TUFTS Health Plan

a Point32Health company

Tufts Medicare Preferred HMO 2025 Formulary (List of Covered Drugs or "Drug List")

Tufts Medicare Preferred HMO Plans

PLEASE READ: This document contains information about the drugs we cover in this plan

25502 Version 18

This formulary was updated on 12/01/2025. For more recent information or other questions, please contact Tufts Medicare Preferred HMO Member Services at **1-800-701-9000** (TTY users should call 711), 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday–Friday from April 1 to September 30, or visit **www.thpmp.org**.

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Tufts Medicare Preferred HMO
2025 Formulary (List of Covered Drugs)

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 Tufts Health Plan. When it refers to "plan" or "our plan," it means Tufts Medicare Preferred HMO.

This document includes the Drug List (formulary) for our plan which is current as of 12/01/2025. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2026, and from time to time during the year.

What is the Tufts Medicare Preferred HMO formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by Tufts Medicare Preferred HMO 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. Tufts Medicare Preferred HMO will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Tufts Medicare Preferred HMO network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

Can the formulary change?

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

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

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

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

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

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled *"How do I request an exception to the Tufts Medicare Preferred HMO Formulary?"*

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

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

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 12/01/2025. To get updated information about the drugs covered by Tufts Medicare Preferred HMO, please contact us. Our contact information appears on the front and back cover pages. In the event of a mid-year non-maintenance formulary change, you will be notified via an errata sheet.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 3. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category *"Cardiovascular Drugs."* 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 62. 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?

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

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

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

For discussion of drug types, please see the *Evidence of Coverage*, Chapter 5, Section 3.1, "The 'Drug List' tells which Part D drugs are covered."

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Tufts Medicare Preferred HMO requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from Tufts Medicare Preferred HMO before you fill your prescriptions. If you don't get approval, Tufts Medicare Preferred HMO may not cover the drug.

- **Quantity Limits:** For certain drugs, Tufts Medicare Preferred HMO limits the amount of the drug that Tufts Medicare Preferred HMO will cover. For example, Tufts Medicare Preferred HMO provides 30 tablets per prescription for *ramelteon*. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Tufts Medicare Preferred HMO 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, Tufts Medicare Preferred HMO may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Tufts Medicare Preferred HMO 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 3. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explains our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Tufts Medicare Preferred HMO 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 Tufts Medicare Preferred HMO Formulary?"* on page VI 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 Member Services and ask if your drug is covered.

If you learn that Tufts Medicare Preferred HMO does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Tufts Medicare Preferred HMO. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Tufts Medicare Preferred HMO.
- You can ask Tufts Medicare Preferred HMO 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 Tufts Medicare Preferred HMO Formulary?

You can ask Tufts Medicare Preferred HMO to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

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

- You can ask us to cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier.

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

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

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

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

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

As a current member, if you are admitted to or discharged from a long-term facility and experience an unplanned drug change, you can request that we approve a one-time, temporary fill of the non-covered medication to allow you time to discuss a transition plan with your physician. Your physician can also request an exception to coverage for the non-covered drug based on review for medical necessity following the standard exception process outlined previously. The temporary "first fill" will generally be up to a 31-day supply, but may be extended to allow you and your physician time to manage the complexities of multiple medications or when special circumstances warrant. You can request a temporary prescription fill by calling the Tufts Medicare Preferred HMO Member Services department.

For more information

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

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

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

Tufts Medicare Preferred HMO Formulary

The formulary that begins on page 3 provides coverage information about the drugs covered by Tufts Medicare Preferred HMO. If you have trouble finding your drug in the list, turn to the Index that begins on page 62.

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., *omeprazole*).

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

PA BvD: Medicare Part B or D

These drugs require prior authorization to determine appropriate coverage under Medicare Part B or Part D. Some Part B drugs may require a 20% coinsurance for Tufts Medicare PreferredHMO Smart Saver Rx, HMO Saver Rx, HMO Basic Rx, and HMO Basic No Rx members

QL: Quantity Limit Applies

Because of potential safety and utilization concerns, Tufts Medicare Preferred HMO has placed dispensing limitations on a small number of prescription drugs. This means that the pharmacy will only dispense a certain quantity of a drug within a given time period. These quantities are based on recognized standards of care, such as U.S. Food and Drug Administration recommendations for use. If your doctor believes you need a quantity greater than the program limitation, your doctor can submit a request for coverage under the Medical Review Process. The Medical Review Process allows you or your doctor to ask Tufts Medicare Preferred HMO to make an exception to our coverage rules. See the section, *"How do I request an exception to the Tufts Medicare Preferred HMO Formulary?"* on page VI for information about how to request an exception.

EC: Enhanced Coverage Drug

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.

HI: Home Infusion Drug

This prescription drug may be covered under your medical benefit. For more information, please call Tufts Medicare Preferred HMO Member Services at **1-800-701-9000** (TTY users should call 711), 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday - Friday from April 1 to September 30, or visit **www.thpmp.org**.

PA: Prior Authorization Required

The Prior Authorization process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member's medical need for a particular drug. If approved, the member pays the designated tier copayment. An appeal process exists for denied requests.

PA NSO: Prior Authorization for New Starts Only

The Prior Authorization restriction only applies if you are a new member or have not taken this drug before.

ST: Step Therapy Prior Authorization Applies

Step Therapy is an automated form of Prior Authorization, which uses claims history for approval of a drug at the point of sale. Step Therapy Programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered.

Members who are currently on drugs that meet the initial Step Therapy criteria will automatically be able to fill their prescriptions for a stepped medication. If the member does not meet the initial Step Therapy criteria, the prescription will deny at the point of sale with a message indicating that Prior Authorization (PA) is required. Physicians may submit Prior Authorization requests to Tufts Medicare Preferred HMO for members who do not meet the Step Therapy criteria at the point of sale under the Medical Review process. The Medical Review Process allows you or your doctor to ask Tufts Medicare Preferred HMO to make an exception to our coverage rules. See the section, *"How do I request an exception to the Tufts Medicare Preferred HMO Formulary?"* on page VI for information about how to request an exception.

ST NSO: Step Therapy Prior Authorization Applies to New Starts Only

The Step Therapy Prior Authorization restriction only applies if you are a new member or have not taken this drug before.

NEDS: Non-extended Day Supply Drug

In an effort to contain drug costs, certain high-cost drugs will be limited up to a 30-day supply per fill.

