine oral tablet 200 mg</i>	5	
EVOTAZ ORAL TABLET 300-150 MG	5	QL (30 EA per 30 days)
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	3	
<i>fosamprenavir calcium oral tablet 700 mg</i>	5	
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG	5	
<i>ganciclovir sodium intravenous solution 500 mg/10ml</i>	2	BD
<i>ganciclovir sodium intravenous solution reconstituted 500 mg</i>	2	BD
GENVOYA ORAL TABLET 150-150-200-10 MG	5	QL (30 EA per 30 days)
INTELENCE ORAL TABLET 25 MG	4	
ISENTRESS HD ORAL TABLET 600 MG	5	
ISENTRESS ORAL PACKET 100 MG	5	
ISENTRESS ORAL TABLET 400 MG	5	
ISENTRESS ORAL TABLET CHEWABLE 100 MG	5	
ISENTRESS ORAL TABLET CHEWABLE 25 MG	3	
JULUCA ORAL TABLET 50-25 MG	5	QL (30 EA per 30 days)
<i>lamivudine oral solution 10 mg/ml</i>	3	
<i>lamivudine oral tablet 100 mg, 150 mg, 300 mg</i>	3	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	4	QL (60 EA per 30 days)
LEXIVA ORAL SUSPENSION 50 MG/ML	4	
LIVTENCITY ORAL TABLET 200 MG	5	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	4	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	4	
<i>maraviroc oral tablet 150 mg, 300 mg</i>	5	
MAVYRET ORAL PACKET 50-20 MG	5	PA; QL (560 EA per 365 days)
MAVYRET ORAL TABLET 100-40 MG	5	PA; QL (336 EA per 365 days)
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	4	
<i>nevirapine oral suspension 50 mg/5ml</i>	2	
<i>nevirapine oral tablet 200 mg</i>	2	
NORVIR ORAL PACKET 100 MG	4	
NORVIR ORAL SOLUTION 80 MG/ML	4	
ODEFSEY ORAL TABLET 200-25-25 MG	5	QL (30 EA per 30 days)
<i>oseltamivir phosphate oral capsule 30 mg</i>	3	QL (168 EA per 365 days)
<i>oseltamivir phosphate oral capsule 45 mg</i>	3	QL (84 EA per 365 days)
<i>oseltamivir phosphate oral capsule 75 mg</i>	3	QL (110 EA per 365 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	3	QL (1080 ML per 365 days)
PIFELTRO ORAL TABLET 100 MG	5	
PREVYMIS ORAL TABLET 240 MG, 480 MG	5	
PREZCOBIX ORAL TABLET 800-150 MG	5	QL (30 EA per 30 days)
PREZISTA ORAL SUSPENSION 100 MG/ML	5	
PREZISTA ORAL TABLET 150 MG, 75 MG	4	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT	4	QL (240 EA per 365 days)
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML	4	
REYATAZ ORAL PACKET 50 MG	5	
<i>ribavirin oral tablet 200 mg</i>	3	
<i>ritonavir oral tablet 100 mg</i>	3	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	5	
SELZENTRY ORAL SOLUTION 20 MG/ML	5	
SELZENTRY ORAL TABLET 25 MG	4	
SELZENTRY ORAL TABLET 75 MG	5	
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	5	PA; QL (84 EA per 365 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg</i>	4	
STRIBILD ORAL TABLET 150-150-200-300 MG	5	QL (30 EA per 30 days)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG	5	
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML	5	
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	QL (30 EA per 30 days)
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	4	
TIVICAY ORAL TABLET 10 MG	4	
TIVICAY ORAL TABLET 25 MG, 50 MG	5	
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	4	
TRIUMEQ ORAL TABLET 600-50-300 MG	5	QL (30 EA per 30 days)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5- 30 MG	5	QL (180 EA per 30 days)
TRIZIVIR ORAL TABLET 300-150-300 MG	5	QL (60 EA per 30 days)
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML	5	
TYBOST ORAL TABLET 150 MG	4	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	3	QL (120 EA per 30 days)
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	5	
<i>valganciclovir hcl oral tablet 450 mg</i>	3	
VIRACEPT ORAL TABLET 250 MG, 625 MG	5	
VIREAD ORAL POWDER 40 MG/GM	5	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	
VOCABRIA ORAL TABLET 30 MG	5	
VOSEVI ORAL TABLET 400-100-100 MG	5	PA; QL (84 EA per 365 days)
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG, 2 X 20 MG	3	QL (4 EA per 365 days)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG	3	QL (2 EA per 365 days)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 2 X 40 MG	3	QL (4 EA per 365 days)
<i>zidovudine oral capsule 100 mg</i>	3	
<i>zidovudine oral syrup 50 mg/5ml</i>	3	
<i>zidovudine oral tablet 300 mg</i>	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
ANXIOLYTICS		
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg</i>	2	QL (120 EA per 30 days)
<i>alprazolam oral tablet 2 mg</i>	2	QL (150 EA per 30 days)
<i>buspirone hcl oral tablet 10 mg, 15 mg, 5 mg</i>	1	*
<i>buspirone hcl oral tablet 30 mg, 7.5 mg</i>	4	
<i>clorazepate dipotassium oral tablet 15 mg</i>	4	QL (180 EA per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	4	QL (720 EA per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	4	QL (360 EA per 30 days)
<i>diazepam injection solution 5 mg/ml</i>	4	
DIAZEPAM INTENSOL ORAL CONCENTRATE 5 MG/ML	2	
<i>diazepam oral solution 5 mg/5ml</i>	2	
<i>diazepam oral tablet 10 mg</i>	2	QL (120 EA per 30 days)
<i>diazepam oral tablet 2 mg</i>	2	QL (300 EA per 30 days)
<i>diazepam oral tablet 5 mg</i>	2	QL (240 EA per 30 days)
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	4	
LORAZEPAM INTENSOL ORAL CONCENTRATE 2 MG/ML	3	
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>lorazepam oral tablet 2 mg</i>	2	QL (150 EA per 30 days)
BIPOLAR AGENTS		
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	2	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	1	*
<i>lithium carbonate oral tablet 300 mg</i>	1	*
<i>lithium oral solution 8 meq/5ml</i>	2	
<i>valproic acid oral capsule 250 mg</i>	2	
<i>valproic acid oral solution 250 mg/5ml</i>	2	
BLOOD GLUCOSE REGULATORS		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	2	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	3	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML	4	PA; QL (3.4 ML per 28 days)
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML	4	PA; QL (2.4 ML per 28 days)
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML	4	PA; QL (4.8 ML per 28 days)
<i>diazoxide oral suspension 50 mg/ml</i>	5	
FARXIGA ORAL TABLET 10 MG, 5 MG	3	
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	1	*
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	*
<i>glipizide oral tablet 10 mg, 5 mg</i>	1	*
<i>glipizide oral tablet 2.5 mg</i>	2	
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	1	*
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG	4	ST
<i>glucagon emergency injection kit 1 mg</i>	3	
<i>glucagon emergency injection solution reconstituted 1 mg/ml</i>	3	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	1	*
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	1	*
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	3	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	3	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	3	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML	3	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML, 1 MG/0.2ML	3	
HUMALOG INJECTION SOLUTION 100 UNIT/ML	3	*

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	*
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	*
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML	3	*
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	3	*
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	3	*
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	*
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	*
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	*
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	*
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	*
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	3	*
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML	3	*
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	3	*
<i>insulin lispro injection solution 100 unit/ml</i>	3	*
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	3	
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG	3	
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	QL (30 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG	3	
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG	3	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	*
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	*
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	*
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	*
LYUMJEV INJECTION SOLUTION 100 UNIT/ML	3	*
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	*
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	1	*
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	1	*
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML	3	PA; QL (2 ML per 28 days)
<i>nateglinide oral tablet 120 mg, 60 mg</i>	1	*
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	*
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	*
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	*
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	*
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	*

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	*
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	*
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	*
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	3	*
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	3	*
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	3	*
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML	3	*
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	*
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	*
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	*
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	3	*
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	*
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	*
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	*
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	*
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	3	*
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML	3	PA; QL (1.5 ML per 28 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML	3	PA; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML, 4 MG/3ML	3	PA; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML	3	PA; QL (3 ML per 28 days)
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	1	*
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	2	
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	*
RYBELSUS ORAL TABLET 14 MG, 7 MG	3	PA; QL (30 EA per 30 days)
RYBELSUS ORAL TABLET 3 MG	3	PA; QL (60 EA per 365 days)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML	3	*
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG	3	
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG	3	
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	*
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	*
TRADJENTA ORAL TABLET 5 MG	3	QL (30 EA per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	*
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	*
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 12.5-2.5-1000 MG, 25-5-1000 MG, 5-2.5-1000 MG	3	
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	3	PA; QL (2 ML per 28 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
BLOOD PRODUCTS AND MODIFIERS		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	3	
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	4	
BRILINTA ORAL TABLET 60 MG, 90 MG	3	
CABLIVI INJECTION KIT 11 MG	5	PA; QL (30 EA per 30 days)
<i>cilostazol oral tablet 100 mg, 50 mg</i>	2	
<i>clopidogrel bisulfate oral tablet 300 mg</i>	2	
<i>clopidogrel bisulfate oral tablet 75 mg</i>	1	*
DOPTELET ORAL TABLET 20 MG, 20 MG (10 PACK), 20 MG(15 PACK)	5	PA
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	3	QL (148 EA per 365 days)
ELIQUIS ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (90 EA per 30 days)
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	4	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml</i>	4	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	5	
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	4	
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML	5	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML	5	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2ML	4	
<i>heparin sodium (porcine) injection solution 5000 unit/ml</i>	3	
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	1	*
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
OXBRYTA ORAL TABLET 300 MG	5	PA; QL (240 EA per 30 days)
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	2	
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA
PROCRIT INJECTION SOLUTION 40000 UNIT/ML	5	PA
PROMACTA ORAL PACKET 12.5 MG, 25 MG	5	PA
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG	5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG	5	PA; QL (60 EA per 30 days)
PYRUKYND ORAL TABLET 50 MG	5	PA; QL (120 EA per 30 days)
PYRUKYND TAPER PACK ORAL TABLET THERAPY PACK 5 MG, 7 X 20 MG & 7 X 5 MG, 7 X 50 MG & 7 X 20 MG	5	PA; QL (30 EA per 30 days)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA
RETACRIT INJECTION SOLUTION 40000 UNIT/ML	5	PA
ROLVEDON SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 13.2 MG/0.6ML	5	PA
<i>tranexamic acid oral tablet 650 mg</i>	3	
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML	5	PA
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	*
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	3	QL (102 EA per 365 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	5	
CARDIOVASCULAR AGENTS		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	2	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	3	
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	2	
<i>amiloride hcl oral tablet 5 mg</i>	1	*
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	2	
<i>amiodarone hcl oral tablet 100 mg, 400 mg</i>	3	
<i>amiodarone hcl oral tablet 200 mg</i>	1	*
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1	*
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	*
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	1	*
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	2	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	*
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	2	
<i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	1	*
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	*
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	1	*
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	3	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	2	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	2	
<i>bumetanide injection solution 0.25 mg/ml</i>	2	
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	*
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	1	*
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	2	
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	2	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	*
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	2	
<i>cholestyramine light oral packet 4 gm</i>	4	
<i>cholestyramine light oral powder 4 gm/dose</i>	4	
<i>cholestyramine oral packet 4 gm</i>	3	
<i>cholestyramine oral powder 4 gm/dose</i>	3	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	*
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	4	
<i>colesevelam hcl oral tablet 625 mg</i>	4	
<i>colestipol hcl oral granules 5 gm</i>	4	
<i>colestipol hcl oral packet 5 gm</i>	4	
<i>colestipol hcl oral tablet 1 gm</i>	3	
CORLANOR ORAL TABLET 5 MG, 7.5 MG	4	PA; QL (60 EA per 30 days)
DIGITEK ORAL TABLET 125 MCG, 250 MCG	2	
<i>digoxin oral solution 0.05 mg/ml</i>	4	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	2	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	4	
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	2	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	4	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	2	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	4	
<i>droxidopa oral capsule 100 mg, 200 mg, 300 mg</i>	5	PA
EDARBI ORAL TABLET 40 MG, 80 MG	4	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	4	
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	*
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	*
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG	3	QL (240 EA per 30 days)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	3	QL (60 EA per 30 days)
<i>epinephrine (anaphylaxis) injection solution 1 mg/ml</i>	3	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	3	
<i>ezetimibe oral tablet 10 mg</i>	2	
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	2	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	2	
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	2	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	2	
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	3	
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	2	
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	4	
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	4	
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1	*
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	2	
<i>furosemide injection solution 10 mg/ml</i>	3	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	*
<i>gemfibrozil oral tablet 600 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	4	
<i>hydralazine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	*
<i>hydralazine hcl oral tablet 100 mg</i>	2	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	*
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	*
<i>icosapent ethyl oral capsule 0.5 gm, 1 gm</i>	4	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	*
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	*
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	1	*
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg</i>	3	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	2	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	1	*
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	2	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	4	
KERENDIA ORAL TABLET 10 MG, 20 MG	4	PA; QL (30 EA per 30 days)
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	2	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	1	*
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	*
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG	4	ST
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	1	*
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	*
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	1	*
MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	4	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	4	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	*

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	*
<i>metyrosine oral capsule 250 mg</i>	5	PA
<i>mexiletine hcl oral capsule 150 mg</i>	3	
<i>mexiletine hcl oral capsule 200 mg, 250 mg</i>	4	
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	2	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	2	
MULTAQ ORAL TABLET 400 MG	3	
<i>nadolol oral tablet 20 mg, 40 mg</i>	2	
<i>nadolol oral tablet 80 mg</i>	3	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	3	
NEXLETOL ORAL TABLET 180 MG	4	PA; QL (30 EA per 30 days)
NEXLIZET ORAL TABLET 180-10 MG	4	PA; QL (30 EA per 30 days)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	3	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	2	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	2	
<i>nimodipine oral capsule 30 mg</i>	4	
NITRO-BID TRANSDERMAL OINTMENT 2 %	4	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	2	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	2	
<i>nitroglycerin translingual solution 0.4 mg/spray</i>	4	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	1	*
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	1	*
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	3	
PACERONE ORAL TABLET 100 MG, 400 MG	3	
PACERONE ORAL TABLET 200 MG	1	*
<i>pentoxifylline er oral tablet extended release 400 mg</i>	2	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>pindolol oral tablet 10 mg, 5 mg</i>	3	
<i>pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg</i>	4	
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML	3	PA; QL (2 ML per 28 days)
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	1	*
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	2	
PREVALITE ORAL PACKET 4 GM	4	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	4	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	2	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	2	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	2	
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	*
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	*
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	3	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	*
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	2	
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML	3	PA; QL (7 ML per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	3	PA; QL (3 ML per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	3	PA; QL (3 ML per 28 days)
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	*
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i>	1	*
SORINE ORAL TABLET 120 MG, 160 MG, 240 MG	2	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	2	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	*
<i>spironolactone-hctz oral tablet 25-25 mg</i>	2	
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	2	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	1	*
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	1	*
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	*
TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	2	
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	*
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	1	*
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	2	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	*
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1	*
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	1	*
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	1	*
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 360 mg</i>	3	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	2	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	*
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	3	PA; QL (30 EA per 30 days)
VYNDAMAX ORAL CAPSULE 61 MG	5	PA; QL (30 EA per 30 days)
CENTRAL NERVOUS SYSTEM AGENTS		
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	3	QL (60 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	3	QL (90 EA per 30 days)
<i>atomoxetine hcl oral capsule 10 mg</i>	4	QL (60 EA per 30 days)
<i>atomoxetine hcl oral capsule 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</i>	4	QL (30 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	5	PA; QL (120 EA per 30 days)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML	5	PA; QL (4 EA per 28 days)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML	5	PA; QL (4 EA per 28 days)
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG	5	PA; QL (120 EA per 30 days)
BETASERON SUBCUTANEOUS KIT 0.3 MG	5	PA; QL (15 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	3	
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	3	PA; QL (60 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</i>	4	QL (180 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	4	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</i>	4	QL (60 EA per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg</i>	3	QL (180 EA per 30 days)
<i>dextroamphetamine sulfate oral tablet 15 mg, 20 mg, 5 mg</i>	3	QL (90 EA per 30 days)
<i>dextroamphetamine sulfate oral tablet 30 mg</i>	3	QL (60 EA per 30 days)
<i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i>	4	PA; QL (60 EA per 30 days)
<i>dimethyl fumarate starter pack oral 120 & 240 mg</i>	4	PA; QL (120 EA per 365 days)
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	4	PA; QL (120 EA per 365 days)
<i>fingolimod hcl oral capsule 0.5 mg</i>	5	PA; QL (30 EA per 30 days)
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml</i>	5	PA; QL (30 ML per 30 days)
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	5	PA; QL (12 ML per 28 days)
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	3	
INGREZZA ORAL CAPSULE 40 MG	5	PA; QL (60 EA per 30 days)
INGREZZA ORAL CAPSULE 60 MG, 80 MG	5	PA; QL (30 EA per 30 days)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG	5	PA; QL (60 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG	5	PA; QL (30 EA per 30 days)
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML	5	PA; QL (0.4 ML per 28 days)
MAYZENT ORAL TABLET 0.25 MG	5	PA; QL (120 EA per 30 days)
MAYZENT ORAL TABLET 1 MG, 2 MG	5	PA; QL (30 EA per 30 days)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG	5	PA; QL (24 EA per 365 days)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG	4	PA; QL (14 EA per 365 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg</i>	4	QL (30 EA per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	4	QL (60 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 24 hour 27 mg, 54 mg</i>	4	QL (30 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 24 hour 36 mg</i>	4	QL (60 EA per 30 days)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	4	
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	2	QL (90 EA per 30 days)
NUEDEXTA ORAL CAPSULE 20-10 MG	5	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 50 mg, 75 mg</i>	2	QL (90 EA per 30 days)
<i>pregabalin oral capsule 300 mg</i>	2	QL (60 EA per 30 days)
<i>pregabalin oral solution 20 mg/ml</i>	4	QL (900 ML per 30 days)
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML	5	PA; QL (6 ML per 28 days)
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG	5	PA; QL (8.4 ML per 365 days)
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML	5	PA; QL (6 ML per 28 days)
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG	5	PA; QL (8.4 ML per 365 days)
<i>riluzole oral tablet 50 mg</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	3	QL (60 EA per 30 days)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG	3	QL (110 EA per 365 days)
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	4	PA
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG	5	PA; QL (120 EA per 30 days)
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG	5	PA; QL (14 EA per 365 days)
ZEPOSIA ORAL CAPSULE 0.92 MG	5	PA; QL (30 EA per 30 days)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG & 0.92MG	5	PA; QL (74 EA per 365 days)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21)	5	PA; QL (56 EA per 365 days)
ZTALMY ORAL SUSPENSION 50 MG/ML	5	PA
DENTAL AND ORAL AGENTS		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	*
<i>doxycycline hyclate oral tablet 20 mg</i>	3	
KEPIVANCE INTRAVENOUS SOLUTION RECONSTITUTED 5.16 MG, 6.25 MG	5	
KOURZEQ MOUTH/THROAT PASTE 0.1 %	3	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	2	
ORALONE MOUTH/THROAT PASTE 0.1 %	3	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	4	
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	3	
DERMATOLOGICAL AGENTS		
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	4	
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	4	
<i>acyclovir external ointment 5 %</i>	4	
<i>alclometasone dipropionate external cream 0.05 %</i>	3	
<i>alclometasone dipropionate external ointment 0.05 %</i>	3	
<i>ammonium lactate external cream 12 %</i>	2	
<i>ammonium lactate external lotion 12 %</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	4	
<i>azelaic acid external gel 15 %</i>	4	
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	4	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	2	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	4	
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	3	
<i>betamethasone dipropionate external cream 0.05 %</i>	3	
<i>betamethasone dipropionate external lotion 0.05 %</i>	3	
<i>betamethasone dipropionate external ointment 0.05 %</i>	4	
<i>betamethasone valerate external cream 0.1 %</i>	3	
<i>betamethasone valerate external lotion 0.1 %</i>	3	
<i>betamethasone valerate external ointment 0.1 %</i>	2	
<i>calcipotriene external cream 0.005 %</i>	4	QL (120 GM per 30 days)
<i>calcipotriene external ointment 0.005 %</i>	4	QL (120 GM per 30 days)
<i>calcipotriene external solution 0.005 %</i>	3	QL (60 ML per 30 days)
CICLODAN EXTERNAL SOLUTION 8 %	2	PA
<i>ciclopirox external gel 0.77 %</i>	2	
<i>ciclopirox external shampoo 1 %</i>	3	
<i>ciclopirox external solution 8 %</i>	2	PA
<i>ciclopirox olamine external cream 0.77 %</i>	2	
<i>ciclopirox olamine external suspension 0.77 %</i>	3	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	4	
<i>clindamycin phosphate external lotion 1 %</i>	4	QL (75 ML per 30 days)
<i>clindamycin phosphate external solution 1 %</i>	2	QL (60 ML per 30 days)
<i>clobetasol propionate e external cream 0.05 %</i>	4	
<i>clobetasol propionate external cream 0.05 %</i>	2	
<i>clobetasol propionate external gel 0.05 %</i>	3	
<i>clobetasol propionate external ointment 0.05 %</i>	2	
<i>clobetasol propionate external shampoo 0.05 %</i>	4	
<i>clobetasol propionate external solution 0.05 %</i>	3	
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>desonide external cream 0.05 %</i>	3	
<i>desonide external ointment 0.05 %</i>	3	QL (120 GM per 30 days)
<i>desoximetasone external cream 0.25 %</i>	3	QL (100 GM per 30 days)
<i>desoximetasone external ointment 0.25 %</i>	3	
<i>diclofenac sodium external gel 3 %</i>	4	QL (300 GM per 30 days); ST
<i>ery external pad 2 %</i>	3	
<i>erythromycin external gel 2 %</i>	2	
<i>erythromycin external solution 2 %</i>	2	
EUCRISA EXTERNAL OINTMENT 2 %	4	PA
FINACEA EXTERNAL FOAM 15 %	3	QL (50 GM per 30 days)
<i>fluocinolone acetonide body external oil 0.01 %</i>	3	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	3	
<i>fluocinolone acetonide external ointment 0.025 %</i>	3	
<i>fluocinolone acetonide external solution 0.01 %</i>	3	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	3	
<i>fluocinonide external cream 0.05 %</i>	3	
<i>fluocinonide external cream 0.1 %</i>	3	QL (120 GM per 30 days)
<i>fluocinonide external gel 0.05 %</i>	3	
<i>fluocinonide external ointment 0.05 %</i>	3	
<i>fluocinonide external solution 0.05 %</i>	3	
<i>fluorouracil external cream 5 %</i>	2	QL (40 GM per 30 days)
<i>fluorouracil external solution 2 %, 5 %</i>	3	
<i>fluticasone propionate external cream 0.05 %</i>	2	
<i>fluticasone propionate external ointment 0.005 %</i>	2	
<i>halobetasol propionate external cream 0.05 %</i>	3	
<i>halobetasol propionate external ointment 0.05 %</i>	4	
<i>hydrocortisone (perianal) external cream 2.5 %</i>	2	
<i>hydrocortisone external cream 2.5 %</i>	2	
<i>hydrocortisone external lotion 2.5 %</i>	2	
<i>hydrocortisone external ointment 2.5 %</i>	2	
<i>hydrocortisone valerate external cream 0.2 %</i>	3	QL (60 GM per 30 days)
<i>imiquimod external cream 5 %</i>	3	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	4	
KLISYRI EXTERNAL OINTMENT 1 %	5	ST

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>malathion external lotion 0.5 %</i>	4	
<i>metronidazole external cream 0.75 %</i>	3	
<i>metronidazole external gel 0.75 %</i>	3	
<i>metronidazole external gel 1 %</i>	4	
<i>mometasone furoate external cream 0.1 %</i>	2	
<i>mometasone furoate external ointment 0.1 %</i>	2	
<i>mometasone furoate external solution 0.1 %</i>	2	
<i>mupirocin calcium external cream 2 %</i>	3	
<i>mupirocin external ointment 2 %</i>	2	QL (110 GM per 30 days)
MYORISAN ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	4	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	3	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	3	
OTEZLA ORAL TABLET 30 MG	5	PA; QL (60 EA per 30 days)
<i>permethrin external cream 5 %</i>	3	
<i>podofilox external solution 0.5 %</i>	3	
ROSADAN EXTERNAL CREAM 0.75 %	3	
ROSADAN EXTERNAL GEL 0.75 %	3	
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	4	
<i>selenium sulfide external lotion 2.5 %</i>	2	
<i>silver sulfadiazine external cream 1 %</i>	2	
SOTYKTU ORAL TABLET 6 MG	5	PA; QL (30 EA per 30 days)
SSD EXTERNAL CREAM 1 %	2	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	4	
<i>tazarotene external cream 0.1 %</i>	4	
<i>tretinoin external cream 0.025 %</i>	2	PA
<i>tretinoin external cream 0.05 %</i>	4	PA
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	2	
<i>triamcinolone acetonide external lotion 0.025 %</i>	3	
<i>triamcinolone acetonide external lotion 0.1 %</i>	2	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
TRIDERM EXTERNAL CREAM 0.1 %, 0.5 %	2	
ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	4	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	4	
<i>calcium acetate oral tablet 667 mg</i>	3	
<i>carglumic acid oral tablet soluble 200 mg</i>	5	
CHEMET ORAL CAPSULE 100 MG	5	
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	5	PA
<i>deferasirox oral tablet 180 mg</i>	2	PA
<i>deferasirox oral tablet 360 mg</i>	4	PA
<i>deferasirox oral tablet 90 mg</i>	3	PA
<i>deferasirox oral tablet soluble 125 mg</i>	4	PA
<i>deferasirox oral tablet soluble 250 mg, 500 mg</i>	5	PA
<i>dextrose intravenous solution 5 %</i>	2	
<i>dextrose-nacl intravenous solution 5-0.45 %, 5-0.9 %</i>	3	
<i>dextrose-sodium chloride intravenous solution 5-0.45 %, 5-0.9 %</i>	3	
KIONEX ORAL SUSPENSION 15 GM/60ML	3	
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	3	
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	2	
KLOR-CON ORAL PACKET 20 MEQ	4	
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	2	
LOKELMA ORAL PACKET 10 GM, 5 GM	4	QL (90 EA per 30 days)
<i>magnesium sulfate injection solution 50 %, 50 % (10ml syringe)</i>	3	
PLENAMINE INTRAVENOUS SOLUTION 15 %	4	BD

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>potassium chloride crys er oral tablet extended release 10 meq, 20 meq</i>	2	
<i>potassium chloride crys er oral tablet extended release 15 meq</i>	3	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	2	
<i>potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq</i>	2	
<i>potassium chloride oral packet 20 meq</i>	4	
<i>potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	4	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	4	
<i>prenatal oral tablet 27-1 mg</i>	2	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	4	
<i>sevelamer carbonate oral tablet 800 mg</i>	4	
<i>sodium chloride intravenous solution 0.45 %, 0.9 %</i>	3	
<i>sodium polystyrene sulfonate oral powder</i>	3	
SPS ORAL SUSPENSION 15 GM/60ML	3	
<i>trientine hcl oral capsule 250 mg</i>	5	PA
VELPHORO ORAL TABLET CHEWABLE 500 MG	5	
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM	4	
GASTROINTESTINAL AGENTS		
<i>alosetron hcl oral tablet 0.5 mg</i>	4	PA
<i>alosetron hcl oral tablet 1 mg</i>	5	PA
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/160ML, 10-3.5-12 MG-GM -GM/175ML	3	
<i>constulose oral solution 10 gm/15ml</i>	2	
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG	4	QL (30 EA per 30 days)
<i>dexlansoprazole oral capsule delayed release 30 mg, 60 mg</i>	4	QL (30 EA per 30 days)
<i>dicyclomine hcl oral capsule 10 mg</i>	2	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	4	
<i>dicyclomine hcl oral tablet 20 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	3	
<i>enulose oral solution 10 gm/15ml</i>	2	
<i>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg</i>	2	QL (60 EA per 30 days)
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	4	
<i>famotidine oral tablet 20 mg, 40 mg</i>	2	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM	2	
GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM	2	
GAVILYTE-N WITH FLAVOR PACK ORAL SOLUTION RECONSTITUTED 420 GM	2	
<i>generlac oral solution 10 gm/15ml</i>	2	
<i>glycopyrrolate injection solution 0.2 mg/ml, 0.4 mg/2ml</i>	4	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	3	PA
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	2	
<i>lactulose oral solution 10 gm/15ml</i>	2	
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg</i>	2	QL (60 EA per 30 days)
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	3	QL (30 EA per 30 days)
<i>loperamide hcl oral capsule 2 mg</i>	2	
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	4	QL (60 EA per 30 days)
<i>metoclopramide hcl injection solution 5 mg/ml</i>	2	
<i>metoclopramide hcl oral solution 5 mg/5ml</i>	2	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	*
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	3	
MOTEGRITY ORAL TABLET 1 MG, 2 MG	3	QL (30 EA per 30 days)
<i>na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml, 17.5-3.13-1.6 gm/177ml 2 pack (480ml)</i>	3	
<i>nitroglycerin rectal ointment 0.4 %</i>	4	
<i>nizatidine oral capsule 150 mg, 300 mg</i>	4	
<i>nizatidine oral solution 15 mg/ml</i>	4	
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	1	QL (60 EA per 30 days); *