SP: Available Through a Designated Special Pharmacy Provider

You have the option to obtain this drug through a designated Specialty Pharmacy provider. These pharmacies specialize in supplying a select number of medications directly to our members. They also provide free delivery to your home, educational support 24/7 by phone, support of nurses and pharmacists, and will work closely with your doctor. Medications include, but are not limited to, drugs used in the treatment of multiple sclerosis, hepatitis C, rheumatoid arthritis, and cancers treated with oral medications.

Optum Specialty Pharmacy: **1-844-265-1705**

Additional coverage

Diabetic Testing Supplies: Diabetic testing supplies including blood glucose monitors, blood glucose test strips, lancet devices, lancets, glucose control solutions, and Continuous Glucose Monitoring Systems (CGMs) are covered under the plan's medical benefit at participating retail or mail-order pharmacies. Our preferred coverage is as follows:

- OneTouch Test Strips
- OneTouch Meters (Quantity Limit: 1 meter per 180 days)
- Covered therapeutic Continuous Glucose Monitors (CGMs) include Dexcom and FreeStyle Libre products that are considered Durable Medical Equipment (DME) by Medicare (Requires prior authorization)

Part B Vaccines: Certain vaccines are covered under the plan's medical benefit and can be obtained at participating retail pharmacies. Vaccines covered under Part B include:

- COVID-19 vaccines
- Flu vaccines
- Pneumonia vaccines (i.e. Pneumovax 23 & Prevnar 13)

Part B Oral Anti-Cancer Drugs: Certain oral anti-cancer drugs are covered under the plan's medical benefit at participating retail or mail-order pharmacies. Oral Anti-Cancer Drugs covered under Part B include:

- Alkeran Tablet
- Capecitabine Tablet
- Etoposide Capsule
- Hycamtin Capsule
- Melphalan Tablet
- Myleran Tablet
- Temozolomide Capsule

Prescription Drug Benefits: Deductible (for Part D prescription drugs)	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not cover Part D prescription drugs	This plan does not have a deductible.
Prescription Drug Benefits: Initial Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic No Rx**	Tufts Medicare Preferred **HMO Basic Rx**
Note: Tier 1 and Tier 2 drugs include enhanced coverage of certain drugs such as select erectile dysfunction (ED) drugs, and vitamins.	You pay the following until your total yearly drug costs reach $2,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following until your total yearly drug costs reach $2,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	This plan does not cover Part D prescription drugs	You pay the following until your total yearly drug costs reach $2,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Prescription Drug Benefits: Initial Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**			Tufts Medicare Preferred **HMO Saver Rx**			Tufts Medicare Preferred **HMO Basic Rx**		
Retail Cost Sharing—Preferred Pharmacy									
Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 2 (Generic)	$6	$12	$18	$6	$12	$18	$4/$0*	$8/$0*	$12/$0*
							* Worcester County Only		
Tier 3 (Preferred Brand)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)
Tier 4 (Non-Preferred Drug)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A	$0	N/A	N/A	$0	N/A	N/A

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
This plan does not cover Part D prescription drugs	This plan does not have a deductible.	This plan does not cover Part D prescription drugs	This plan does not have a deductible	

Tufts Medicare Preferred **HMO Value No Rx**	Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime No Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
This plan does not cover Part D prescription drugs	You pay the following until your total yearly drug costs reach $2,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	This plan does not cover Part D prescription drugs	You pay the following until your total yearly drug costs reach $2,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	

Tufts Medicare Preferred **HMO Value Rx**			Tufts Medicare Preferred **HMO Prime Rx**			Tufts Medicare Preferred **HMO Prime Rx Plus**		
Retail Cost Sharing—Preferred Pharmacy								
30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
$0	$0	$0	N/A	N/A	N/A	N/A	N/A	N/A
$4	$8	$12	N/A	N/A	N/A	N/A	N/A	N/A
23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)	N/A	N/A	N/A	N/A	N/A	N/A
50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	N/A	N/A	N/A	N/A	N/A	N/A
33% of the cost	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
$0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Prescription Drug Benefits: Initial Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**			Tufts Medicare Preferred **HMO Saver Rx**			Tufts Medicare Preferred **HMO Basic Rx**		
Retail Cost Sharing—Non-Preferred Pharmacy									
Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$14	$28	$42	$14	$28	$42	$14/$6*	$28/$12*	$42/$18*
							* Worcester County Only		
Tier 2 (Generic)	$20	$40	$60	$20	$40	$60	$19/$11*	$38/$22*	$57/$33*
							* Worcester County Only		
Tier 3 (Preferred Brand)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)
Tier 4 (Non-Preferred Drug)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	$0	N/A	N/A	$0	N/A	N/A	$0	N/A	N/A
Mail Order Cost Sharing									
Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 2 (Generic)	$6	$12	$12	$6	$12	$12	$4/$0*	$8/$0*	$8/$0*
							* Worcester County Only		
Tier 3 (Preferred Brand)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $70	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $70)
Tier 4 (Non-Preferred Drug)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)
Tier 5 (Specialty Tier)	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
Tier 6 (Vaccines)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Prescription Drug Benefits: Catastrophic Coverage	Tufts Medicare Preferred **HMO Smart Saver Rx**	Tufts Medicare Preferred **HMO Saver Rx**	Tufts Medicare Preferred **HMO Basic Rx**
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.		

Tufts Medicare Preferred **HMO Value Rx**			Tufts Medicare Preferred **HMO Prime Rx**			Tufts Medicare Preferred **HMO Prime Rx Plus**		
Retail Cost Sharing—Non-Preferred Pharmacy								
30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
$14	$28	$42	$4	$8	$12	$2	$4	$6
$19	$38	$57	$8	$16	$24	$4	$8	$12
23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $105)	23% of the cost (Insulin: $30)	23% of the cost (Insulin: $60)	23% of the cost (Insulin: $90)
50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)
33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
$0	N/A	N/A	$0	N/A	N/A	$0	N/A	N/A
Mail Order Cost Sharing								
30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
$0	$0	$0	$4	$8	$8	$2	$4	$4
$4	$8	$8	$8	$16	$16	$4	$8	$8
23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $35)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $70)	23% of the cost (Insulin: $30)	23% of the cost (Insulin: $60)	23% of the cost (Insulin: $60)
50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)	50% of the cost (Insulin: $35)	50% of the cost (Insulin: $70)	50% of the cost (Insulin: $105)
33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Tufts Medicare Preferred **HMO Value Rx**	Tufts Medicare Preferred **HMO Prime Rx**	Tufts Medicare Preferred **HMO Prime Rx Plus**
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.		

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Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Analgesics		
JOURNAVX	4	QL(30 EA per 90 days)
Nonsteroidal Anti-inflammatory Drugs		
celecoxib caps 100mg, 200mg, 50mg	2	
celecoxib caps 400mg	3	
diclofenac epolamine	4	QL(60 EA per 30 days); PA
diclofenac potassium tabs 50mg	3	
diclofenac sodium dr tbec 50mg, 75mg	2	
diclofenac sodium dr tbec 25mg	4	
diclofenac sodium er	4	
diclofenac sodium gel 1%	3	QL(960 GM per 30 days)
diclofenac sodium external soln 1.5%	4	
diflunisal tabs 500mg	4	
ec-naproxen tbec 500mg	4	
etodolac er	4	
etodolac tabs	2	
etodolac caps	3	
flurbiprofen tabs 100mg	3	
ibu	1	
ibuprofen susp	2	
ibuprofen tabs 400mg, 600mg, 800mg	1	
indomethacin caps 25mg, 50mg	2	
meloxicam tabs	1	
nabumetone tabs	2	
naproxen dr	4	
naproxen sodium cr tb24 375mg	4	
naproxen sodium tabs 275mg, 550mg	2	
naproxen susp	4	
naproxen tabs 250mg, 375mg, 500mg	1	
naproxen tbec 500mg	4	
oxaprozin tabs	2	
piroxicam caps	3	
salsalate tabs	2	
sulindac tabs	2	
Opioid Analgesics, Long-acting		
buprenorphine	4	QL(4 EA per 28 days)
fentanyl pt72 100mcg/hr, 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr	4	QL(10 EA per 30 days)
hydromorphone hcl er tb24 12mg, 16mg, 8mg	4	QL(30 EA per 30 days)
methadone hcl tabs	2	QL(120 EA per 30 days)
methadone hcl soln 5mg/5ml	3	QL(1200 ML per 30 days)
methadone hydrochloride soln 10mg/5ml	3	QL(600 ML per 30 days)

Drug Name	Drug Tier	Requirements/Limits
morphine sulfate er tbcr	2	QL(60 EA per 30 days)
tramadol hydrochloride er	4	QL(30 EA per 30 days)
Opioid Analgesics, Short-acting		
acetaminophen/codeine phosphate tabs 300mg; 60mg	2	QL(240 EA per 30 days)
acetaminophen/codeine soln	2	QL(3600 ML per 30 days)
acetaminophen/codeine tabs 300mg; 15mg, 300mg; 30mg, 300mg; 60mg	2	QL(240 EA per 30 days)
butorphanol tartrate soln	4	QL(7.5 ML per 30 days)
codeine sulfate tabs 15mg	3	QL(180 EA per 30 days)
codeine sulfate tabs 30mg, 60mg	4	QL(180 EA per 30 days)
endocet tabs 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	2	QL(240 EA per 30 days)
fentanyl citrate oral transmucosal lpop 200mcg	4	QL(120 EA per 30 days); PA
fentanyl citrate oral transmucosal lpop 1200mcg, 1600mcg, 400mcg, 600mcg, 800mcg	5	QL(120 EA per 30 days); PA; NEDS SP
hydrocodone bitartrate/acetaminophen soln 325mg/15ml; 7.5mg/15ml	2	QL(3600 ML per 30 days)
hydrocodone bitartrate/acetaminophen tabs 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg, 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg	2	QL(240 EA per 30 days)
hydrocodone/acetaminophen tabs 325mg; 7.5mg	2	QL(240 EA per 30 days)
hydromorphone hcl liqd	3	QL(1350 ML per 30 days)
hydromorphone hcl tabs 8mg	2	QL(120 EA per 30 days)
hydromorphone hcl tabs 2mg, 4mg	2	QL(240 EA per 30 days)
morphine sulfate tabs	2	QL(180 EA per 30 days)
morphine sulfate soln 100mg/5ml	3	QL(180 ML per 30 days)
morphine sulfate soln 10mg/5ml, 20mg/5ml	3	QL(900 ML per 30 days)
oxycodone hydrochloride soln	2	QL(2400 ML per 30 days)
oxycodone hydrochloride caps	3	QL(240 EA per 30 days)
oxycodone hydrochloride conc	4	QL(120 ML per 30 days)
oxycodone hydrochloride tabs 20mg, 30mg	2	QL(120 EA per 30 days)
oxycodone hydrochloride tabs 10mg, 15mg	2	QL(180 EA per 30 days)
oxycodone hydrochloride tabs 5mg	2	QL(240 EA per 30 days)
oxycodone/acetaminophen tabs 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	2	QL(240 EA per 30 days)
tramadol hydrochloride/acetaminophen	2	QL(240 EA per 30 days)
tramadol hydrochloride tabs 50mg	1	QL(240 EA per 30 days)
tramadol hydrochloride tabs 100mg	4	QL(120 EA per 30 days)
Anesthetics		
Local Anesthetics		
glydo	2	QL(100 ML per 30 days)
lidocaine hcl jelly prsy	2	QL(100 ML per 30 days)
lidocaine hcl prsy	2	QL(100 ML per 30 days)
lidocaine hcl inj 0.5%, 1.5%, 4%	2	