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	1	QL (60 EA per 30 days); *
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	2	
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	2	
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	3	QL (60 EA per 30 days)
RECTIV RECTAL OINTMENT 0.4 %	4	
RELISTOR ORAL TABLET 150 MG	5	QL (90 EA per 30 days); ST
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 12 MG/0.6ML (0.6ML SYRINGE)	5	QL (18 ML per 30 days); ST
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML	5	QL (12 ML per 30 days); ST
<i>sucralfate oral suspension 1 gm/10ml</i>	4	
<i>sucralfate oral tablet 1 gm</i>	2	
SUTAB ORAL TABLET 1479-225-188 MG	3	
<i>ursodiol oral capsule 300 mg</i>	4	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	3	
VOWST ORAL CAPSULE	5	PA
XERMELO ORAL TABLET 250 MG	5	PA; QL (90 EA per 30 days)
XIFAXAN ORAL TABLET 200 MG	4	PA
XIFAXAN ORAL TABLET 550 MG	5	PA
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
<i>betaine oral powder</i>	5	
CERDELGA ORAL CAPSULE 84 MG	5	PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	5	PA
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	3	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	4	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	4	
ENDARI ORAL PACKET 5 GM	5	PA
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML	5	PA; QL (240 ML per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Drug Name	Tier	Restrictions/Limits
JAVYGTOR ORAL PACKET 100 MG, 500 MG	5	PA
JAVYGTOR ORAL TABLET 100 MG	5	PA
<i>miglustat oral capsule 100 mg</i>	5	PA
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	5	
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML	5	PA
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	5	PA
REVCOVI INTRAMUSCULAR SOLUTION 2.4 MG/1.5ML	5	PA
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	5	PA
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	5	PA
<i>sodium phenylbutyrate oral powder 3 gmltsp</i>	5	
<i>sodium phenylbutyrate oral tablet 500 mg</i>	5	
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML	5	PA
SUCRAID ORAL SOLUTION 8500 UNIT/ML	5	PA
TEGSEDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML	5	PA
YARGESA ORAL CAPSULE 100 MG	5	PA
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT	3	
GENITOURINARY AGENTS		
<i>acetic acid irrigation solution 0.25 %</i>	1	
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	2	
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	2	
<i>dutasteride oral capsule 0.5 mg</i>	2	
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	4	
ELMIRON ORAL CAPSULE 100 MG	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>finasteride oral tablet 5 mg</i>	1	*
GEMTESA ORAL TABLET 75 MG	4	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML	3	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	3	
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	2	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	2	
<i>oxybutynin chloride oral tablet 5 mg</i>	2	
<i>penicillamine oral tablet 250 mg</i>	5	
<i>silodosin oral capsule 4 mg, 8 mg</i>	4	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	2	
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	3	PA; QL (30 EA per 30 days)
<i>tamsulosin hcl oral capsule 0.4 mg</i>	1	*
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	3	
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	3	
<i>trospium chloride er oral capsule extended release 24 hour 60 mg</i>	4	
<i>trospium chloride oral tablet 20 mg</i>	3	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
<i>cortisone acetate oral tablet 25 mg</i>	3	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	3	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	2	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	2	
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	2	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	2	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	2	
<i>prednisolone oral solution 15 mg/5ml</i>	2	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>prednisone oral solution 5 mg/5ml</i>	4	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	1	*
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	4	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	3	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	5	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	4	
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG	5	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG	5	PA
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	5	PA
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT 45 MG	5	PA; QL (1 EA per 168 days)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)		
KORLYM ORAL TABLET 300 MG	5	PA; QL (120 EA per 30 days)
<i>mifepristone oral tablet 300 mg</i>	5	PA; QL (120 EA per 30 days)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	3	
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	3	
AMABELZ ORAL TABLET 1-0.5 MG	4	
AMETHIA ORAL TABLET 0.15-0.03 & 0.01 MG	4	QL (91 EA per 91 days)
ASHLYNA ORAL TABLET 0.15-0.03 & 0.01 MG	4	QL (91 EA per 91 days)
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	3	
AVIANE ORAL TABLET 0.1-20 MG-MCG	3	
BALZIVA ORAL TABLET 0.4-35 MG-MCG	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	3	
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	3	
CAMILA ORAL TABLET 0.35 MG	3	
CAMRESE LO ORAL TABLET 0.1-0.02 & 0.01 MG	4	QL (91 EA per 91 days)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY	4	
CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG	3	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	4	
DEBLITANE ORAL TABLET 0.35 MG	3	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML	4	QL (0.65 ML per 90 days)
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	3	
DOLISHALE ORAL TABLET 90-20 MCG	3	
DOTTI TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	4	
ELURYNG VAGINAL RING 0.12-0.015 MG/24HR	4	
EMZAHH ORAL TABLET 0.35 MG	3	
ENILLORING VAGINAL RING 0.12-0.015 MG/24HR	4	
ENPRESSE-28 ORAL TABLET 50-30/75-40/ 125-30 MCG	3	
ERRIN ORAL TABLET 0.35 MG	3	
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	3	
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	
<i>estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm</i>	4	
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	4	
<i>estradiol vaginal cream 0.1 mg/gm</i>	2	
<i>estradiol vaginal tablet 10 mcg</i>	4	
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	4	
ESTRING VAGINAL RING 7.5 MCG/24HR	4	QL (1 EA per 90 days)
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	3	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	4	
FALMINA ORAL TABLET 0.1-20 MG-MCG	3	
FYAVOLV ORAL TABLET 0.5-2.5 MG-MCG, 1-5 MG-MCG	4	
HALOETTE VAGINAL RING 0.12-0.015 MG/24HR	4	
HEATHER ORAL TABLET 0.35 MG	3	
ICLEVIA ORAL TABLET 0.15-0.03 MG	4	QL (91 EA per 91 days)
INCASSIA ORAL TABLET 0.35 MG	3	
INTROVALE ORAL TABLET 0.15-0.03 MG	4	QL (91 EA per 91 days)
JINTELI ORAL TABLET 1-5 MG-MCG	4	
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	3	
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	3	
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	3	
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	3	
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	3	
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	3	
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	3	
KURVELO ORAL TABLET 0.15-30 MG-MCG	3	
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	3	
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	3	
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	3	
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
LESSINA ORAL TABLET 0.1-20 MG-MCG	3	
LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG	3	
<i>levonorgest-eth est & eth est oral tablet 42-21-21-7 days</i>	4	QL (91 EA per 91 days)
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg, 0.15-0.03 mg</i>	4	QL (91 EA per 91 days)
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	3	
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	3	
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	3	
LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG	3	
LUTERA ORAL TABLET 0.1-20 MG-MCG	3	
LYLEQ ORAL TABLET 0.35 MG	3	
LYLLANA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	4	
LYZA ORAL TABLET 0.35 MG	3	
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	3	
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	2	QL (1 ML per 90 days)
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	2	QL (1 ML per 90 days)
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	*
<i>megestrol acetate oral suspension 40 mg/ml</i>	3	PA
<i>megestrol acetate oral suspension 625 mg/5ml</i>	4	PA
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	2	PA
MENEST ORAL TABLET 2.5 MG	4	
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	3	
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	3	
MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	3	
MILI ORAL TABLET 0.25-35 MG-MCG	3	
MIMVEY ORAL TABLET 1-0.5 MG	4	
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	3	
NORA-BE ORAL TABLET 0.35 MG	3	
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg</i>	3	
<i>norethindrone acetate oral tablet 5 mg</i>	2	
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg</i>	3	
<i>norethindrone oral tablet 0.35 mg</i>	3	
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	4	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	3	
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	3	
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	3	
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	3	
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	3	
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	3	
NYLIA 1/35 ORAL TABLET 1-35 MG-MCG	3	
NYLIA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	3	
NYMYO ORAL TABLET 0.25-35 MG-MCG	3	
OSPHENA ORAL TABLET 60 MG	3	PA; QL (30 EA per 30 days)
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	3	
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	3	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	4	
PREMARIN VAGINAL CREAM 0.625 MG/GM	4	
PREMPHASE ORAL TABLET 0.625-5 MG	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	4	
<i>progesterone oral capsule 100 mg, 200 mg</i>	2	
<i>raloxifene hcl oral tablet 60 mg</i>	2	
RIVELSA ORAL TABLET 42-21-21-7 DAYS	4	QL (91 EA per 91 days)
SETLAKIN ORAL TABLET 0.15-0.03 MG	4	QL (91 EA per 91 days)
SHAROBEL ORAL TABLET 0.35 MG	3	
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	3	
SRONYX ORAL TABLET 0.1-20 MG-MCG	3	
TARINA FE 1/20 EQ ORAL TABLET 1-20 MG-MCG	3	
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	2	PA
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	3	PA
<i>testosterone transdermal gel 12.5 mg/lact (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/lact (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)</i>	3	PA
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	3	
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	3	
TRI-NYMYO ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	3	
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	3	
TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MCG	3	
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	3	
TURQOZ ORAL TABLET 0.3-30 MG-MCG	3	
VIENVA ORAL TABLET 0.1-20 MG-MCG	3	
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	3	
VYLIBRA ORAL TABLET 0.25-35 MG-MCG	3	
YUVAFEM VAGINAL TABLET 10 MCG	4	
ZOVIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
EUTHYROX ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	3	
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	*
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	3	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	2	
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
ISTURISA ORAL TABLET 1 MG	5	PA; QL (240 EA per 30 days)
ISTURISA ORAL TABLET 5 MG	5	PA; QL (60 EA per 30 days)
LYSODREN ORAL TABLET 500 MG	5	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
<i>cabergoline oral tablet 0.5 mg</i>	3	
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL	5	PA; QL (4 EA per 365 days)
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG	4	PA; QL (1 EA per 28 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Drug Name	Tier	Restrictions/Limits
<i>lanreotide acetate subcutaneous solution 120 mg/0.5ml</i>	5	PA
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	5	PA
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	5	PA; QL (1 EA per 28 days)
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	5	PA; QL (1 EA per 84 days)
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	5	PA; QL (1 EA per 112 days)
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	5	PA; QL (1 EA per 168 days)
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG	5	PA; QL (1 EA per 28 days)
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG	5	PA; QL (1 EA per 84 days)
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	PA
<i>octreotide acetate injection solution 1000 mcg/ml, 500 mcg/ml</i>	5	PA
ORGOVYX ORAL TABLET 120 MG	5	PA
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 10 MG, 20 MG, 30 MG, 40 MG, 60 MG	5	PA; QL (1 EA per 28 days)
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML	5	PA; QL (60 ML per 30 days)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML	5	PA
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG	4	PA; QL (1 EA per 84 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 22.5 MG	4	PA; QL (1 EA per 168 days)
TRIPTODUR INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 22.5 MG	5	PA; QL (1 EA per 168 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
<i>methimazole oral tablet 10 mg, 5 mg</i>	2	
<i>propylthiouracil oral tablet 50 mg</i>	2	
IMMUNOLOGICAL AGENTS		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML	3	*
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	3	*
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML	5	PA
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5	3	*
ADBRY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	5	PA; QL (6 ML per 28 days)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (4 ML per 28 days)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML	3	*
ASCENIV INTRAVENOUS SOLUTION 5 GM/50ML	5	PA
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG	4	BD
<i>azathioprine oral tablet 50 mg</i>	2	BD
<i>bcg vaccine injection solution reconstituted 50 mg</i>	3	*
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5	PA
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5	PA
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	*
BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML, 5 GM/50ML	5	PA
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5	3	*
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5	3	*

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	5	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (10 ML per 28 days)
COSENTYX INTRAVENOUS SOLUTION 125 MG/5ML	5	PA
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; QL (10 ML per 28 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; QL (10 ML per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML	5	PA; QL (10 ML per 28 days)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	5	PA; QL (10 ML per 28 days)
CUTAQUIG SUBCUTANEOUS SOLUTION 1 GM/6ML, 1.65 GM/10ML, 2 GM/12ML, 3.3 GM/20ML, 4 GM/24ML, 8 GM/48ML	5	PA
CUVITRU SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML, 8 GM/40ML	5	PA
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	4	BD
<i>cyclosporine modified oral solution 100 mg/ml</i>	4	BD
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	4	BD
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML	5	PA; QL (2 EA per 28 days)
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML, 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	3	*
<i>diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lful0.5ml</i>	3	*
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML	5	PA; QL (4.56 ML per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML	5	PA; QL (8 ML per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML	5	PA; QL (1.34 ML per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML	5	PA; QL (4.56 ML per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	5	PA; QL (8 ML per 28 days)
EMPAVELI SUBCUTANEOUS SOLUTION 1080 MG/20ML	5	PA
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML	5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML	5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	5	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5	PA; QL (8 ML per 28 days)
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML	3	BD; *
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML	3	BD; *
ENVARUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG	4	BD
ENVARUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG	5	BD

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Drug Name	Tier	Restrictions/Limits
<i>everolimus oral tablet 0.25 mg</i>	4	BD
<i>everolimus oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	5	BD
GAMASTAN INTRAMUSCULAR INJECTABLE	3	PA
GAMMAKED INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML	5	PA
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	5	PA
GARDASIL 9 INTRAMUSCULAR SUSPENSION	3	*
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	*
GENGRAF ORAL CAPSULE 100 MG, 25 MG	4	BD
GENGRAF ORAL SOLUTION 100 MG/ML	4	BD
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML	3	*
HEPAGAM B INJECTION SOLUTION 312 UNIT/ML	5	BD
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML	3	BD; *
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	3	*
HIZENTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 GM/5ML, 2 GM/10ML, 4 GM/20ML	5	PA
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML	5	PA; QL (4 EA per 28 days)
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.8ML	5	PA; QL (2 EA per 28 days)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	5	PA; QL (4 EA per 28 days)
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML	5	PA; QL (2 EA per 28 days)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	5	PA; QL (4 EA per 28 days)
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; QL (4 EA per 365 days)
HUMIRA-PED>=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML	5	PA; QL (6 EA per 365 days)
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	5	PA; QL (4 EA per 28 days)
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; QL (6 EA per 365 days)
HYPERHEP B INTRAMUSCULAR SOLUTION 220 UNIT/ML	4	BD
HYPERHEP B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 110 UNIT/0.5ML, 220 UNIT/ML	4	BD
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	5	PA
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML	5	PA; QL (2 ML per 28 days)
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML	3	BD; *
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	3	*
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	5	PA
INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
IPOL INJECTION INJECTABLE	3	*
IXCHIQ INTRAMUSCULAR SOLUTION RECONSTITUTED	3	*
IXIARO INTRAMUSCULAR SUSPENSION	3	*
JYLAMVO ORAL SOLUTION 2 MG/ML	4	
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML	3	*
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML	5	PA
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	3	*
<i>leflunomide oral tablet 10 mg, 20 mg</i>	2	
MENACTRA INTRAMUSCULAR SOLUTION	3	*
MENQUADFI INTRAMUSCULAR SOLUTION	3	*
MENVEO INTRAMUSCULAR SOLUTION	3	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	3	*
<i>methotrexate sodium (pf) injection solution 1 gml/40ml, 250 mg/10ml, 50 mg/2ml</i>	2	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	2	
<i>methotrexate sodium oral tablet 2.5 mg</i>	2	
M-M-R II INJECTION SOLUTION RECONSTITUTED	3	*
<i>mycophenolate mofetil oral capsule 250 mg</i>	4	BD
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	5	BD
<i>mycophenolate mofetil oral tablet 500 mg</i>	4	BD
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	4	BD
NABI-HB INTRAMUSCULAR SOLUTION 312 UNIT/ML	4	BD
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML	5	PA; QL (4 ML per 28 days)
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML	5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML	5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML	5	PA; QL (2.8 ML per 28 days)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	5	PA; QL (110 EA per 365 days)
PANZYGA INTRAVENOUS SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	5	PA
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	*
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML	3	*
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML	5	PA
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	*
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	*
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML	3	BD; *
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED	3	*
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	5	PA
PROGRAF ORAL PACKET 0.2 MG, 1 MG	4	BD
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	3	*
QUADRACEL INTRAMUSCULAR SUSPENSION , (58 UNT/ML)	3	*
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	3	*
RABAERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	BD; *

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	3	BD; *
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML	3	BD; *
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5	PA
RENFLXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5	PA
REZUROCK ORAL TABLET 200 MG	5	PA; QL (60 EA per 30 days)
RINVOQ LQ ORAL SOLUTION 1 MG/ML	5	PA; QL (360 ML per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG	5	PA; QL (30 EA per 30 days)
ROTARIX ORAL SUSPENSION	3	*
ROTARIX ORAL SUSPENSION RECONSTITUTED	3	*
ROTATEQ ORAL SOLUTION	3	*
SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML	5	PA
SANDIMMUNE ORAL SOLUTION 100 MG/ML	4	BD
SAPHNELO INTRAVENOUS SOLUTION 300 MG/2ML	5	PA
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	3	*
<i>sirolimus oral solution 1 mg/ml</i>	4	BD
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	4	BD
SKYRIZI (150 MG DOSE) SUBCUTANEOUS PREFILLED SYRINGE KIT 75 MG/0.83ML	5	PA
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML	5	PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; QL (1 ML per 28 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML	5	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML	5	PA; QL (2.4 ML per 56 days)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (1 ML per 28 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
STELARA INTRAVENOUS SOLUTION 130 MG/26ML	5	PA
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; QL (3 ML per 84 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML	5	PA; QL (3 ML per 84 days)
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML	5	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	4	BD
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML	3	*
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)	3	*
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25ML, 2.4 MCG/0.5ML	3	*
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	*
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	3	*
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML	3	*
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML	3	*
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML	3	*
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML	3	*
VEOPOZ INJECTION SOLUTION 400 MG/2ML	5	PA
VYVGART HYTRULO SUBCUTANEOUS SOLUTION 180-2000 MG-UNIT/ML	5	PA
XATMEP ORAL SOLUTION 2.5 MG/ML	4	
XELJANZ ORAL SOLUTION 1 MG/ML	5	PA; QL (300 ML per 30 days)
XELJANZ ORAL TABLET 10 MG, 5 MG	5	PA; QL (60 EA per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG	5	PA; QL (30 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
XEMBIFY SUBCUTANEOUS SOLUTION 1 GM/5ML, 10 GM/50ML, 2 GM/10ML, 4 GM/20ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	5	PA
YF-VAX SUBCUTANEOUS INJECTABLE , (2.5 ML IN 1 VIAL, MULTI-DOSE)	3	*
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	5	PA; QL (6 EA per 28 days)
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; QL (3 EA per 28 days)
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	5	PA; QL (2 EA per 28 days)
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	5	PA; QL (6 EA per 28 days)
YUFLYMA SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; QL (3 EA per 28 days)
YUFLYMA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; QL (3 EA per 28 days)
INFLAMMATORY BOWEL DISEASE AGENTS		
<i>balsalazide disodium oral capsule 750 mg</i>	4	
<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	5	
<i>budesonide oral capsule delayed release particles 3 mg</i>	4	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	4	
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	4	
<i>mesalamine oral tablet delayed release 1.2 gm</i>	4	
<i>mesalamine rectal enema 4 gm</i>	4	
<i>mesalamine rectal suppository 1000 mg</i>	4	
<i>mesalamine-cleanser rectal kit 4 gm</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
PROCTO-MED HC EXTERNAL CREAM 2.5 %	2	
PROCTOSOL HC EXTERNAL CREAM 2.5 %	2	
PROCTOZONE-HC EXTERNAL CREAM 2.5 %	2	
SFROWASA RECTAL ENEMA 4 GM/60ML	4	
<i>sulfasalazine oral tablet 500 mg</i>	2	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	2	
METABOLIC BONE DISEASE AGENTS		
<i>alendronate sodium oral solution 70 mg/75ml</i>	4	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg</i>	1	*
<i>alendronate sodium oral tablet 70 mg</i>	1	QL (4 EA per 28 days); *
<i>calcitonin (salmon) nasal solution 200 unit/lact</i>	3	QL (3.7 ML per 30 days)
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	2	
<i>cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg</i>	4	
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 600 MCG/2.4ML	5	PA
<i>ibandronate sodium oral tablet 150 mg</i>	2	QL (1 EA per 28 days)
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	3	
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	4	QL (2 ML per 365 days)
RAYALDEE ORAL CAPSULE EXTENDED RELEASE 30 MCG	5	
<i>risedronate sodium oral tablet 150 mg</i>	4	QL (1 EA per 28 days)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	4	
<i>risedronate sodium oral tablet 35 mg</i>	4	QL (4 EA per 28 days)
<i>risedronate sodium oral tablet delayed release 35 mg</i>	4	QL (4 EA per 28 days)
<i>teriparatide (recombinant) subcutaneous solution pen-injector 600 mcg/2.4ml, 620 mcg/2.48ml</i>	5	PA
<i>teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml</i>	5	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	5	PA
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML	5	PA
MISCELLANEOUS THERAPEUTIC AGENTS		
ADVOCATE INSULIN PEN NEEDLE 32G X 4 MM	2	QL (200 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM	2	QL (200 EA per 30 days)
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML	2	QL (200 EA per 30 days)
ASSURE ID PRO PEN NEEDLES 30G X 5 MM	2	QL (200 EA per 30 days)
AUGTYRO ORAL CAPSULE 40 MG	5	PA
BD INSULIN SYRINGE 25G X 1" 1 ML, 25G X 5/8" 1 ML, 26G X 1/2" 1 ML, 27.5G X 5/8" 2 ML	2	QL (200 EA per 30 days)
BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML	2	QL (200 EA per 30 days)
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML	2	QL (200 EA per 30 days)
<i>careone unifine pentips 29g x 12mm , 31g x 8 mm</i>	2	QL (200 EA per 30 days)
CARETOUCH INSULIN SYRINGE 28G X 5/16" 1 ML	2	QL (200 EA per 30 days)
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML	2	QL (200 EA per 30 days)
COMFORT EZ PEN NEEDLES 33G X 8 MM	2	QL (200 EA per 30 days)
DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML, 30G X 15/64" 0.5 ML, 30G X 15/64" 1 ML	2	QL (200 EA per 30 days)
DROPLET MICRON 34G X 3.5 MM	2	QL (200 EA per 30 days)
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.5 ML	2	QL (200 EA per 30 days)
<i>easy comfort insulin syringe 31g x 1/2" 0.3 ml</i>	2	QL (200 EA per 30 days)
<i>easy comfort pen needles 31g x 5 mm , 31g x 6 mm , 32g x 4 mm</i>	2	QL (200 EA per 30 days)
EASY TOUCH PEN NEEDLES 30G X 6 MM	2	QL (200 EA per 30 days)
EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM , 29G X 8MM	2	QL (200 EA per 30 days)
ELLA ORAL TABLET 30 MG	3	
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM , 31G X 4 MM	2	QL (200 EA per 30 days)
<i>global alcohol prep ease pad 70 %</i>	3	
IGALMI SUBLINGUAL FILM 120 MCG, 180 MCG	4	PA
<i>insulin syringeneedle 27g x 1/2" 0.5 ml</i>	2	QL (200 EA per 30 days)
INSUPEN SENSITIVE 32G X 8 MM	2	QL (200 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>kmart valu insulin syringe 29g u-100 0.5 ml</i>	2	QL (200 EA per 30 days)
<i>kmart valu insulin syringe 30g u-100 0.3 ml</i>	2	QL (200 EA per 30 days)
<i>croger pen needles 33g x 4 mm</i>	2	QL (200 EA per 30 days)
LAGEVRIO ORAL CAPSULE 200 MG	3	QL (40 EA per 5 days)
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, U-100 1 ML	2	QL (200 EA per 30 days)
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8 MM	2	QL (200 EA per 30 days)
NOVOFINE PEN NEEDLE 32G X 6 MM	2	QL (200 EA per 30 days)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM	2	QL (200 EA per 30 days)
NOVOTWIST PEN NEEDLE 32G X 5 MM	2	QL (200 EA per 30 days)
NUTRILIPID INTRAVENOUS EMULSION 20 %	2	BD
OMNIPOD 5 G6 INTRO (GEN 5) KIT	3	QL (1 EA per 365 days)
OMNIPOD 5 G6 PODS (GEN 5)	3	QL (30 EA per 30 days)
OMNIPOD 5 G7 INTRO (GEN 5) KIT	3	QL (1 EA per 365 days)
OMNIPOD 5 G7 PODS (GEN 5)	3	QL (30 EA per 30 days)
OMNIPOD CLASSIC PDM (GEN 3) KIT	3	QL (1 EA per 365 days)
OMNIPOD CLASSIC PODS (GEN 3)	3	QL (30 EA per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT	3	QL (1 EA per 365 days)
OMNIPOD DASH PDM (GEN 4) KIT	3	QL (1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	3	QL (30 EA per 30 days)
OXLUMO SUBCUTANEOUS SOLUTION 94.5 MG/0.5ML	5	PA
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	3	QL (20 EA per 5 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	3	QL (30 EA per 5 days)
<i>pc unifine pentips 31g x 5 mm , 31g x 6 mm</i>	2	QL (200 EA per 30 days)
<i>pen needles 31g x 8 mm , 32g x 4 mm</i>	2	QL (200 EA per 30 days)
<i>preferred plus insulin syringe 28g x 1/2" 0.5 ml</i>	2	QL (200 EA per 30 days)
SKYCLARYS ORAL CAPSULE 50 MG	5	PA; QL (90 EA per 30 days)
<i>sodium chloride irrigation solution 0.9 %</i>	2	
TECHLITE PEN NEEDLES 29G X 10MM	2	QL (200 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>true comfort pro insulin syr 32g x 5/16" 0.5 ml, 32g x 5/16" 1 ml</i>	2	QL (200 EA per 30 days)
<i>true comfort pro pen needles 33g x 5 mm , 33g x 6 mm</i>	2	QL (200 EA per 30 days)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT	4	QL (8.4 ML per 30 days)
ULTICARE INSULIN SAFETY SYR 29G X 1/2" 0.5 ML	2	QL (200 EA per 30 days)
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.3 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 1/4" 0.3 ML, 31G X 1/4" 0.5 ML, 31G X 1/4" 1 ML	2	QL (200 EA per 30 days)
ULTICARE MINI PEN NEEDLES 30G X 5 MM	2	QL (200 EA per 30 days)
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM , 32G X 4 MM	2	QL (200 EA per 30 days)
VANISHPOINT INSULIN SYRINGE 29G X 5/16" 1 ML, 30G X 3/16" 0.5 ML, 30G X 3/16" 1 ML	2	QL (200 EA per 30 days)
V-GO 20 KIT 20 UNIT/24HR	3	
V-GO 30 KIT 30 UNIT/24HR	3	
V-GO 40 KIT 40 UNIT/24HR	3	
VYJUVEK EXTERNAL GEL 5000000000 PFU/2.5ML	5	PA
OPHTHALMIC AGENTS		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	3	
ALPHAGAN P OPTHALMIC SOLUTION 0.1 %	3	
<i>atropine sulfate ophthalmic solution 1 %</i>	2	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	2	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	4	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	2	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	3	
BESIVANCE OPTHALMIC SUSPENSION 0.6 %	4	
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	3	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>brimonidine tartrate ophthalmic solution 0.1 %</i>	3	
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	2	
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	3	
<i>brinzolamide ophthalmic suspension 1 %</i>	4	
<i>bromfenac sodium ophthalmic solution 0.07 %</i>	4	QL (12 ML per 365 days)
<i>carteolol hcl ophthalmic solution 1 %</i>	2	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	2	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 %	3	
<i>cromolyn sodium ophthalmic solution 4 %</i>	2	
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	3	
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	5	QL (60 ML per 28 days)
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	3	
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	2	
<i>dorzolamide hcl ophthalmic solution 2 %</i>	2	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	2	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	2	
FLAREX OPHTHALMIC SUSPENSION 0.1 %	3	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	3	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	2	
<i>gatifloxacin ophthalmic solution 0.5 %</i>	4	
GENTAK OPHTHALMIC OINTMENT 0.3 %	2	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	2	
ILEVRO OPHTHALMIC SUSPENSION 0.3 %	3	QL (4 ML per 30 days)
<i>ketorolac tromethamine ophthalmic solution 0.4 %</i>	3	
<i>ketorolac tromethamine ophthalmic solution 0.5 %</i>	2	
<i>latanoprost ophthalmic solution 0.005 %</i>	1	*
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	2	
<i>levofloxacin ophthalmic solution 0.5 %</i>	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 %	4	QL (20 GM per 365 days)
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	QL (2.5 ML per 25 days)
<i>methazolamide oral tablet 25 mg, 50 mg</i>	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	3	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000</i>	3	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	2	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	2	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	3	
NEO-POLYCIN HC OPHTHALMIC OINTMENT 1 %	3	
NEO-POLYCIN OPHTHALMIC OINTMENT 3.5-400-10000	3	
<i>ofloxacin ophthalmic solution 0.3 %</i>	2	
<i>olopatadine hcl ophthalmic solution 0.2 %</i>	3	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	3	
POLYCIN OPHTHALMIC OINTMENT 500-10000 UNIT/GM	2	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1	*
<i>prednisolone acetate ophthalmic suspension 1 %</i>	2	
PROLENSA OPHTHALMIC SOLUTION 0.07 %	4	QL (12 ML per 365 days)
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 %	3	
RESTASIS OPHTHALMIC EMULSION 0.05 %	3	
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	3	QL (2.5 ML per 25 days)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 %	3	QL (2.5 ML per 25 days)
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	3	
<i>sulfacetamide sodium ophthalmic ointment 10 %</i>	3	
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	2	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	2	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	*
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %	4	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 %	4	
<i>tobramycin ophthalmic solution 0.3 %</i>	1	*
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	4	
<i>trifluridine ophthalmic solution 1 %</i>	4	
VYZULTA OPHTHALMIC SOLUTION 0.024 %	4	QL (5 ML per 25 days)
XIIDRA OPHTHALMIC SOLUTION 5 %	4	QL (60 EA per 30 days)
ZIRGAN OPHTHALMIC GEL 0.15 %	4	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 %	4	
OTIC AGENTS		
<i>acetic acid otic solution 2 %</i>	2	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	4	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	4	
<i>neomycin-polymyxin-hc otic solution 1 %</i>	3	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	3	
<i>ofloxacin otic solution 0.3 %</i>	3	
RESPIRATORY TRACT/PULMONARY AGENTS		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5	PA; QL (90 EA per 30 days)
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	QL (24 GM per 30 days)
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcglact</i>	2	QL (17 GM per 30 days)
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcglact (nda020503)</i>	2	QL (13.4 GM per 30 days)
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcglact (nda020983)</i>	2	QL (48 GM per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%</i>	2	BD; QL (525 ML per 30 days)
<i>albuterol sulfate inhalation nebulization solution 0.63 mg/3ml, 1.25 mg/3ml</i>	4	BD; QL (375 ML per 30 days)
<i>albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml</i>	2	BD; QL (100 EA per 30 days)
ALYQ ORAL TABLET 20 MG	4	PA; QL (60 EA per 30 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Drug Name	Tier	Restrictions/Limits
<i>ambisentan oral tablet 10 mg, 5 mg</i>	5	PA; QL (30 EA per 30 days)
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	4	PA; QL (120 ML per 30 days)
ARNUIITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	QL (30 EA per 30 days)
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT	4	QL (1 EA per 30 days)
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT	4	QL (1 EA per 30 days)
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT	4	QL (1 EA per 30 days)
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT	4	QL (1 EA per 30 days)
ASMANEX (7 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT	4	QL (1 EA per 30 days)
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	4	QL (13 GM per 30 days)
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	4	QL (25.8 GM per 30 days)
<i>azelastine hcl nasal solution 0.1 %, 0.15 %</i>	2	QL (60 ML per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH	3	QL (60 EA per 30 days)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT	3	QL (23.6 GM per 28 days)
BRONCHITOL INHALATION CAPSULE 40 MG	5	PA; QL (560 EA per 28 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml</i>	4	BD; QL (120 ML per 30 days)
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	5	PA

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	3	QL (8 GM per 30 days)
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	5	BD
<i>cyproheptadine hcl oral tablet 4 mg</i>	4	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	4	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT	4	PA; QL (17.6 GM per 30 days)
DULERA INHALATION AEROSOL 50-5 MCG/ACT	4	PA; QL (13 GM per 30 days)
<i>epinephrine injection solution 0.3 mg/0.3ml</i>	3	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	3	
<i>epoprostenol sodium intravenous solution reconstituted 0.5 mg</i>	4	PA
<i>epoprostenol sodium intravenous solution reconstituted 1.5 mg</i>	5	PA
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML	5	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML	4	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML	5	PA
<i>flunisolide nasal solution 25 mcg/lact (0.025%)</i>	4	QL (50 ML per 30 days)
<i>fluticasone propionate nasal suspension 50 mcg/lact</i>	1	*
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/lact, 250-50 mcg/lact, 500-50 mcg/lact</i>	2	QL (60 EA per 30 days)
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	4	BD; QL (120 ML per 30 days)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	4	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	3	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT	3	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	2	BD; QL (312.5 ML per 30 days)
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	2	BD; QL (540 ML per 30 days)
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG	5	PA
KALYDECO ORAL TABLET 150 MG	5	PA
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml</i>	4	BD; QL (540 ML per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml</i>	4	BD; QL (90 EA per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/3ml</i>	4	BD; QL (270 ML per 30 days)
<i>levalbuterol tartrate inhalation aerosol 45 mcglact</i>	3	QL (30 GM per 30 days)
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	2	
LONHALA MAGNAIR REFILL KIT INHALATION SOLUTION 25 MCG/ML	5	QL (60 ML per 30 days)
<i>mometasone furoate nasal suspension 50 mcglact</i>	4	QL (34 GM per 30 days)
<i>montelukast sodium oral packet 4 mg</i>	2	
<i>montelukast sodium oral tablet 10 mg</i>	1	*
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	2	
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	5	PA; QL (0.4 ML per 28 days)
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG	5	PA; QL (3 EA per 28 days)
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA
OPSUMIT ORAL TABLET 10 MG	5	PA; QL (30 EA per 30 days)
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG	5	PA; QL (336 EA per 365 days)
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG	5	PA; QL (672 EA per 365 days)
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25	5	PA; QL (504 EA per 365 days)

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG, 5 MG	5	PA
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; QL (112 EA per 28 days)
<i>pirfenidone oral capsule 267 mg</i>	5	PA
<i>pirfenidone oral tablet 267 mg, 534 mg, 801 mg</i>	5	PA
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT	3	QL (2 EA per 30 days)
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5	PA
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT	3	QL (21.2 GM per 30 days)
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	4	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	3	QL (60 EA per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	3	PA; QL (90 EA per 30 days)
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG	3	QL (30 EA per 30 days)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT	3	QL (8 GM per 30 days)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT	3	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	3	QL (24 GM per 30 days)
<i>tadalafil (pah) oral tablet 20 mg</i>	4	PA; QL (60 EA per 30 days)
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	4	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	2	
<i>tiotropium bromide monohydrate inhalation capsule 18 mcg</i>	3	QL (30 EA per 30 days)
TOBI PODHALER INHALATION CAPSULE 28 MG	5	QL (224 EA per 56 days)
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	5	BD

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	5	PA; QL (84 EA per 28 days)
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML	5	PA; QL (270 ML per 30 days)
WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT	2	QL (60 EA per 30 days)
YUPELRI INHALATION SOLUTION 175 MCG/3ML	5	BD; QL (90 ML per 30 days)
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	4	
SKELETAL MUSCLE RELAXANTS		
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	3	
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	4	
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	4	
SLEEP DISORDER AGENTS		
<i>armodafinil oral tablet 150 mg, 200 mg</i>	3	PA; QL (30 EA per 30 days)
<i>armodafinil oral tablet 250 mg</i>	4	PA; QL (30 EA per 30 days)
<i>armodafinil oral tablet 50 mg</i>	3	PA; QL (60 EA per 30 days)
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	3	QL (30 EA per 30 days)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	4	QL (30 EA per 30 days)
<i>modafinil oral tablet 100 mg, 200 mg</i>	3	PA; QL (30 EA per 30 days)
<i>ramelteon oral tablet 8 mg</i>	4	QL (30 EA per 30 days)
<i>sodium oxybate oral solution 500 mg/ml</i>	5	PA; QL (540 ML per 30 days)
<i>temazepam oral capsule 15 mg, 30 mg</i>	3	QL (30 EA per 30 days)
<i>zaleplon oral capsule 10 mg</i>	4	QL (60 EA per 30 days)
<i>zaleplon oral capsule 5 mg</i>	4	QL (30 EA per 30 days)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	4	QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	2	QL (30 EA per 30 days)
SUPPLEMENTAL		
<i>folic acid oral tablet 1 mg</i>	1	QL (30 EA per 30 days); EX

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Drug Name	Tier	Restrictions/Limits
<i>sildenafil citrate oral tablet 25 mg, 50 mg</i>	1	QL (4 EA per 30 days); EX
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)</i>	1	QL (4 EA per 28 days); EX
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES		
<i>kosher prenatal plus iron oral tablet 30-1 mg</i>	2	
<i>pnv prenatal plus multivit+dha oral 27-1 & 312 mg</i>	2	
<i>pnv tabs 29-1 oral tablet 29-1 mg</i>	2	
<i>pnv-dha oral capsule 27-0.6-0.4-300 mg</i>	2	
<i>pnv-dha+docusate oral capsule 27-1.25-300 mg</i>	2	
<i>pnv-omega oral capsule 28-0.6-0.4-340 mg</i>	2	
<i>pnv-select oral tablet 27-0.6-0.4 mg</i>	2	
<i>prenatal 19 oral tablet 29-1 mg</i>	2	
<i>prenatal 19 oral tablet chewable 29-1 mg</i>	2	
<i>virt-c dha oral capsule 53.5-38-1 mg</i>	2	
<i>virt-pn plus oral capsule 28-0.6-0.4-340 mg</i>	2	
<i>vp-pnv-dha oral capsule 28-1-215.8 mg</i>	2	

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. You can find information on what the symbols and abbreviations on this table mean by going to page vii of the introduction.