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Drug Name	Drug Tier	Requirements/Limits
lidocaine hydrochloride jelly	2	QL(100 ML per 30 days)
lidocaine hydrochloride external soln	3	QL(100 ML per 30 days)
lidocaine hydrochloride inj 1%, 2%	2	
lidocaine/prilocaine crea	3	QL(60 GM per 30 days)
lidocaine oint 5%	3	QL(100 GM per 30 days)
lidocaine ptch 5%	4	QL(90 EA per 30 days); PA
premium lidocaine	3	QL(100 GM per 30 days)
Anti-Addiction/Substance Abuse Treatment Agents		
Alcohol Deterrents/Anti-craving		
acamprosate calcium dr	4	
disulfiram tabs	4	
naltrexone hydrochloride tabs	2	
VIVITROL	5	NEDS SP
Opioid Dependence		
buprenorphine hcl/naloxone hcl subl 2mg; 0.5mg	2	QL(360 EA per 30 days)
buprenorphine hcl/naloxone hcl subl 8mg; 2mg	2	QL(90 EA per 30 days)
buprenorphine hcl subl 2mg	2	QL(360 EA per 30 days)
buprenorphine hcl subl 8mg	2	QL(90 EA per 30 days)
buprenorphine hydrochloride/naloxone hydrochloride film 4mg; 1mg	2	QL(180 EA per 30 days)
buprenorphine hydrochloride/naloxone hydrochloride film 2mg; 0.5mg	2	QL(360 EA per 30 days)
buprenorphine hydrochloride/naloxone hydrochloride film 12mg; 3mg, 8mg; 2mg	2	QL(90 EA per 30 days)
Opioid Reversal Agents		
naloxone hcl inj 4mg/10ml	2	
naloxone hydrochloride liqd	3	QL(4 EA per 30 days)
naloxone hydrochloride inj 0.4mg/ml, 4mg/10ml	2	
naloxone hydrochloride inj 2mg/2ml	3	
naloxone hydrochloride inj 0.4mg/ml	4	
OPVEE	3	QL(4 EA per 30 days)
Smoking Cessation Agents		
bupropion hydrochloride er (sr) tb12 150mg	3	
NICOTROL INHALER	4	
NICOTROL NS	4	
TYRVAYA	4	
varenicline starting month	4	QL(53 EA per 28 days)
varenicline tartrate tabs 1mg	3	QL(60 EA per 30 days)
varenicline tartrate tabs 0.5mg, 1mg	4	QL(60 EA per 30 days)
Antibacterials		
Aminoglycosides		
amikacin sulfate inj 1gm/4ml, 500mg/2ml	4	HI
ARIKAYCE	5	PA; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
gentamicin sulfate/0.9% sodium chloride inj 1.2mg/ml; 0.9%, 1.6mg/ml; 0.9%, 1mg/ml; 0.9%, 2mg/ml; 0.9%	4	HI
gentamicin sulfate crea 0.1%	3	
gentamicin sulfate inj 40mg/ml	4	HI
gentamicin sulfate oint 0.1%	2	
isotonic gentamicin inj 0.8mg/ml; 0.9%	4	HI
neomycin sulfate	2	
streptomycin sulfate inj 1gm	5	NEDS SP
tobramycin sulfate inj 1.2gm/30ml, 40mg/ml	2	HI
tobramycin sulfate inj 10mg/ml, 80mg/2ml	4	HI
Antibacterials, Other		
aztreonam inj 1gm	4	HI
aztreonam inj 2gm	5	NEDS SP; HI
clindacin-p	3	
clindamycin hcl caps 300mg	2	
clindamycin hydrochloride caps 150mg, 75mg	2	
clindamycin palmitate hydrochloride	4	
clindamycin phosphate crea 2%	4	
clindamycin phosphate inj 9000mg/60ml	2	HI
clindamycin phosphate inj 300mg/2ml, 600mg/4ml, 900mg/6ml	4	HI
clindamycin phosphate swab 1%	3	
colistimethate sodium	5	NEDS SP; HI
daptomycin	5	NEDS SP; HI
daptomycin/sodium chloride	4	HI
IMPAVIDO	5	NEDS SP
linezolid tabs	4	
linezolid susr	5	NEDS SP
linezolid inj 600mg/300ml	4	HI
methenamine hippurate	4	
methenamine mandelate tabs 0.5gm, 1gm	2	
metronidazole vaginal	3	
metronidazole inj 500mg/100ml	2	HI
metronidazole tabs 250mg, 500mg	2	
nitrofurantoin macrocrystals	4	
nitrofurantoin monohydrate/macrocrystals	2	
NUVESSA	4	
tigecycline	5	NEDS SP
tinidazole	4	
trimethoprim tabs	3	
vancomycin hcl inj 0.9%; 1gm/200ml	2	HI
vancomycin hcl inj 100gm, 10gm	4	HI
vancomycin hydrochloride caps	3	

Drug Name	Drug Tier	Requirements/Limits
vancomycin hydrochloride inj 1.25gm, 1.5gm, 1.75gm, 1gm, 2gm, 500mg, 5gm, 750mg	4	HI
vancomycin inj 0.9%; 500mg/100ml, 0.9%; 750mg/150ml	2	HI
Beta-lactam, Cephalosporins		
cefaclor caps	4	
cefaclor susr 125mg/5ml, 375mg/5ml	2	
cefadroxil caps	2	
cefadroxil susr	4	
cefazolin sodium/dextrose inj 1gm; 4%, 2gm; 3%, 3gm; 2%	2	HI
cefazolin sodium inj 1gm/50ml; 4%, 1gm, 2gm	2	HI
cefazolin sodium inj 10gm, 500mg	3	HI
cefazolin sodium inj 1gm	4	HI
cefazolin/dextrose inj 3gm/150ml; 4%	2	HI
cefazolin inj 2gm/100ml; 4%, 2gm, 3gm	2	HI
cefdinir	2	
cefepime	4	HI
cefepime hydrochloride inj 2gm	4	HI
cefepime/dextrose	4	HI
cefixime	4	
cefotetan inj 1gm, 2gm	4	HI
cefoxitin sodium inj 10gm, 1gm, 2gm	4	HI
cefpodoxime proxetil tabs	3	
cefpodoxime proxetil susr	4	
cefprozil tabs	3	
cefprozil susr 125mg/5ml	3	
cefprozil susr 250mg/5ml	4	
ceftazidime inj 1gm, 2gm, 6gm	4	HI
ceftriaxone in iso-osmotic dextrose	2	HI
ceftriaxone sodium inj 10gm, 1gm, 250mg, 2gm, 500mg	4	HI
ceftriaxone/dextrose inj 1gm; 3.74%	2	HI
cefuroxime axetil tabs	2	
cefuroxime sodium inj 1.5gm, 750mg	4	HI
cephalexin caps 250mg, 500mg	2	
cephalexin caps 750mg	4	
cephalexin susr, tabs	3	
tazicef inj 1gm, 2gm, 6gm	4	HI
TEFLARO	5	NEDS SP; HI
Beta-lactam, Penicillins		
amoxicillin/clavulanate potassium er	4	
amoxicillin/clavulanate potassium susr, tabs	2	
amoxicillin/clavulanate potassium chew	4	
amoxicillin chew 125mg, 250mg	2	
amoxicillin caps, susr, tabs	2	
ampicillin sodium inj	4	HI

Drug Name	Drug Tier	Requirements/Limits
ampicillin-sulbactam inj 10gm; 5gm, 1gm; 0.5gm	4	HI
ampicillin/sulbactam inj 2gm; 1gm	4	HI
ampicillin caps 500mg	2	
BICILLIN L-A INJ 1200000UNIT/2ML, 2400000UNIT/4ML, 600000UNIT/ML	4	
dicloxacillin sodium	3	
nafcillin sodium inj 10gm, 1gm, 2gm	4	HI
oxacillin sodium inj 10gm, 1gm, 2gm	4	HI
penicillin g potassium in iso-osmotic dextrose inj 0; 20000unit/ml	2	HI
penicillin g potassium inj 20000000unit, 5000000unit	4	HI
penicillin g sodium	5	NEDS SP; HI
penicillin v potassium	2	
piperacillin sodium/tazobactam sodium	4	HI
ZOSYN INJ 5%; 4GM/100ML; 0.5GM/100ML	3	HI
Carbapenems		
ertapenem sodium	4	HI
imipenem/cilastatin	4	HI
meropenem inj 500mg	3	HI
meropenem inj 1gm, 2gm	4	HI
Macrolides		
azithromycin tabs	2	
azithromycin pack, susr	3	
azithromycin inj 500mg	4	HI
clarithromycin er	3	
clarithromycin tabs	1	
clarithromycin susr	4	
DIFICID	5	NEDS SP
erythromycin dr	4	
erythromycin ethylsuccinate tabs	4	
fidaxomicin	5	NEDS SP
Quinolones		
ciprofloxacin hcl tabs 100mg, 750mg	1	
ciprofloxacin hydrochloride tabs 250mg, 500mg	1	
ciprofloxacin i.v.-in d5w	4	HI
ciprofloxacin susr 500mg/5ml, 5gm/100ml	4	
levofloxacin in d5w inj 5%; 250mg/50ml, 5%; 500mg/100ml	3	HI
levofloxacin in d5w inj 5%; 750mg/150ml	4	HI
levofloxacin oral soln 25mg/ml	4	
levofloxacin tabs 250mg, 500mg, 750mg	2	
moxifloxacin hydrochloride/sodium hydrochloride	4	HI
moxifloxacin hydrochloride tabs 400mg	2	
Sulfonamides		
sulfacetamide sodium lotn 10%	4	

Drug Name	Drug Tier	Requirements/Limits
sulfadiazine tabs	4	
sulfamethoxazole/trimethoprim ds	1	
sulfamethoxazole/trimethoprim tabs	1	
sulfamethoxazole/trimethoprim susp	3	
Tetracyclines		
DOXY 100	3	HI
doxycycline hyclate caps	2	
doxycycline hyclate inj	3	HI
doxycycline hyclate tabs 100mg, 20mg	2	
doxycycline hyclate tabs 150mg	4	
doxycycline monohydrate caps 100mg, 50mg	2	
doxycycline monohydrate tabs	2	
doxycycline susr	4	
minocycline hcl caps 75mg	3	
minocycline hcl tabs 100mg, 75mg	4	
minocycline hydrochloride caps 100mg, 50mg	3	
minocycline hydrochloride tabs 50mg	4	
mondoxyne nl caps 100mg	2	
tetracycline hydrochloride caps	3	
VIBRAMYCIN SYRP	4	
Anticonvulsants		
Anticonvulsants, Other		
BRIVIACT SOLN, TABS	5	NEDS SP
EPIDIOLEX	5	PA NSO; NEDS SP
EPRONTIA	4	
felbamate	4	
FINTEPLA	5	PA NSO; NEDS SP
FYCOMPA	4	
lamotrigine er	4	
lamotrigine odt	4	
lamotrigine starter kit/blue	4	
lamotrigine starter kit/green	4	
lamotrigine starter kit/orange	4	
lamotrigine tabs	2	
lamotrigine chew	3	
levetiracetam er	4	
levetiracetam inj	2	
levetiracetam oral soln, tabs	3	
levetiracetam tb3d	4	
NAYZILAM	4	QL(10 EA per 30 days); PA NSO
perampanel	4	
roweepra tabs 500mg	3	
SPRITAM	4	
subvenite	2	

Drug Name	Drug Tier	Requirements/Limits
subvenite starter kit/blue	4	
subvenite starter kit/green	4	
subvenite starter kit/orange	4	
topiramate tabs	2	
topiramate cpsp, soln	4	
valproic acid	2	
Calcium Channel Modifying Agents		
ethosuximide soln	3	
ethosuximide caps	4	
methsuximide	3	
Gamma-aminobutyric Acid (GABA) Modulating Agents		
clobazam susp	3	
clobazam tabs	3	QL(60 EA per 30 days)
clonazepam odt	3	
clonazepam tabs	1	
DIACOMIT	5	PA NSO; NEDS SP
diazepam rectal gel	4	
divalproex sodium dr tbec	2	
divalproex sodium dr csdr	3	
divalproex sodium er	3	
gabapentin caps	2	
gabapentin soln	4	
gabapentin tabs 600mg, 800mg	2	
LIBERVANT	4	QL(10 EA per 30 days)
phenobarbital elix 20mg/5ml	3	
phenobarbital tabs 100mg, 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg	2	
pregabalin caps	2	
pregabalin soln	4	
primidone tabs	2	
SYMPAZAN FILM 5MG	4	
SYMPAZAN FILM 10MG, 20MG	5	NEDS SP
tiagabine hydrochloride	4	
VALTOCO 10 MG DOSE	5	QL(10 EA per 30 days); PA NSO; NEDS SP
VALTOCO 15 MG DOSE	5	QL(10 EA per 30 days); PA NSO; NEDS SP
VALTOCO 20 MG DOSE	5	QL(10 EA per 30 days); PA NSO; NEDS SP
VALTOCO 5 MG DOSE	5	QL(10 EA per 30 days); PA NSO; NEDS SP
vigabatrin	5	NEDS SP
vigadrone	5	NEDS SP
VIGAFYDE	5	PA NSO; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
vigpoder	5	NEDS SP
ZTALMY	5	PA NSO; NEDS SP
Sodium Channel Agents		
APTIOM	4	
carbamazepine er	4	
carbamazepine chew 100mg	3	
carbamazepine tabs	3	
carbamazepine susp	4	
epitol	3	
eslicarbazepine acetate	4	
lacosamide tabs	3	QL(60 EA per 30 days)
lacosamide inj, oral soln	4	
oxcarbazepine tabs	3	
oxcarbazepine susp	4	
phenytek	2	
phenytoin sodium extended	2	
phenytoin chew, susp	2	
rufinamide susp	5	NEDS SP
rufinamide tabs 200mg	4	
rufinamide tabs 400mg	5	NEDS SP
XCOPRI TABS	5	NEDS SP
XCOPRI TBPK 0	4	
XCOPRI TBPK 0	5	NEDS SP
ZONISADE	4	
zonisamide	2	
Antidementia Agents		
Antidementia Agents, Other		
memantine/donepezil hydrochloride er	3	
NAMZARIC	3	
Cholinesterase Inhibitors		
donepezil hcl tbdp	3	
donepezil hcl tabs 10mg	2	
donepezil hcl tabs 23mg	3	
donepezil hydrochloride tabs 5mg	2	
galantamine hydrobromide er	3	
galantamine hydrobromide tabs	3	
galantamine hydrobromide soln	4	
rivastigmine tartrate	3	
rivastigmine transdermal system	4	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hcl titration pak	2	
memantine hydrochloride er	3	
memantine hydrochloride tabs	2	
memantine hydrochloride soln	3	