Formulary ID 00024469 Formulary Version 15

Formulary Effective Date: 08/01/2024 Last Updated Date: 07/24/2024

Index of Drugs

<i>abacavir sulfate</i>	32	<i>amlodipine besylate</i>	44	<i>atenolol-chlorthalidone</i>	44
<i>abacavir sulfate-lamivudine</i>	32	<i>amlodipine besylate-valsartan</i>	44	<i>atomoxetine hcl</i>	50
ABELCET.....	16	<i>amlodipine-olmesartan</i>	44	<i>atorvastatin calcium</i>	44
ABILIFY MAINTENA.....	28	<i>ammonium lactate</i>	53	<i>atovaquone</i>	26
<i>abiraterone acetate</i>	19	AMNESTEEM.....	54	<i>atovaquone-proguanil hcl</i>	27
ABRYSVO.....	71	<i>amoxapine</i>	13	<i>atropine sulfate</i>	84
<i>acamprosate calcium</i>	3	<i>amoxicillin</i>	4	ATROVENT HFA.....	88
<i>acarbose</i>	36	<i>amoxicillin-pot clavulanate</i>	4	AUBRA EQ.....	63
ACCUTANE.....	53	<i>amoxicillin-pot clavulanate er</i>	4	AUGMENTIN.....	4
<i>acebutolol hcl</i>	44	<i>amphetamine-dextroamphet er</i>	50	AUGTYRO.....	82
<i>acetaminophen-codeine</i>	1	<i>amphetamine-dextroamphetamine</i>	50	AUSTEDO.....	51
<i>acetazolamide</i>	44	<i>amphotericin b</i>	16	AUVELITY.....	13
<i>acetazolamide er</i>	84	<i>amphotericin b liposome</i>	16	AVIANE.....	63
<i>acetic acid</i>	61, 87	<i>ampicillin</i>	4	AVONEX PEN.....	51
<i>acitretin</i>	53	<i>ampicillin sodium</i>	4	AVONEX PREFILLED.....	51
ACTHIB.....	71	<i>ampicillin-sulbactam sodium</i>	4	AYVAKIT.....	19
ACTIMMUNE.....	71	<i>anagrelide hcl</i>	42	<i>azathioprine</i>	71
<i>acyclovir</i>	32, 53	<i>anastrozole</i>	19	<i>azelaic acid</i>	54
<i>acyclovir sodium</i>	32	ANORO ELLIPTA.....	88	<i>azelastine hcl</i>	84, 88
ADACEL.....	71	<i>aprepitant</i>	15, 16	<i>azithromycin</i>	4, 5
ADBRY.....	71	APRETUDE.....	32	<i>aztreonam</i>	5
<i>adefovir dipivoxil</i>	32	APTIOM.....	9	<i>bacitracin</i>	84
ADEMPAS.....	87	APTIVUS.....	32	<i>bacitracin-polymyxin b</i>	84
ADVAIR HFA.....	87	AREXVY.....	71	<i>bacitra-neomycin-polymyxin-hc</i>	84
ADVOCATE INSULIN PEN NEEDLE.....	81	<i>arformoterol tartrate</i>	88	<i>baclofen</i>	31
AIMOVIG.....	18	<i>aripiprazole</i>	28	BAFIERTAM.....	51
AKEEGA.....	19	ARISTADA.....	28	<i>balsalazide disodium</i>	80
<i>albendazole</i>	26	ARISTADA INITIO.....	28	BALVERSA.....	19
<i>albuterol sulfate</i>	87	<i>armodafinil</i>	92	BALZIVA.....	63
<i>albuterol sulfate hfa</i>	87	ARNUIITY ELLIPTA.....	88	BAQSIMI ONE PACK.....	36
<i>alclometasone dipropionate</i>	53	ASCENIV.....	71	BAQSIMI TWO PACK.....	36
ALECENSA.....	19	<i>asenapine maleate</i>	28	BARACLUDGE.....	32
<i>alendronate sodium</i>	81	ASHLYNA.....	63	<i>bcg vaccine</i>	71
<i>alfuzosin hcl er</i>	61	ASMANEX (120 METERED DOSES).....	88	BD INSULIN SYRINGE.....	82
<i>aliskiren fumarate</i>	44	ASMANEX (14 METERED DOSES).....	88	BD INSULIN SYRINGE MICROFINE.....	82
<i>allopurinol</i>	17	ASMANEX (30 METERED DOSES).....	88	BD INSULIN SYRINGE U-500.....	82
<i>alosetron hcl</i>	58	ASMANEX (60 METERED DOSES).....	88	BELSOMRA.....	92
ALPHAGAN P.....	84	ASMANEX (7 METERED DOSES).....	88	<i>benazepril hcl</i>	44
<i>alprazolam</i>	36	ASMANEX HFA.....	88	<i>benazepril-hydrochlorothiazide</i>	44
ALTAVERA.....	63	<i>aspirin-dipyridamole er</i>	42	BENLYSTA.....	71
ALUNBRIG.....	19	ASSURE ID DUO PRO PEN NEEDLES.....	82	<i>benzoyl peroxide-erythromycin</i>	54
<i>alyacen 1/35</i>	63	ASSURE ID INSULIN SAFETY SYR.....	82	<i>benztropine mesylate</i>	27
ALYQ.....	87	ASSURE ID PRO PEN NEEDLES.....	82	BESIVANCE.....	84
AMABELZ.....	63	ASTAGRAF XL.....	71	BESREMI.....	19
<i>amantadine hcl</i>	32	<i>atazanavir sulfate</i>	32	<i>betaine</i>	60
<i>ambrisentan</i>	88	<i>atenolol</i>	44	<i>betamethasone dipropionate</i>	54
AMETHIA.....	63			<i>betamethasone dipropionate aug</i>	54
<i>amikacin sulfate</i>	4			<i>betamethasone valerate</i>	54
<i>amiloride hcl</i>	44			BETASERON.....	51
<i>amiloride-hydrochlorothiazide</i>	44			<i>betaxolol hcl</i>	44, 84
<i>amiodarone hcl</i>	44			<i>bethanechol chloride</i>	61
<i>amitriptyline hcl</i>	13			<i>bexarotene</i>	19
<i>amlodipine besy-benazepril hcl</i>	44			BEXSERO.....	71

<i>bicalutamide</i>	19	<i>carbamazepine</i>	9	<i>cisplatin</i>	20
BICILLIN L-A.....	5	<i>carbamazepine er</i>	9	<i>citalopram hydrobromide</i>	14
BIKTARVY.....	32	<i>carbidopa</i>	27	CLARAVIS.....	54
<i>bisoprolol fumarate</i>	44	<i>carbidopa-levodopa</i>	27	<i>clarithromycin</i>	6
<i>bisoprolol-hydrochlorothiazide</i>	44	<i>carbidopa-levodopa er</i>	27	<i>clarithromycin er</i>	6
BIVIGAM.....	71	<i>careone unifine pentips</i>	82	CLENPIQ.....	58
BLISOVI FE 1.5/30.....	64	CARETOUCH ALCOHOL		CLIMARA PRO.....	64
BOOSTRIX.....	71	PREP.....	5	CLINDACIN ETZ.....	6
BOSULIF.....	19, 20	CARETOUCH INSULIN		<i>clindamycin hcl</i>	6
BRAFTOVI.....	20	SYRINGE.....	82	<i>clindamycin palmitate hcl</i>	6
BREO ELLIPTA.....	88	<i>carglumic acid</i>	57	<i>clindamycin phosphate</i>	6, 54
BREZTRI AEROSPHERE.....	88	<i>carteolol hcl</i>	85	<i>clobazam</i>	9
<i>briellyn</i>	64	CARTIA XT.....	45	<i>clobetasol propionate</i>	54
BRILINTA.....	42	<i>carvedilol</i>	45	<i>clobetasol propionate e</i>	54
<i>brimonidine tartrate</i>	85	<i>casprofungin acetate</i>	16	<i>clomipramine hcl</i>	14
<i>brimonidine tartrate-timolol</i>	85	CAYSTON.....	88	<i>clonazepam</i>	9, 10
<i>brinzolamide</i>	85	<i>cefaclor</i>	5	<i>clonidine</i>	45
BRIVIACT.....	9	<i>cefadroxil</i>	5	<i>clonidine hcl</i>	45
<i>bromfenac sodium</i>	85	<i>cefazolin sodium</i>	5	<i>clopidogrel bisulfate</i>	42
<i>bromocriptine mesylate</i>	27	<i>cefdinir</i>	5	<i>clorazepate dipotassium</i>	36
BRONCHITOL.....	88	<i>cefepime hcl</i>	5	<i>clotrimazole</i>	16
BRUKINSA.....	20	<i>cefixime</i>	5	<i>clotrimazole-betamethasone</i>	54
<i>budesonide</i>	80, 88	<i>cefotetan disodium</i>	5	<i>clozapine</i>	29
<i>budesonide er</i>	80	<i>cefoxitin sodium</i>	5	COARTEM.....	27
<i>bumetanide</i>	44	<i>cefpodoxime proxetil</i>	5	<i>colchicine</i>	17
<i>buprenorphine</i>	1	<i>cefprozil</i>	5	<i>colchicine-probenecid</i>	18
<i>buprenorphine hcl</i>	3	<i>ceftazidime</i>	6	<i>colesevelam hcl</i>	45
<i>buprenorphine hcl-naloxone hcl</i>	3	<i>ceftazidime and dextrose</i>	5	<i>colestipol hcl</i>	45
<i>bupropion hcl</i>	14	<i>ceftriaxone sodium</i>	6	<i>colistimethate sodium (cba)</i>	6
<i>bupropion hcl er (smoking det)</i>	3	<i>cefuroxime axetil</i>	6	COLUMVI.....	20
<i>bupropion hcl er (sr)</i>	13	<i>cefuroxime sodium</i>	6	COMBIGAN.....	85
<i>bupropion hcl er (xl)</i>	13, 14	<i>celecoxib</i>	1	COMBIVENT RESPIMAT.....	89
<i>bupirone hcl</i>	36	<i>cephalexin</i>	6	COMETRIQ (100 MG DAILY	
<i>butalbital-apap-caffeine</i>	51	CERDELGA.....	60	DOSE).....	20
BYDUREON BCISE.....	37	CHEMET.....	57	COMETRIQ (140 MG DAILY	
BYETTA 10 MCG PEN.....	37	<i>chlorhexidine gluconate</i>	53	DOSE).....	20
BYETTA 5 MCG PEN.....	37	<i>chloroquine phosphate</i>	27	COMETRIQ (60 MG DAILY	
CABENUVA.....	32	<i>chlorpromazine hcl</i>	28, 29	DOSE).....	20
<i>cabergoline</i>	69	<i>chlorthalidone</i>	45	COMFORT ASSIST INSULIN	
CABLIVI.....	42	CHOLBAM.....	60	SYRINGE.....	82
CABOMETYX.....	20	<i>cholestyramine</i>	45	COMFORT EZ PEN	
<i>calcipotriene</i>	54	<i>cholestyramine light</i>	45	NEEDLES.....	82
<i>calcitonin (salmon)</i>	81	CICLODAN.....	54	COMPLERA.....	32
<i>calcitriol</i>	81	<i>ciclopirox</i>	54	COMPRO.....	16
<i>calcium acetate</i>	57	<i>ciclopirox olamine</i>	54	<i>constulose</i>	58
<i>calcium acetate (phos binder)</i>	57	<i>cidofovir</i>	32	COPIKTRA.....	20
CALQUENCE.....	20	<i>cilostazol</i>	42	CORLANOR.....	45
CAMILA.....	64	CIMDUO.....	32	<i>cortisone acetate</i>	62
CAMRESE LO.....	64	<i>cinacalcet hcl</i>	81	COSENTYX.....	72
<i>candesartan cilexetil</i>	44	CINRYZE.....	72	COSENTYX (300 MG DOSE)....	72
<i>candesartan cilexetil-hctz</i>	44	CIPRO.....	6	COSENTYX SENSOREADY	
CAPLYTA.....	28	<i>ciprofloxacin</i>	6	(300 MG).....	72
CAPRELSA.....	20	<i>ciprofloxacin hcl</i>	6, 85	COSENTYX SENSOREADY	
<i>captopril</i>	44	<i>ciprofloxacin in d5w</i>	6	PEN.....	72
<i>captopril-hydrochlorothiazide</i>	45	<i>ciprofloxacin-dexamethasone</i>	87	COSENTYX UNOREADY.....	72

COTELLIC.....	20	DIACOMIT.....	10	<i>easy comfort insulin syringe</i>	82
CREON.....	60	<i>diazepam</i>	10, 36	<i>easy comfort pen needles</i>	82
<i>cromolyn sodium</i>	60, 85, 89	DIAZEPAM INTENSOL.....	36	EASY TOUCH PEN NEEDLES	82
CRYSSELLE-28.....	64	<i>diazoxide</i>	37	EASY TOUCH SAFETY PEN	
CUTAQUIG.....	72	<i>diclofenac potassium</i>	1	NEEDLES.....	82
CUVITRU.....	72	<i>diclofenac sodium</i>	1, 55, 85	<i>econazole nitrate</i>	16
<i>cyclobenzaprine hcl</i>	92	<i>diclofenac sodium er</i>	1	EDARBI.....	46
<i>cyclophosphamide</i>	20	<i>dicloxacillin sodium</i>	7	EDARBYCLOR.....	46
<i>cycloserine</i>	19	<i>dicyclomine hcl</i>	58	EDURANT.....	32
<i>cyclosporine</i>	72, 85	DIFICID.....	7	<i>efavirenz</i>	32
<i>cyclosporine modified</i>	72	<i>diflunisal</i>	1	<i>efavirenz-emtricitab-tenofo df</i>	33
CYLTEZO (2 PEN).....	72	DIGITEK.....	45	<i>efavirenz-lamivudine-tenofovir</i>	33
CYLTEZO (2 SYRINGE).....	72	<i>digoxin</i>	45	ELIQUIS.....	42
CYLTEZO-CD/UC/HS		<i>dihydroergotamine mesylate</i>	18	ELIQUIS DVT/PE STARTER	
STARTER.....	72	DILANTIN.....	10	PACK.....	42
CYLTEZO-PSORIASIS/UV		<i>diltiazem hcl</i>	45	ELLA.....	82
STARTER.....	73	<i>diltiazem hcl er</i>	45	ELMIRON.....	61
<i>cyproheptadine hcl</i>	89	<i>diltiazem hcl er beads</i>	45	ELURYNG.....	64
CYSTAGON.....	60	<i>diltiazem hcl er coated beads</i>	45	EMGALITY.....	18
CYSTARAN.....	85	<i>dilt-xr</i>	46	EMGALITY (300 MG DOSE)....	18
<i>dalfampridine er</i>	51	<i>dimethyl fumarate</i>	51	EMPAVELI.....	73
<i>danazol</i>	64	<i>dimethyl fumarate starter pack</i>	51	EMSAM.....	14
<i>dantrolene sodium</i>	31	<i>diphenhydramine hcl</i>	89	<i>emtricitabine</i>	33
<i>dapsone</i>	19	<i>diphenoxylate-atropine</i>	59	<i>emtricitabine-tenofovir df</i>	33
DAPTACEL.....	73	<i>diphtheria-tetanus toxoids dt</i>	73	EMTRIVA.....	33
<i>daptomycin</i>	7	<i>disulfiram</i>	3	EMZAHH.....	64
<i>daptomycin-sodium chloride</i>	7	<i>divalproex sodium</i>	10	<i>enalapril maleate</i>	46
<i>darunavir</i>	32	<i>divalproex sodium er</i>	10	<i>enalapril-hydrochlorothiazide</i>	46
DARZALEX FASPRO.....	20	<i>dofetilide</i>	46	ENBREL.....	73
DAURISMO.....	20	DOLISHALE.....	64	ENBREL MINI.....	73
DEBLITANE.....	64	<i>donepezil hcl</i>	13	ENBREL SURECLICK.....	73
<i>deferasirox</i>	57	DOPTelet.....	42	ENDARI.....	60
<i>deferasirox granules</i>	57	<i>dorzolamide hcl</i>	85	ENDOCET.....	1
DELSTRIGO.....	32	<i>dorzolamide hcl-timolol mal</i>	85	ENGERIX-B.....	73
<i>demeclocycline hcl</i>	7	DOTTI.....	64	ENILLORING.....	64
DEPO-SUBQ PROVERA 104....	64	DOVATO.....	32	<i>enoxaparin sodium</i>	42
DESCOVY.....	32	<i>doxazosin mesylate</i>	61	ENPRESSE-28.....	64
<i>desipramine hcl</i>	14	<i>doxepin hcl</i>	14	<i>entacapone</i>	27
<i>desmopressin ace spray refrig</i>	63	DOXY 100.....	7	<i>entecavir</i>	33
<i>desmopressin acetate</i>	63	<i>doxycycline hyclate</i>	7, 53	ENTRESTO.....	46
<i>desmopressin acetate pf</i>	63	<i>doxycycline monohydrate</i>	7	<i>enulose</i>	59
<i>desmopressin acetate spray</i>	63	DRIZALMA SPRINKLE.....	14	ENVARUSUS XR.....	73
<i>desogestrel-ethinyl estradiol</i>	64	<i>dronabinol</i>	16	EPIDIOLEX.....	10
<i>desonide</i>	55	DROPLET INSULIN		<i>epinephrine</i>	89
<i>desoximetasone</i>	55	SYRINGE.....	82	<i>epinephrine (anaphylaxis)</i>	46
<i>desvenlafaxine succinate er</i>	14	DROPLET MICRON.....	82	EPITOL.....	10
<i>dexamethasone</i>	62	DROPSAFE SAFETY		EPKINLY.....	20
<i>dexamethasone sodium phosphate</i>	85	SYRINGE/NEEDLE.....	82	<i>eplerenone</i>	46
DEXILANT.....	58	DROXIA.....	20	<i>epoprostenol sodium</i>	89
<i>dexlansoprazole</i>	58	<i>droxidopa</i>	46	EPRONTIA.....	10
<i>dextroamphetamine sulfate</i>	51	DULERA.....	89	<i>ergoloid mesylates</i>	13
<i>dextroamphetamine sulfate er</i>	51	<i>duloxetine hcl</i>	14	<i>ergotamine-caffeine</i>	18
<i>dextrose</i>	57	DUPIXENT.....	73	ERIVEDGE.....	20
<i>dextrose-nacl</i>	57	<i>dutasteride</i>	61	ERLEADA.....	20
<i>dextrose-sodium chloride</i>	57	<i>dutasteride-tamsulosin hcl</i>	61	<i>erlotinib hcl</i>	20

ERRIN.....	64	<i>fluconazole in sodium chloride</i>	16	GENOTROPIN MINIQUICK...	63
<i>ertapenem sodium</i>	7	<i>flucytosine</i>	17	GENTAK.....	85
<i>ery</i>	55	<i>fludrocortisone acetate</i>	62	<i>gentamicin sulfate</i>	7, 85
<i>erythromycin</i>	7, 55, 85	<i>flunisolide</i>	89	GENVOYA.....	33
<i>erythromycin ethylsuccinate</i>	7	<i>fluocinolone acetonide</i>	55	GILOTRIF.....	21
<i>escitalopram oxalate</i>	14	<i>fluocinolone acetonide body</i>	55	<i>glatiramer acetate</i>	51
<i>esomeprazole magnesium</i>	59	<i>fluocinolone acetonide scalp</i>	55	GLEOSTINE.....	21
ESTARYLLA.....	64	<i>fluocinonide</i>	55	<i>glimepiride</i>	37
<i>estradiol</i>	64, 65	<i>fluorometholone</i>	85	<i>glipizide</i>	37
<i>estradiol-norethindrone acet</i>	65	<i>fluorouracil</i>	55	<i>glipizide er</i>	37
ESTRING.....	65	<i>fluoxetine hcl</i>	14	<i>glipizide-metformin hcl</i>	37
<i>eszopiclone</i>	92	<i>fluphenazine decanoate</i>	29	<i>global alcohol prep ease</i>	82
<i>ethambutol hcl</i>	19	<i>fluphenazine hcl</i>	29	GLUCAGEN HYPOKIT.....	37
<i>ethosuximide</i>	10	<i>flurbiprofen</i>	1	<i>glucagon emergency</i>	37
<i>ethynodiol diac-eth estradiol</i>	65	<i>flurbiprofen sodium</i>	85	<i>glyburide</i>	37
<i>etodolac</i>	1	<i>flutamide</i>	21	<i>glyburide-metformin</i>	37
<i>etonogestrel-ethinyl estradiol</i>	65	<i>fluticasone propionate</i>	55, 89	<i>glycopyrrolate</i>	59
<i>etravirine</i>	33	<i>fluticasone-salmeterol</i>	89	GLYXAMBI.....	37
EUCRISA.....	55	<i>fluvastatin sodium</i>	46	<i>griseofulvin microsize</i>	17
EUTHYROX.....	69	<i>fluvastatin sodium er</i>	46	<i>griseofulvin ultramicrosize</i>	17
<i>everolimus</i>	20, 74	<i>fluvoxamine maleate</i>	14	<i>guanfacine hcl</i>	47
EVOTAZ.....	33	<i>folic acid</i>	92	<i>guanfacine hcl er</i>	51
EVRYSDI.....	60	<i>fondaparinux sodium</i>	42	GVOKE HYPOPEN 1-PACK....	37
EXEL COMFORT POINT PEN		<i>formoterol fumarate</i>	89	GVOKE HYPOPEN 2-PACK....	37
NEEDLE.....	82	FORTEO.....	81	GVOKE KIT.....	37
<i>exemestane</i>	20	<i>fosamprenavir calcium</i>	33	GVOKE PFS.....	37
<i>ezetimibe</i>	46	<i>fosinopril sodium</i>	46	<i>halobetasol propionate</i>	55
<i>ezetimibe-simvastatin</i>	46	<i>fosinopril sodium-hetz</i>	46	HALOETTE.....	65
FALMINA.....	65	FOTIVDA.....	21	<i>haloperidol</i>	29
<i>famciclovir</i>	33	FRAGMIN.....	42	<i>haloperidol decanoate</i>	29
<i>famotidine</i>	59	FRUZAQLA.....	21	<i>haloperidol lactate</i>	29
FANAPT.....	29	<i>furosemide</i>	46	HAVRIX.....	74
FANAPT TITRATION PACK...	29	FUZEON.....	33	HEATHER.....	65
FARXIGA.....	37	FYAVOLV.....	65	HEPAGAM B.....	74
FASENRA.....	89	FYCOMPA.....	10	<i>heparin sodium (porcine)</i>	42
FASENRA PEN.....	89	<i>gabapentin</i>	10	HEPLISAV-B.....	74
<i>febuxostat</i>	18	<i>galantamine hydrobromide</i>	13	HIBERIX.....	74
<i>felbamate</i>	10	<i>galantamine hydrobromide er</i>	13	HIZENTRA.....	74
<i>felodipine er</i>	46	GAMASTAN.....	74	HUMALOG.....	37, 38
<i>fenofibrate</i>	46	GAMMAKED.....	74	HUMALOG JUNIOR	
<i>fenofibrate micronized</i>	46	GAMUNEX-C.....	74	KWIKPEN.....	38
<i>fenofibric acid</i>	46	<i>ganciclovir sodium</i>	33	HUMALOG KWIKPEN.....	38
<i>fentanyl</i>	1	GARDASIL 9.....	74	HUMALOG MIX 50/50	
<i>fentanyl citrate</i>	1	<i>gatifloxacin</i>	85	KWIKPEN.....	38
FETZIMA.....	14	GAVILYTE-C.....	59	HUMALOG MIX 75/25.....	38
FETZIMA TITRATION.....	14	GAVILYTE-G.....	59	HUMALOG MIX 75/25	
FINACEA.....	55	GAVILYTE-N WITH FLAVOR		KWIKPEN.....	38
<i>finasteride</i>	62	PACK.....	59	HUMATIN.....	7
<i>fingolimod hcl</i>	51	GAVRETO.....	21	HUMIRA.....	75
FINTEPLA.....	10	<i>gefitinib</i>	21	HUMIRA (2 PEN).....	74
FIRMAGON.....	69	<i>gemfibrozil</i>	46	HUMIRA (2 SYRINGE).....	74
FIRMAGON (240 MG DOSE)...	69	GEMTESA.....	62	HUMIRA PEN.....	74
FLAREX.....	85	<i>generlac</i>	59	HUMIRA-CD/UC/HS	
<i>flecainide acetate</i>	46	GENGRAF.....	74	STARTER.....	75
<i>fluconazole</i>	17	GENOTROPIN.....	63		

HUMIRA-PED<40KG	INCRUSE ELLIPTA.....	89	JUNEL FE 1.5/30.....	65
CROHNS STARTER.....	<i>indapamide</i>	47	JUNEL FE 1/20.....	65
HUMIRA-PED>/=40KG	<i>indomethacin</i>	2	JYLAMVO.....	76
CROHNS START.....	<i>indomethacin er</i>	2	JYNNEOS.....	76
HUMIRA-PED>/=40KG UC	INFANRIX.....	75	KALYDECO.....	90
STARTER.....	INFLECTRA.....	75	KANJINTI.....	21
HUMIRA-PS/UV/ADOL HS	<i>infliximab</i>	75	KARIVA.....	65
STARTER.....	INGREZZA.....	51, 52	KELNOR 1/35.....	65
HUMIRA-PSORIASIS/UEVIT	INLYTA.....	21	KELNOR 1/50.....	65
STARTER.....	INQOVI.....	21	KEPIVANCE.....	53
HUMULIN 70/30.....	INREBIC.....	21	KERENDIA.....	47
HUMULIN 70/30 KWIKPEN... 38	<i>insulin lispro</i>	38	KESIMPTA.....	52
HUMULIN N.....	<i>insulin syringe/needle</i>	82	<i>ketoconazole</i>	17
HUMULIN N KWIKPEN.....	INSUPEN SENSITIVE.....	82	<i>ketorolac tromethamine</i>	2, 85
HUMULIN R.....	INTELENCE.....	33	KINERET.....	76
HUMULIN R U-500	INTRON A.....	75	KINRIX.....	76
(CONCENTRATED).....	INTROVALE.....	65	KIONEX.....	57
HUMULIN R U-500	INVEGA HAFYERA.....	29	KISQALI (200 MG DOSE).....	21
KWIKPEN.....	INVEGA SUSTENNA.....	29	KISQALI (400 MG DOSE).....	22
<i>hydralazine hcl</i>	INVEGA TRINZA.....	30	KISQALI (600 MG DOSE).....	22
<i>hydrochlorothiazide</i>	IPOL.....	76	KISQALI FEMARA (200 MG	
<i>hydrocodone-acetaminophen</i>	<i>ipratropium bromide</i>	89	DOSE).....	22
<i>hydrocortisone</i>	<i>ipratropium-albuterol</i>	90	KISQALI FEMARA (400 MG	
<i>hydrocortisone (perianal)</i>	<i>irbesartan</i>	47	DOSE).....	22
<i>hydrocortisone valerate</i>	<i>irbesartan-hydrochlorothiazide</i>	47	KISQALI FEMARA (600 MG	
<i>hydrocortisone-acetic acid</i>	ISENTRESS.....	33	DOSE).....	22
<i>hydromorphone hcl</i>	ISENTRESS HD.....	33	KLAYESTA.....	17
<i>hydromorphone hcl pf</i>	<i>isoniazid</i>	19	KLISYRI.....	55
<i>hydroxychloroquine sulfate</i>	<i>isosorb dinitrate-hydralazine</i>	47	KLOR-CON.....	57
<i>hydroxyurea</i>	<i>isosorbide dinitrate</i>	47	KLOR-CON 10.....	57
<i>hydroxyzine hcl</i>	<i>isosorbide mononitrate</i>	47	KLOR-CON M10.....	57
<i>hydroxyzine pamoate</i>	<i>isosorbide mononitrate er</i>	47	KLOR-CON M15.....	57
HYPERHEP B.....	<i>isotretinoin</i>	55	KLOR-CON M20.....	57
<i>ibandronate sodium</i>	<i>isradipine</i>	47	<i>kmart valu insulin syringe 29g</i>	83
IBRANCE.....	ISTURISA.....	69	<i>kmart valu insulin syringe 30g</i>	83
IBU.....	<i>itraconazole</i>	17	KORLYM.....	63
<i>ibuprofen</i>	<i>ivermectin</i>	27	KOSELUGO.....	22
<i>icatibant acetate</i>	IWILFIN.....	21	<i>kosher prenatal plus iron</i>	93
ICLEVIA.....	IXCHIQ.....	76	KOURZEQ.....	53
ICLUSIG.....	IXIARO.....	76	KRAZATI.....	22
<i>icosapent ethyl</i>	JAKAFI.....	21	<i>kroger pen needles</i>	83
IDHIFA.....	JANTOVEN.....	42	KURVELO.....	65
IGALMI.....	JANUMET.....	38	KYNMOBI.....	27
ILARIS.....	JANUMET XR.....	38	KYNMOBI TITRATION KIT... 27	
ILEVRO.....	JANUVIA.....	38	<i>labetalol hcl</i>	47
<i>imatinib mesylate</i>	JARDIANCE.....	39	<i>lacosamide</i>	10
IMBRUVICA.....	JAVYGTOR.....	61	<i>lactulose</i>	59
<i>imipenem-cilastatin</i>	JAYPIRCA.....	21	<i>lactulose encephalopathy</i>	59
<i>imipramine hcl</i>	JENTADUETO.....	39	LAGEVRIO.....	83
<i>imiquimod</i>	JENTADUETO XR.....	39	<i>lamivudine</i>	33
IMOVAX RABIES.....	JINTELI.....	65	<i>lamivudine-zidovudine</i>	33
IMPAVIDO.....	JUBLIA.....	17	<i>lamotrigine</i>	11
INBRIJA.....	JULUCA.....	33	<i>lamotrigine er</i>	10
INCASSIA.....	JUNEL 1.5/30.....	65	<i>lamotrigine starter kit-blue</i>	11
INCRELEX.....	JUNEL 1/20.....	65	<i>lamotrigine starter kit-green</i>	11