Drug Name	Drug Tier	Requirements/Limits
Antidepressants		
Antidepressants, Other		
AUVELITY	4	
bupropion hydrochloride er (sr) tb12 100mg, 150mg, 200mg	2	
bupropion hydrochloride er (xl) tb24 150mg, 300mg	2	
bupropion hydrochloride tabs	2	
mirtazapine odt	3	
mirtazapine tabs	2	
ZURZUVAE CAPS 30MG	5	QL(14 EA per 14 days); PA NSO; NEDS SP
ZURZUVAE CAPS 20MG, 25MG	5	QL(28 EA per 14 days); PA NSO; NEDS SP
Monoamine Oxidase Inhibitors		
EMSAM	5	ST NSO; NEDS SP
MARPLAN	4	
phenelzine sulfate	3	
tranylcypromine sulfate	4	
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		
citalopram hydrobromide tabs	1	
citalopram hydrobromide soln	4	
desvenlafaxine er	3	
DRIZALMA SPRINKLE CSDR 20MG, 60MG	4	QL(60 EA per 30 days)
DRIZALMA SPRINKLE CSDR 30MG, 40MG	4	QL(90 EA per 30 days)
duloxetine hydrochloride dr cpep 20mg, 60mg	2	QL(60 EA per 30 days)
duloxetine hydrochloride dr cpep 30mg	2	QL(90 EA per 30 days)
duloxetine hydrochloride dr cpep 40mg	4	QL(90 EA per 30 days)
escitalopram oxalate tabs	2	
escitalopram oxalate soln	4	
FETZIMA	4	ST NSO
FETZIMA TITRATION PACK	4	ST NSO
fluoxetine dr	4	
fluoxetine hydrochloride caps	1	
fluoxetine hydrochloride soln	4	
fluvoxamine maleate	3	
nefazodone hydrochloride	4	
paroxetine hcl tabs 30mg, 40mg	2	
paroxetine hydrochloride susp	4	
paroxetine hydrochloride tabs 10mg, 20mg	2	
RALDESY	5	NEDS SP
sertraline hcl conc	3	
sertraline hcl tabs 50mg	1	
sertraline hydrochloride tabs 100mg, 25mg	1	
trazodone hydrochloride	2	

Drug Name	Drug Tier	Requirements/Limits
TRINTELLIX	4	
venlafaxine hydrochloride	2	
venlafaxine hydrochloride er cp24	3	
venlafaxine hydrochloride er tb24 37.5mg	3	
VIIBRYD STARTER PACK	4	
vilazodone hydrochloride	4	
Tricyclics		
amitriptyline hcl tabs 100mg, 150mg, 25mg, 75mg	2	
amitriptyline hydrochloride tabs 100mg, 10mg, 25mg, 50mg, 75mg	2	
amoxapine	3	
clomipramine hydrochloride	3	
desipramine hydrochloride	4	
doxepin hcl caps 75mg	3	
doxepin hcl conc	2	
doxepin hydrochloride caps 100mg, 10mg, 150mg, 25mg, 50mg	3	
imipramine hcl tabs 25mg, 50mg	2	
imipramine hydrochloride tabs 10mg	2	
nortriptyline hcl caps 25mg, 75mg	2	
nortriptyline hcl soln	4	
nortriptyline hydrochloride caps 10mg, 50mg	2	
protriptyline hcl	4	
trimipramine maleate caps	4	
Antiemetics		
Antiemetics, Other		
meclizine hcl tabs	4	
prochlorperazine edisylate inj 10mg/2ml	2	
prochlorperazine maleate tabs	2	
prochlorperazine supp 25mg	4	
promethazine hcl inj	2	
promethazine hydrochloride plain	2	
promethazine hydrochloride tabs	2	
scopolamine	4	
Emetogenic Therapy Adjuncts		
aprepitant caps 0, 40mg, 80mg	4	PA BvD
aprepitant caps 125mg	5	PA BvD; NEDS SP
dronabinol	4	PA BvD
granisetron hydrochloride tabs	3	PA BvD
ondansetron hcl soln	2	PA BvD
ondansetron hcl tabs 24mg	2	PA BvD
ondansetron hydrochloride tabs	2	PA BvD
ondansetron odt tbdp 4mg, 8mg	2	PA BvD
Antifungals		

Drug Name	Drug Tier	Requirements/Limits
Antifungals		
ABELCET	4	PA
amphotericin b liposome	5	PA; NEDS SP
amphotericin b inj	4	PA
clotrimazole crea	2	
clotrimazole soln, troc	3	
econazole nitrate crea	2	
fluconazole in sodium chloride	4	
fluconazole tabs	2	
fluconazole susr	4	
flucytosine caps	5	NEDS SP
griseofulvin microsize	4	
griseofulvin ultramicrosize tabs 125mg, 250mg	4	
itraconazole caps	3	
ketoconazole sham, tabs	2	
ketoconazole crea	2	QL(120 GM per 30 days)
klayesta	2	
micafungin	4	
miconazole 3 supp	3	
naftifine hydrochloride crea	4	
nyamyc	2	
nystatin crea, oint, powd, susp	2	
nystatin tabs	3	
nystop	2	
posaconazole dr	5	NEDS SP
posaconazole susp	5	NEDS SP
terbinafine hcl tabs	2	QL(42 EA per 42 days)
terconazole crea	3	
terconazole supp	4	
voriconazole tabs	4	
voriconazole susr	5	NEDS SP
voriconazole inj	5	PA; NEDS SP
Antigout Agents		
Antigout Agents		
allopurinol tabs 100mg, 300mg	2	
colchicine caps	3	
colchicine tabs 0.6mg	3	
GLOPERBA	4	
probenecid/colchicine	3	
probenecid tabs	3	
Antimigraine Agents		
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists		
AIMOVIG	3	QL(1 ML per 30 days); PA
EMGALITY INJ 120MG/ML	3	QL(2 ML per 30 days); PA

Drug Name	Drug Tier	Requirements/Limits
EMGALITY INJ 100MG/ML	3	QL(3 ML per 30 days); PA
NURTEC	4	PA
UBRELVY	4	PA
Ergot Alkaloids		
dihydroergotamine mesylate soln	5	QL(8 ML per 30 days); NEDS SP
ergotamine tartrate/caffeine	3	
Prophylactic		
timolol maleate tabs 10mg, 5mg	3	
timolol maleate tabs 20mg	4	
Serotonin (5-HT) Receptor Agonist		
naratriptan hcl	2	
rizatriptan benzoate	2	
rizatriptan benzoate odt	2	
sumatriptan succinate refill inj 6mg/0.5ml	3	
sumatriptan succinate tabs	2	
sumatriptan succinate inj 6mg/0.5ml	3	
sumatriptan succinate inj 4mg/0.5ml, 6mg/0.5ml	4	
sumatriptan soln	4	
Antimyasthenic Agents		
Parasympathomimetics		
pyridostigmine bromide er tbcr	4	
pyridostigmine bromide tabs 60mg	3	
Antimycobacterials		
Antimycobacterials, Other		
dapsone tabs	3	
rifabutin	4	
Antituberculars		
ethambutol hydrochloride	3	
isoniazid tabs	1	
isoniazid syrp	4	
PRIFTIN	4	
pyrazinamide tabs	4	
rifampin caps, inj	4	
SIRTURO	5	PA; NEDS SP
TRECATOR	4	
Antineoplastics		
Alkylating Agents		
cyclophosphamide tabs	3	PA BvD
cyclophosphamide caps	4	PA BvD
GLEOSTINE CAPS 100MG, 10MG, 40MG	4	
LEUKERAN	5	NEDS SP
MATULANE	5	NEDS SP
VALCHLOR	5	NEDS SP
Antiandrogens		