<i>lamotrigine starter kit-orange</i>	11	<i>lidocaine</i>	3	LYUMJEV.....	39
<i>lanreotide acetate</i>	70	<i>lidocaine viscous hcl</i>	53	LYUMJEV KWIKPEN.....	39
<i>lansoprazole</i>	59	<i>lidocaine-prilocaine</i>	3	LYZA.....	66
LANTUS.....	39	<i>linezolid</i>	8	<i>magnesium sulfate</i>	57
LANTUS SOLOSTAR.....	39	LINZESS.....	59	<i>malathion</i>	56
<i>lapatinib ditosylate</i>	22	<i>liothyronine sodium</i>	69	<i>maraviroc</i>	34
LARIN 1.5/30.....	65	<i>lisinopril</i>	47	<i>marlissa</i>	66
LARIN 1/20.....	65	<i>lisinopril-hydrochlorothiazide</i>	47	MARPLAN.....	15
LARIN FE 1.5/30.....	65	<i>lithium</i>	36	MATULANE.....	23
LARIN FE 1/20.....	65	<i>lithium carbonate</i>	36	MATZIM LA.....	47
<i>latanoprost</i>	85	<i>lithium carbonate er</i>	36	MAVYRET.....	34
<i>leflunomide</i>	76	LIVALO.....	47	MAYZENT.....	52
<i>lenalidomide</i>	22	LIVTENCITY.....	33	MAYZENT STARTER PACK.....	52
LENVIMA (10 MG DAILY DOSE).....	22	LOKELMA.....	57	<i>meclizine hcl</i>	16
LENVIMA (12 MG DAILY DOSE).....	22	LONHALA MAGNAIR REFILL KIT.....	90	<i>medroxyprogesterone acetate</i>	66
LENVIMA (14 MG DAILY DOSE).....	22	LONSURF.....	22	<i>mefloquine hcl</i>	27
LENVIMA (18 MG DAILY DOSE).....	22	<i>loperamide hcl</i>	59	<i>megestrol acetate</i>	66
LENVIMA (20 MG DAILY DOSE).....	22	<i>lopinavir-ritonavir</i>	34	MEKINIST.....	23
LENVIMA (24 MG DAILY DOSE).....	22	LOQTORZI.....	23	MEKTOVI.....	23
LENVIMA (4 MG DAILY DOSE).....	22	<i>lorazepam</i>	36	<i>meloxicam</i>	2
LENVIMA (8 MG DAILY DOSE).....	22	LORAZEPAM INTENSOL.....	36	<i>memantine hcl</i>	13
LESSINA.....	66	LORBRENA.....	23	<i>memantine hcl er</i>	13
<i>letrozole</i>	22	<i>losartan potassium</i>	47	MENACTRA.....	76
<i>leucovorin calcium</i>	22	<i>losartan potassium-hctz</i>	47	MENEST.....	66
LEUKERAN.....	22	LOTEMAX SM.....	85	MENQUADFI.....	76
<i>leuprolide acetate</i>	70	<i>lovastatin</i>	47	MENVEO.....	76
<i>levabuterol hcl</i>	90	LOW-OGESTREL.....	66	<i>mercaptopurine</i>	23
<i>levabuterol tartrate</i>	90	<i>loxapine succinate</i>	30	<i>meropenem</i>	8
LEVEMIR.....	39	<i>lubiprostone</i>	59	<i>mesalamine</i>	80
LEVEMIR FLEXPEN.....	39	LUMAKRAS.....	23	<i>mesalamine er</i>	80
<i>levetiracetam</i>	11	LUMIGAN.....	85	<i>mesalamine-cleanser</i>	80
<i>levetiracetam er</i>	11	LUPRON DEPOT (1-MONTH).....	70	MESNEX.....	23
<i>levobunolol hcl</i>	85	LUPRON DEPOT (3-MONTH).....	70	<i>metformin hcl</i>	39
<i>levocetirizine dihydrochloride</i>	90	LUPRON DEPOT (4-MONTH).....	70	<i>metformin hcl er</i>	39
<i>levofloxacin</i>	7, 85	LUPRON DEPOT (6-MONTH).....	70	<i>methadone hcl</i>	2
<i>levofloxacin in d5w</i>	7	LUPRON DEPOT-PED (1-MONTH).....	70	<i>methazolamide</i>	85
LEVONEST.....	66	LUPRON DEPOT-PED (3-MONTH).....	70	<i>methenamine hippurate</i>	8
<i>levonorgest-eth est & eth est</i>	66	LUPRON DEPOT-PED (6-MONTH).....	63	<i>methimazole</i>	71
<i>levonorgest-eth estrad 91-day</i>	66	<i>lurasidone hcl</i>	30	<i>methocarbamol</i>	92
<i>levonorgestrel-ethinyl estrad</i>	66	LUTERA.....	66	<i>methotrexate sodium</i>	76
<i>levonorg-eth estrad triphasic</i>	66	LYBALVI.....	30	<i>methotrexate sodium (pf)</i>	76
LEVORA 0.15/30 (28).....	66	LYLEQ.....	66	<i>methsuximide</i>	11
LEVO-T.....	69	LYLLANA.....	66	<i>methylidopa</i>	47
<i>levothyroxine sodium</i>	69	LYNPARZA.....	23	<i>methylphenidate hcl</i>	52
LEVOXYL.....	69	LYSODREN.....	69	<i>methylphenidate hcl er</i>	52
LEXIVA.....	33	LYTGOBI (12 MG DAILY DOSE).....	23	<i>methylphenidate hcl er (osm)</i>	52
LIBERVANT.....	11	LYTGOBI (16 MG DAILY DOSE).....	23	<i>methylprednisolone</i>	62
		LYTGOBI (20 MG DAILY DOSE).....	23	<i>metoclopramide hcl</i>	59
				<i>metolazone</i>	47
				<i>metoprolol succinate er</i>	47
				<i>metoprolol tartrate</i>	48
				<i>metronidazole</i>	8, 56
				<i>metyrosine</i>	48
				<i>mexiletine hcl</i>	48
				MICROGESTIN 1.5/30.....	66

MICROGESTIN 1/20.....	66	<i>neomycin-polymyxin-gramicidin</i>	86	NOVOLIN R.....	40
MICROGESTIN FE 1.5/30.....	66	<i>neomycin-polymyxin-hc</i>	87	NOVOLIN R FLEXPEN.....	40
MICROGESTIN FE 1/20.....	67	NEO-POLYCIN.....	86	NOVOLIN R FLEXPEN	
<i>midodrine hcl</i>	48	NEO-POLYCIN HC.....	86	RELION.....	40
<i>mifepristone</i>	63	NERLYNX.....	23	NOVOLIN R RELION.....	40
<i>miglustat</i>	61	NEULASTA.....	43	NOVOLOG.....	40
MILI.....	67	NEULASTA ONPRO.....	42	NOVOLOG 70/30 FLEXPEN	
<i>mimvey</i>	67	NEUPRO.....	27	RELION.....	40
<i>minocycline hcl</i>	8	<i>nevirapine</i>	34	NOVOLOG FLEXPEN.....	40
<i>minoxidil</i>	48	<i>nevirapine er</i>	34	NOVOLOG FLEXPEN	
<i>mirtazapine</i>	15	NEXLETOL.....	48	RELION.....	40
<i>misoprostol</i>	59	NEXLIZET.....	48	NOVOLOG MIX 70/30.....	40
M-M-R II.....	76	<i>niacin er (antihyperlipidemic)</i>	48	NOVOLOG MIX 70/30	
<i>modafinil</i>	92	NICOTROL NS.....	3	FLEXPEN.....	40
<i>moexipril hcl</i>	48	<i>nifedipine er</i>	48	NOVOLOG MIX 70/30	
<i>molindone hcl</i>	30	<i>nifedipine er osmotic release</i>	48	RELION.....	40
<i>mometasone furoate</i>	56, 90	<i>nilutamide</i>	23	NOVOLOG PENFILL.....	40
MONDOXYNE NL.....	8	<i>nimodipine</i>	48	NOVOLOG RELION.....	40
MONOJECT INSULIN		NINLARO.....	23	NOVOTWIST PEN NEEDLE....	83
SYRINGE.....	83	<i>nitazoxanide</i>	27	NUBEQA.....	23
<i>montelukast sodium</i>	90	<i>nitisinone</i>	61	NUCALA.....	90
<i>morphine sulfate</i>	2	NITRO-BID.....	48	NUEDEXTA.....	52
<i>morphine sulfate (concentrate)</i>	2	<i>nitrofurantoin macrocrystal</i>	8	NUPLAZID.....	30
<i>morphine sulfate (pf)</i>	2	<i>nitrofurantoin monohyd macro</i>	8	NURTEC.....	18
<i>morphine sulfate er</i>	2	<i>nitroglycerin</i>	48, 59	NUTRILIPID.....	83
MOTEGRITY.....	59	<i>nizatidine</i>	59	NYAMYC.....	17
MOUNJARO.....	39	NORA-BE.....	67	NYLIA 1/35.....	67
<i>moxifloxacin hcl</i>	8, 86	<i>norethin ace-eth estrad-fe</i>	67	NYLIA 7/7/7.....	67
<i>moxifloxacin hcl in nacl</i>	8	<i>norethindrone</i>	67	NYMYO.....	67
MULTAQ.....	48	<i>norethindrone acetate</i>	67	<i>nystatin</i>	17
<i>mupirocin</i>	56	<i>norethindrone acet-ethinyl est</i>	67	<i>nystatin-triamcinolone</i>	56
<i>mupirocin calcium</i>	56	<i>norethindrone-eth estradiol</i>	67	NYSTOP.....	17
<i>mycophenolate mofetil</i>	76	<i>norgestimate-eth estradiol</i>	67	<i>octreotide acetate</i>	70
<i>mycophenolate sodium</i>	76	<i>norgestim-eth estrad triphasic</i>	67	ODEFSEY.....	34
MYORISAN.....	56	NORTREL 0.5/35 (28).....	67	ODOMZO.....	23
MYRBETRIQ.....	62	NORTREL 1/35 (21).....	67	OFEV.....	90
<i>na sulfate-k sulfate-mg sulf</i>	59	NORTREL 1/35 (28).....	67	<i>ofloxacin</i>	86, 87
NABI-HB.....	76	NORTREL 7/7/7.....	67	OGSIVEO.....	23
<i>nabumetone</i>	2	<i>nortriptyline hcl</i>	15	OJEMDA.....	23
<i>nadolol</i>	48	NORVIR.....	34	OJJAARA.....	23
<i>nafcillin sodium</i>	8	NOVOFINE AUTOCOVER		<i>olanzapine</i>	30
<i>naloxone hcl</i>	3	PEN NEEDLE.....	83	<i>olmesartan medoxomil</i>	48
<i>naltrexone hcl</i>	3	NOVOFINE PEN NEEDLE.....	83	<i>olmesartan medoxomil-hctz</i>	48
NAMZARIC.....	13	NOVOFINE PLUS PEN		<i>olopatadine hcl</i>	86
<i>naproxen</i>	2	NEEDLE.....	83	<i>omega-3-acid ethyl esters</i>	48
<i>naproxen sodium</i>	2	NOVOLIN 70/30.....	39	<i>omeprazole</i>	59
<i>naratriptan hcl</i>	18	NOVOLIN 70/30 FLEXPEN.....	39	OMNIPOD 5 G6 INTRO (GEN	
<i>nateglinide</i>	39	NOVOLIN 70/30 FLEXPEN		5).....	83
NAYZILAM.....	11	RELION.....	39	OMNIPOD 5 G6 PODS (GEN	
<i>nebivolol hcl</i>	48	NOVOLIN 70/30 RELION.....	39	5).....	83
NECON 0.5/35 (28).....	67	NOVOLIN N.....	40	OMNIPOD 5 G7 INTRO (GEN	
<i>nefazodone hcl</i>	15	NOVOLIN N FLEXPEN.....	40	5).....	83
<i>neomycin sulfate</i>	8	NOVOLIN N FLEXPEN		OMNIPOD 5 G7 PODS (GEN	
<i>neomycin-bacitracin zn-polymyx</i> ... 86		RELION.....	39	5).....	83
<i>neomycin-polymyxin-dexameth</i> 86		NOVOLIN N RELION.....	40		

OMNIPOD CLASSIC PDM (GEN 3).....	83	PEDIARIX.....	77	<i>potassium chloride crys er</i>	58
OMNIPOD CLASSIC PODS (GEN 3).....	83	PEDVAX HIB.....	77	<i>potassium chloride er</i>	58
OMNIPOD DASH INTRO (GEN 4).....	83	<i>peg 3350-kcl-na bicarb-nacl</i>	60	<i>potassium citrate er</i>	58
OMNIPOD DASH PDM (GEN 4).....	83	<i>peg-3350/electrolytes</i>	60	PRALUENT.....	49
OMNIPOD DASH PODS (GEN 4).....	83	PEGASYS.....	77	<i>pramipexole dihydrochloride</i>	28
<i>ondansetron</i>	16	PEMAZYRE.....	24	<i>prasugrel hcl</i>	43
<i>ondansetron hcl</i>	16	<i>pen needles</i>	83	<i>pravastatin sodium</i>	49
ONUREG.....	23	PENBRAYA.....	77	<i>praziquantel</i>	27
OPDUALAG.....	23	<i>penicillamine</i>	62	<i>prazosin hcl</i>	49
OPSUMIT.....	90	<i>penicillin g sodium</i>	8	<i>prednisolone</i>	62
ORALONE.....	53	<i>penicillin v potassium</i>	8	<i>prednisolone acetate</i>	86
ORENCIA.....	76, 77	PENTACEL.....	77	<i>prednisolone sodium phosphate</i>	62
ORENCIA CLICKJECT.....	76	<i>pentamidine isethionate</i>	27	<i>prednisone</i>	63
ORENITRAM.....	91	<i>pentoxifylline er</i>	48	<i>preferred plus insulin syringe</i>	83
ORENITRAM MONTH 1.....	90	<i>perindopril erbumine</i>	48	<i>pregabalin</i>	52
ORENITRAM MONTH 2.....	90	<i>permethrin</i>	56	PREHEVBRIO.....	77
ORENITRAM MONTH 3.....	90	<i>perphenazine</i>	30	PREMARIN.....	67
ORGOVYX.....	70	PERSERIS.....	30	PREMPHASE.....	67
ORKAMBI.....	91	<i>phenelzine sulfate</i>	15	PREMPRO.....	68
<i>orphenadrine citrate er</i>	92	<i>phenobarbital</i>	11	<i>prenatal</i>	58
ORSERDU.....	23	PHENYTEK.....	11	<i>prenatal 19</i>	93
<i>oseltamivir phosphate</i>	34	<i>phenytoin</i>	11	PREVALITE.....	49
OSMOLEX ER.....	28	<i>phenytoin sodium extended</i>	11	PREVYMIS.....	34
OSPHENA.....	67	PHESGO.....	24	PREZCOBIX.....	34
OTEZLA.....	56, 77	PIFELTRO.....	34	PREZISTA.....	34
<i>oxacillin sodium</i>	8	<i>pilocarpine hcl</i>	53, 86	PRIFTIN.....	19
<i>oxaprozin</i>	2	<i>pimozide</i>	30	<i>primaquine phosphate</i>	27
OXBRYTA.....	43	PIMTREA.....	67	<i>primidone</i>	11
<i>oxcarbazepine</i>	11	<i>pindolol</i>	49	PRIORIX.....	77
OXLUMO.....	83	<i>pioglitazone hcl</i>	41	PRIVIGEN.....	77
<i>oxybutynin chloride</i>	62	<i>pioglitazone hcl-metformin hcl</i>	41	PROAIR RESPICLICK.....	91
<i>oxybutynin chloride er</i>	62	<i>piperacillin sod-tazobactam so</i>	8	<i>probenecid</i>	18
<i>oxycodone hcl</i>	2	PIQRAY (200 MG DAILY DOSE).....	24	<i>prochlorperazine</i>	16
<i>oxycodone-acetaminophen</i>	2	PIQRAY (250 MG DAILY DOSE).....	24	<i>prochlorperazine edisylate</i>	16
OZEMPIC (0.25 OR 0.5 MG/DOSE).....	40, 41	PIQRAY (300 MG DAILY DOSE).....	24	<i>prochlorperazine maleate</i>	16
OZEMPIC (1 MG/DOSE).....	41	<i>pirfenidone</i>	91	PROCRIT.....	43
OZEMPIC (2 MG/DOSE).....	41	<i>piroxicam</i>	2	PROCTO-MED HC.....	81
PACERONE.....	48	<i>pitavastatin calcium</i>	49	PROCTOSOL HC.....	81
<i>paliperidone er</i>	30	PLENAMINE.....	57	PROCTOZONE-HC.....	81
PANRETIN.....	23	<i>pnv prenatal plus multivit+dha</i>	93	<i>progesterone</i>	68
<i>pantoprazole sodium</i>	60	<i>pnv tabs 29-1</i>	93	PROGRAF.....	77
PANZYGA.....	77	<i>pnv-dha</i>	93	PROLASTIN-C.....	61
<i>paricalcitol</i>	81	<i>pnv-dha+docusate</i>	93	PROLENSA.....	86
<i>paroxetine hcl</i>	15	<i>pnv-omega</i>	93	PROLIA.....	81
PASER.....	19	<i>pnv-select</i>	93	PROMACTA.....	43
PAXLOVID (150/100).....	83	<i>podofilox</i>	56	<i>promethazine hcl</i>	16
PAXLOVID (300/100).....	83	POLYCIN.....	86	PROMETHEGAN.....	16
<i>pazopanib hcl</i>	23	<i>polymyxin b-trimethoprim</i>	86	<i>propafenone hcl</i>	49
<i>pc unifine pentips</i>	83	POMALYST.....	24	<i>propafenone hcl er</i>	49
		PORTIA-28.....	67	<i>propranolol hcl</i>	49
		<i>posaconazole</i>	17	<i>propranolol hcl er</i>	49
		<i>potassium chloride</i>	58	<i>propylthiouracil</i>	71
				PROQUAD.....	77
				<i>protriptyline hcl</i>	15
				PULMOZYME.....	91

PURIXAN.....	24	<i>riluzole</i>	52	SIMBRINZA.....	86
<i>pyrazinamide</i>	19	RINVOQ.....	78	<i>simvastatin</i>	49
<i>pyridostigmine bromide</i>	18	RINVOQ LQ.....	78	<i>sirolimus</i>	78
<i>pyrimethamine</i>	27	<i>risedronate sodium</i>	81	SIRTURO.....	19
PYRUKYND.....	43	RISPERDAL CONSTA.....	31	SKYCLARYS.....	83
PYRUKYND TAPER PACK.....	43	<i>risperidone</i>	31	SKYRIZI.....	78
QINLOCK.....	24	<i>risperidone microspheres er</i>	31	SKYRIZI (150 MG DOSE).....	78
QUADRACEL.....	77	<i>ritonavir</i>	34	SKYRIZI PEN.....	78
<i>quetiapine fumarate</i>	30	<i>rivastigmine</i>	13	<i>sodium chloride</i>	58, 83
<i>quetiapine fumarate er</i>	30	<i>rivastigmine tartrate</i>	13	<i>sodium oxybate</i>	92
<i>quinapril hcl</i>	49	RIVELSA.....	68	<i>sodium phenylbutyrate</i>	61
<i>quinapril-hydrochlorothiazide</i>	49	<i>rizatriptan benzoate</i>	18	<i>sodium polystyrene sulfonate</i>	58
<i>quinidine sulfate</i>	49	ROCKLATAN.....	86	<i>sofosbuvir-velpatasvir</i>	34
<i>quinine sulfate</i>	27	<i>roflumilast</i>	91	<i>solifenacin succinate</i>	62
QULIPTA.....	18	ROLVEDON.....	43	SOLQUA.....	41
QVAR REDIHALER.....	91	<i>ropinirole hcl</i>	28	SOLTAMOX.....	24
RABAVERT.....	77	<i>ropinirole hcl er</i>	28	SOMATULINE DEPOT.....	70
<i>rabeprazole sodium</i>	60	ROSDAN.....	56	SOMAVERT.....	70
<i>raloxifene hcl</i>	68	<i>rosuvastatin calcium</i>	49	<i>sorafenib tosylate</i>	24
<i>ramelteon</i>	92	ROTARIX.....	78	SORINE.....	49
<i>ramipril</i>	49	ROTATEQ.....	78	<i>sotalol hcl</i>	49
<i>ranolazine er</i>	49	ROWEEPRA.....	11	<i>sotalol hcl (af)</i>	49
<i>rasagiline mesylate</i>	28	ROZLYTREK.....	24	SOTYKTU.....	56
RAYALDEE.....	81	RUBRACA.....	24	SPIRIVA HANDIHALER.....	91
REBIF.....	52	<i>rufinamide</i>	11	SPIRIVA RESPIMAT.....	91
REBIF REBIDOSE.....	52	RUKOBIA.....	34	<i>spironolactone</i>	50
REBIF REBIDOSE		RUXIENCE.....	24	<i>spironolactone-hctz</i>	50
TITRATION PACK.....	52	RYBELSUS.....	41	SPRAVATO (56 MG DOSE).....	15
REBIF TITRATION PACK.....	52	RYDAPT.....	24	SPRAVATO (84 MG DOSE).....	15
RECOMBIVAX HB.....	78	RYTARY.....	28	SPRINTEC 28.....	68
RECTIV.....	60	SAJAZIR.....	78	SPRITAM.....	12
RELENZA DISKHALER.....	34	SANDIMMUNE.....	78	SPRYCEL.....	24
RELISTOR.....	60	SANTYL.....	56	SPS.....	58
REMICADE.....	78	SAPHNELO.....	78	SRONYX.....	68
RENFLEXIS.....	78	<i>sapropterin dihydrochloride</i>	61	SSD.....	56
<i>repaglinide</i>	41	SAVELLA.....	53	<i>stavudine</i>	35
REPATHA.....	49	SAVELLA TITRATION PACK.....	53	STELARA.....	79
REPATHA PUSHTRONEX		SCEMBLIX.....	24	STIOLTO RESPIMAT.....	91
SYSTEM.....	49	<i>scopolamine</i>	16	STIVARGA.....	24
REPATHA SURECLICK.....	49	SECUADO.....	31	STRENSIQ.....	61
RESTASIS.....	86	<i>selegiline hcl</i>	28	<i>streptomycin sulfate</i>	8
RESTASIS MULTIDOSE.....	86	<i>selenium sulfide</i>	56	STRIBILD.....	35
RETACRIT.....	43	SELZENTRY.....	34	SUBVENITE.....	12
RETEVMO.....	24	SEREVENT DISKUS.....	91	SUBVENITE STARTER KIT-	
RETROVIR.....	34	<i>sertraline hcl</i>	15	BLUE.....	12
REVCovi.....	61	SETLAKIN.....	68	SUBVENITE STARTER KIT-	
REVLIMID.....	24	<i>sevelamer carbonate</i>	58	GREEN.....	12
REXULTI.....	30	SFROWASA.....	81	SUBVENITE STARTER KIT-	
REYATAZ.....	34	SHAROBEL.....	68	ORANGE.....	12
REZLIDHIA.....	24	SHINGRIX.....	78	SUCRAID.....	61
REZUROCK.....	78	SIGNIFOR.....	70	<i>sucralfate</i>	60
RHOPRESSA.....	86	SIGNIFOR LAR.....	70	<i>sulfacetamide sodium</i>	86
<i>ribavirin</i>	34	<i>sildenafil citrate</i>	91, 93	<i>sulfacetamide-prednisolone</i>	86
<i>rifabutin</i>	19	<i>silodosin</i>	62	<i>sulfadiazine</i>	8
<i>rifampin</i>	19	<i>silver sulfadiazine</i>	56	<i>sulfamethoxazole-trimethoprim</i>	9

<i>sulfasalazine</i>	81	TIADYLT ER.....	50	TRI-SPRINTEC.....	68
<i>sulindac</i>	2	<i>tiagabine hcl</i>	12	TRIUMEQ.....	35
<i>sumatriptan</i>	18	TIBSOVO.....	25	TRIUMEQ PD.....	35
<i>sumatriptan succinate</i>	18	TICOVAC.....	79	TRIVORA (28).....	68
<i>sumatriptan succinate refill</i>	18	<i>timolol maleate</i>	86	TRI-VYLIBRA.....	68
<i>sunitinib malate</i>	24	<i>tinidazole</i>	9	TRIZIVIR.....	35
SUNLENCA.....	35	<i>tiotropium bromide monohydrate</i> ..	91	TROGARZO.....	35
SUTAB.....	60	TIVICAY.....	35	<i>tropium chloride</i>	62
SYMPAZAN.....	12	TIVICAY PD.....	35	<i>tropium chloride er</i>	62
SYMTUZA.....	35	<i>tizanidine hcl</i>	32	<i>true comfort pro insulin syr</i>	84
SYNAGIS.....	79	TOBI PODHALER.....	91	<i>true comfort pro pen needles</i>	84
SYNJARDY.....	41	TOBRADEX.....	86	TRULICITY.....	41
SYNJARDY XR.....	41	TOBRADEX ST.....	87	TRUMENBA.....	79
SYNRIBO.....	25	<i>tobramycin</i>	87, 91	TRUQAP.....	25
SYNTHROID.....	69	<i>tobramycin sulfate</i>	9	TUKYSA.....	25
TABLOID.....	25	<i>tobramycin-dexamethasone</i>	87	TURALIO.....	25
TABRECTA.....	25	<i>tolterodine tartrate</i>	62	TURQOZ.....	68
<i>tacrolimus</i>	56, 79	<i>tolterodine tartrate er</i>	62	TWINRIX.....	79
<i>tadalafil</i>	62	<i>topiramate</i>	12	TYBOST.....	35
<i>tadalafil (pah)</i>	91	<i>toremifene citrate</i>	25	TYMLOS.....	81
TAFINLAR.....	25	TORPENZ.....	25	TYPHIM VI.....	79
TAGRISSE.....	25	<i>torse mide</i>	50	TYRVAYA.....	84
TALZENNA.....	25	TOUJEO MAX SOLOSTAR.....	41	UBRELVY.....	18
<i>tamoxifen citrate</i>	25	TOUJEO SOLOSTAR.....	41	UDENYCA.....	43
<i>tamsulosin hcl</i>	62	TRADJENTA.....	41	UDENYCA ONBODY.....	43
TARINA FE 1/20 EQ.....	68	<i>tramadol hcl</i>	3	ULTICARE INSULIN	
TASIGNA.....	25	<i>tramadol-acetaminophen</i>	3	SAFETY SYR.....	84
<i>tazarotene</i>	56	<i>trandolapril</i>	50	ULTICARE INSULIN	
TAZICEF.....	9	<i>trandolapril-verapamil hcl er</i>	50	SYRINGE.....	84
TAZTIA XT.....	50	<i>tranexamic acid</i>	43	ULTICARE MINI PEN	
TAZVERIK.....	25	<i>tranylcypromine sulfate</i>	15	NEEDLES.....	84
TDVAX.....	79	TRAZIMERA.....	25	UNIFINE PROTECT PEN	
TECHLITE PEN NEEDLES.....	83	<i>trazodone hcl</i>	15	NEEDLE.....	84
TEFLARO.....	9	TRECATOR.....	19	UNITHROID.....	69
TEGSEDI.....	61	TRELEGY ELLIPTA.....	92	<i>ursodiol</i>	60
<i>telmisartan</i>	50	TRELSTAR MIXJECT.....	70	<i>valacyclovir hcl</i>	35
<i>telmisartan-hctz</i>	50	TRESIBA.....	41	VALCHLOR.....	25
<i>temazepam</i>	92	TRESIBA FLEXTOUCH.....	41	<i>valganciclovir hcl</i>	35
TENIVAC.....	79	<i>tretinoin</i>	25, 56	<i>valproic acid</i>	36
<i>tenofovir disoproxil fumarate</i>	35	<i>triamcinolone acetonide</i>	53, 56	<i>valsartan</i>	50
TEPMETKO.....	25	<i>triamterene-hctz</i>	50	<i>valsartan-hydrochlorothiazide</i>	50
<i>terazosin hcl</i>	50	TRIDERM.....	57	VALTOCO 10 MG DOSE.....	12
<i>terbinafine hcl</i>	17	<i>trientine hcl</i>	58	VALTOCO 15 MG DOSE.....	12
<i>terconazole</i>	17	TRI-ESTARYLLA.....	68	VALTOCO 20 MG DOSE.....	12
<i>teriparatide</i>	81	<i>trifluoperazine hcl</i>	31	VALTOCO 5 MG DOSE.....	12
<i>teriparatide (recombinant)</i>	81	<i>trifluridine</i>	87	<i>vancomycin hcl</i>	9
<i>testosterone</i>	68	<i>trihexyphenidyl hcl</i>	28	VANFLYTA.....	25
<i>testosterone cypionate</i>	68	TRIJARDY XR.....	41	VANISHPOINT INSULIN	
<i>testosterone enanthate</i>	68	TRIKAFTA.....	92	SYRINGE.....	84
<i>tetrabenazine</i>	53	<i>trimethoprim</i>	9	VAQTA.....	79
<i>tetracycline hcl</i>	9	TRI-MILI.....	68	<i>varenicline tartrate</i>	3, 4
THALOMID.....	25	<i>trimipramine maleate</i>	15	<i>varenicline tartrate (starter)</i>	3
<i>theophylline er</i>	91	TRINTELLIX.....	15	VARIVAX.....	79
<i>thioridazine hcl</i>	31	TRI-NYMYO.....	68	VELPHORO.....	58
<i>thiothixene</i>	31	TRIPTODUR.....	70	VELTASSA.....	58

VENCLEXTA.....	25	XELJANZ.....	79	<i>zolpidem tartrate er</i>	92
VENCLEXTA STARTING PACK.....	25	XELJANZ XR.....	79	ZONISADE.....	13
<i>venlafaxine hcl</i>	15	XEMBIFY.....	80	<i>zonisamide</i>	13
<i>venlafaxine hcl er</i>	15	XERMELO.....	60	ZOVIA 1/35 (28).....	68
VENTAVIS.....	92	XGEVA.....	81	ZTALMY.....	53
VEOPOZ.....	79	XIFAXAN.....	60	ZURZUVAE.....	15
<i>verapamil hcl</i>	50	XIGDUO XR.....	41	ZYDELIG.....	26
<i>verapamil hcl er</i>	50	XIIDRA.....	87	ZYKADIA.....	26
VERQUVO.....	50	XOFLUZA (40 MG DOSE).....	35	ZYLET.....	87
VERSACLOZ.....	31	XOFLUZA (80 MG DOSE).....	35	ZYPREXA RELPREVV.....	31
VERZENIO.....	25	XOLAIR.....	80		
V-GO 20.....	84	XOSPATA.....	26		
V-GO 30.....	84	XPOVIO (100 MG ONCE WEEKLY).....	26		
V-GO 40.....	84	XPOVIO (40 MG ONCE WEEKLY).....	26		
VIENVA.....	68	XPOVIO (40 MG TWICE WEEKLY).....	26		
<i>vigabatrin</i>	12	XPOVIO (60 MG ONCE WEEKLY).....	26		
VIGADRONE.....	12	XPOVIO (60 MG TWICE WEEKLY).....	26		
VIGPODER.....	12	XPOVIO (80 MG ONCE WEEKLY).....	26		
<i>vilazodone hcl</i>	15	XPOVIO (80 MG TWICE WEEKLY).....	26		
VIRACEPT.....	35	XTAMPZA ER.....	3		
VIREAD.....	35	XTANDI.....	26		
<i>virt-c dha</i>	93	YARGESA.....	61		
<i>virt-pn plus</i>	93	YF-VAX.....	80		
<i>vitamin d (ergocalciferol)</i>	93	YUFLYMA.....	80		
VITRAKVI.....	25, 26	YUFLYMA (1 PEN).....	80		
VIVITROL.....	4	YUFLYMA (2 SYRINGE).....	80		
VIZIMPRO.....	26	YUFLYMA-CD/UC/HS STARTER.....	80		
VOCABRIA.....	35	YUPELRI.....	92		
VONJO.....	26	YUVAFEM.....	68		
<i>voriconazole</i>	17	<i>zafirlukast</i>	92		
VOSEVI.....	35	<i>zaleplon</i>	92		
VOTRIENT.....	26	ZARXIO.....	44		
VOWST.....	60	ZEJULA.....	26		
<i>vp-pnv-dha</i>	93	ZELBORAF.....	26		
VRAYLAR.....	31	ZENATANE.....	57		
VUMERITY.....	53	ZENPEP.....	61		
VYFEMLA.....	68	ZEPOSIA.....	53		
VYJUVEK.....	84	ZEPOSIA 7-DAY STARTER PACK.....	53		
VYLIBRA.....	68	ZEPOSIA STARTER KIT.....	53		
VYNDAMAX.....	50	<i>zidovudine</i>	35		
VYVGART HYTRULO.....	79	<i>ziprasidone hcl</i>	31		
VYZULTA.....	87	<i>ziprasidone mesylate</i>	31		
<i>warfarin sodium</i>	43	ZIRGAN.....	87		
WELIREG.....	26	ZOLINZA.....	26		
WIXELA INHUB.....	92	<i>zolmitriptan</i>	18		
XALKORI.....	26	<i>zolpidem tartrate</i>	92		
XARELTO.....	43				
XARELTO STARTER PACK.....	43				
XATMEP.....	79				
XCOPRI.....	12, 13				
XCOPRI (250 MG DAILY DOSE).....	12				
XCOPRI (350 MG DAILY DOSE).....	12				

Multi-language Interpreter Services

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-888-965-1965 TTY: 711**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 **1-888-965-1965 TTY: 711**。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 **1-888-965-1965 TTY: 711**。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-888-965-1965 TTY: 711**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-888-965-1965 TTY: 711**. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi **1-888-965-1965 TTY: 711** sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-888-965-1965 TTY: 711**. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-888-965-1965 TTY: 711** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-888-965-1965 TTY: 711**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

:Arabic نا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية في الحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-888-965-1965 TTY: 711**. سيقوم ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे &वा&(य या दवा क, योजना के बारे में आपके 4कसी भी 89न के वाब देने के लिए हमारे पास म>त दभा@षया सेवाएँ उपलब्ध हैं। एक दभा@षया श्रुत करने के लिए, बस हमें **1-888-965-1965 TTY: 711** पर फोन करें। कोई व्यक्ति जो मंहनदो बोलता है आपको, मदद कर सकता है। यह एक म>त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-888-965-1965 TTY: 711**. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-888-965-1965 TTY: 711**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal ouwa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-888-965-1965 TTY: 711**. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-888-965-1965 TTY: 711**. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、**1-888-965-1965 TTY: 711**にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

HealthTeam Advantage Contact Information

WEB ADDRESS

Visit HealthTeam Advantage at healthteamadvantage.com.

HEALTHCARE CONCIERGE

Current HealthTeam Advantage members call your Healthcare Concierge toll-free at 888-965-1965 for questions related to your HealthTeam Advantage Medicare Advantage Plan from October 1 - March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1 - September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

SALES INFORMATION

Prospective members call toll-free 877-905-9216 for questions related to HealthTeam Advantage Medicare Advantage Plans from October 1 - March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1 - September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

TTY USERS

TTY users call toll-free 711 for questions related to Medicare Advantage Plans.

PRESCRIPTION DRUG BENEFIT

Current HealthTeam Advantage members call toll-free 888-965-1965 for questions related to your HealthTeam Advantage Part D Prescription Drug Benefit. Prospective members call toll-free 855-547-0344 for questions related to the HealthTeam Advantage Part D Prescription Drug Benefit.

MEDICARE INFORMATION

For more information about Medicare, call Medicare at 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, seven days a week or visit medicare.gov.

Formulary ID: 24469, Version Number 15

This formulary was updated on 07/24/2024. For more recent information or other questions, please contact us, HealthTeam Advantage HealthCare Concierge at 888-965-1965 (TTY users should call 711), October 1 - March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1 - September 30, 8 a.m. to 8 p.m. ET, Monday through Friday, or visit healthteamadvantage.com.

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

MULTI-PLAN_2431_C