Drug Name	Drug Tier	Requirements/Limits
abiraterone acetate	5	PA NSO; NEDS SP
ABIRTEGA	4	PA NSO
bicalutamide	2	
ERLEADA	5	PA NSO; NEDS SP
EULEXIN	4	
flutamide	2	
nilutamide	5	NEDS SP
NUBEQA	5	PA NSO; NEDS SP
XTANDI	5	PA NSO; NEDS SP
Antiangiogenic Agents		
lenalidomide	5	PA NSO; NEDS SP
POMALYST	5	PA NSO; NEDS SP
REVLIMID	5	PA NSO; NEDS SP
THALOMID	5	NEDS SP
Antiestrogens/Modifiers		
EMCYT	5	NEDS SP
ORSERDU	5	PA NSO; NEDS SP
SOLTAMOX	5	NEDS SP
tamoxifen citrate tabs	3	
toremifene citrate	5	NEDS SP
Antimetabolites		
DROXIA	3	
hydroxyurea caps	3	
mercaptopurine tabs	4	
mercaptopurine susp	5	NEDS SP
PURIXAN	5	NEDS SP
TABLOID	4	
Antineoplastics, Other		
AKEEGA	5	PA NSO; NEDS SP
bortezomib inj 1mg, 2.5mg	4	
bortezomib inj 3.5mg/1.4ml, 3.5mg	5	NEDS SP
boruzu	4	
docetaxel inj 160mg/8ml, 20mg/ml, 80mg/4ml	4	
IBRANCE TABS 100MG, 125MG, 75MG	5	PA NSO; NEDS SP
INREBIC	5	PA NSO; NEDS SP
ITOVEBI TABS 9MG	5	PA NSO; NEDS SP
ITOVEBI TABS 3MG	5	QL(60 EA per 30 days); PA NSO; NEDS SP
IWILFIN	5	PA NSO; NEDS SP
KISQALI FEMARA 200 DOSE	5	PA NSO; NEDS SP
KISQALI FEMARA 400 DOSE	5	PA NSO; NEDS SP
KISQALI FEMARA 600 DOSE	5	PA NSO; NEDS SP
LAZCLUZE TABS 240MG	5	PA NSO; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
LAZCLUZE TABS 80MG	5	QL(60 EA per 30 days); PA NSO; NEDS SP
leucovorin calcium tabs	2	
LONSURF	5	PA NSO; NEDS SP
LYSODREN	5	NEDS SP
MODEYSO	5	PA NSO; NEDS SP
OGSIVEO	5	PA NSO; NEDS SP
OJEMDA	5	PA NSO; NEDS SP
ONUREG	5	PA NSO; NEDS SP
paclitaxel inj 100mg/16.7ml, 150mg/25ml, 300mg/50ml, 30mg/5ml	2	
REVUFORJ	5	PA NSO; NEDS SP
SYNRIBO	5	NEDS SP
TRUSELTIQ	5	PA NSO; NEDS SP
VONJO	5	PA NSO; NEDS SP
ZOLINZA	5	PA NSO; NEDS SP
Aromatase Inhibitors, 3rd Generation		
anastrozole tabs	3	
exemestane	4	
letrozole	3	
Enzyme Inhibitors		
AVMAPKI FAKZYNJA CO-PACK	5	PA NSO; NEDS SP
KYPROLIS	5	NEDS SP
Molecular Target Inhibitors		
ALECENSA	5	PA NSO; NEDS SP
ALUNBRIG	5	PA NSO; NEDS SP
AUGTYRO	5	PA NSO; NEDS SP
AYVAKIT	5	QL(30 EA per 30 days); PA NSO; NEDS SP
BALVERSA	5	PA NSO; NEDS SP
BOSULIF CAPS 50MG	5	PA NSO; NEDS SP
BOSULIF CAPS 100MG	5	QL(120 EA per 30 days); PA NSO; NEDS SP
BOSULIF TABS 100MG	5	QL(120 EA per 30 days); PA NSO; NEDS SP
BOSULIF TABS 400MG, 500MG	5	QL(30 EA per 30 days); PA NSO; NEDS SP
BRAFTOVI CAPS 75MG	5	PA NSO; NEDS SP
BRUKINSA CAPS	5	PA NSO; NEDS SP
BRUKINSA TABS	5	PA; NEDS SP
CABOMETYX	5	PA NSO; NEDS SP
CALQUENCE	5	PA NSO; NEDS SP
CAPRELSA TABS 300MG	5	QL(30 EA per 30 days); PA NSO; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
CAPRELSA TABS 100MG	5	QL(60 EA per 30 days); PA NSO; NEDS SP
COMETRIQ	5	PA NSO; NEDS SP
COPIKTRA	5	PA NSO; NEDS SP
COTELLIC	5	PA NSO; NEDS SP
DANZITEN	5	PA NSO; NEDS SP
dasatinib	5	PA NSO; NEDS SP
DAURISMO	5	PA NSO; NEDS SP
ERIVEDGE	5	PA NSO; NEDS SP
erlotinib hydrochloride tabs 150mg, 25mg	5	QL(30 EA per 30 days); NEDS SP
erlotinib hydrochloride tabs 100mg	5	QL(90 EA per 30 days); NEDS SP
everolimus tabs 10mg, 2.5mg, 5mg, 7.5mg	5	QL(30 EA per 30 days); PA NSO; NEDS SP
everolimus tbso 2mg, 3mg, 5mg	5	QL(60 EA per 30 days); PA NSO; NEDS SP
EXKIVITY	5	PA NSO; NEDS SP
FOTIVDA	5	PA NSO; NEDS SP
FRUZAQLA	5	PA NSO; NEDS SP
GAVRETO	5	PA NSO; NEDS SP
gefitinib	5	PA NSO; NEDS SP
GILOTRIF	5	PA NSO; NEDS SP
GOMEKLI	5	PA NSO; NEDS SP
HERNEXEOS	5	PA NSO; NEDS SP
IBRANCE CAPS 100MG, 125MG, 75MG	5	PA NSO; NEDS SP
IBTROZI	5	PA NSO; NEDS SP
ICLUSIG	5	PA NSO; NEDS SP
IDHIFA	5	QL(30 EA per 30 days); PA NSO; NEDS SP
imatinib mesylate tabs	5	NEDS SP
IMBRUVICA	5	PA NSO; NEDS SP
IMKELDI	5	PA NSO; NEDS SP
INLYTA	5	PA NSO; NEDS SP
INQOVI	5	PA NSO; NEDS SP
JAKAFI	5	PA NSO; NEDS SP
JAYPIRCA	5	PA NSO; NEDS SP
KISQALI	5	PA NSO; NEDS SP
KOSELUGO	5	PA NSO; NEDS SP
KRAZATI	5	PA NSO; NEDS SP
lapatinib ditosylate	5	QL(180 EA per 30 days); PA NSO; NEDS SP
LENVIMA 10 MG DAILY DOSE	5	PA NSO; NEDS SP
LENVIMA 12MG DAILY DOSE	5	PA NSO; NEDS SP
LENVIMA 14 MG DAILY DOSE	5	PA NSO; NEDS SP
LENVIMA 18 MG DAILY DOSE	5	PA NSO; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
LENVIMA 20 MG DAILY DOSE	5	PA NSO; NEDS SP
LENVIMA 24 MG DAILY DOSE	5	PA NSO; NEDS SP
LENVIMA 4 MG DAILY DOSE	5	PA NSO; NEDS SP
LENVIMA 8 MG DAILY DOSE	5	PA NSO; NEDS SP
LORBRENA	5	PA NSO; NEDS SP
LUMAKRAS	5	PA NSO; NEDS SP
LYNPARZA TABS	5	PA NSO; NEDS SP
LYTGOBI	5	PA NSO; NEDS SP
MEKINIST	5	PA NSO; NEDS SP
MEKTOVI	5	PA NSO; NEDS SP
NERLYNX	5	PA NSO; NEDS SP
nilotinib hydrochloride	5	PA NSO; NEDS SP
NINLARO	5	PA NSO; NEDS SP
ODOMZO	5	PA NSO; NEDS SP
OJJAARA	5	PA NSO; NEDS SP
pazopanib hydrochloride tabs 200mg	5	QL(120 EA per 30 days); PA NSO; NEDS SP
PEMAZYRE	5	PA NSO; NEDS SP
PIQRAY 200MG DAILY DOSE	5	PA NSO; NEDS SP
PIQRAY 250MG DAILY DOSE	5	PA NSO; NEDS SP
PIQRAY 300MG DAILY DOSE	5	PA NSO; NEDS SP
QINLOCK	5	PA NSO; NEDS SP
RETEVMO CAPS	5	PA NSO; NEDS SP
RETEVMO TABS 120MG, 160MG	5	PA NSO; NEDS SP
RETEVMO TABS 80MG	5	QL(60 EA per 30 days); PA NSO; NEDS SP
RETEVMO TABS 40MG	5	QL(90 EA per 30 days); PA NSO; NEDS SP
REZLIDHIA	5	PA NSO; NEDS SP
ROMVIMZA	5	PA NSO; NEDS SP
ROZLYTREK	5	PA NSO; NEDS SP
RUBRACA	5	QL(120 EA per 30 days); PA NSO; NEDS SP
RYDAPT	5	PA NSO; NEDS SP
SCEMBLIX TABS 20MG, 40MG	5	PA NSO; NEDS SP
SCEMBLIX TABS 100MG	5	QL(120 EA per 30 days); PA NSO; NEDS SP
sorafenib	5	QL(220 EA per 30 days); PA NSO; NEDS SP
sorafenib tosylate	5	QL(220 EA per 30 days); PA NSO; NEDS SP
SPRYCEL	5	PA NSO; NEDS SP
STIVARGA	5	QL(90 EA per 30 days); PA NSO; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
sunitinib malate	5	PA NSO; NEDS SP
TABRECTA	5	PA NSO; NEDS SP
TAFINLAR	5	PA NSO; NEDS SP
TAGRISSO	5	PA NSO; NEDS SP
TALZENNA	5	PA NSO; NEDS SP
TASIGNA	5	PA NSO; NEDS SP
TAZVERIK	5	PA NSO; NEDS SP
TEPMETKO	5	PA NSO; NEDS SP
TIBSOVO	5	PA NSO; NEDS SP
TRUQAP	5	PA NSO; NEDS SP
TUKYSA	5	PA NSO; NEDS SP
TURALIO	5	PA NSO; NEDS SP
VANFLYTA	5	PA NSO; NEDS SP
VENCLEXTA STARTING PACK	5	PA NSO; NEDS SP
VENCLEXTA TABS 10MG, 50MG	3	PA NSO
VENCLEXTA TABS 100MG	5	PA NSO; NEDS SP
VERZENIO	5	PA NSO; NEDS SP
VITRAKVI	5	PA NSO; NEDS SP
VIZIMPRO	5	PA NSO; NEDS SP
XALKORI	5	PA NSO; NEDS SP
XOSPATA	5	PA NSO; NEDS SP
XPOVIO	5	PA NSO; NEDS SP
XPOVIO 60 MG TWICE WEEKLY	5	PA NSO; NEDS SP
XPOVIO 80 MG TWICE WEEKLY	5	PA NSO; NEDS SP
ZEJULA	5	PA NSO; NEDS SP
ZELBORAF	5	PA NSO; NEDS SP
ZYDELIG	5	PA NSO; NEDS SP
ZYKADIA TABS	5	PA NSO; NEDS SP
Monoclonal Antibodies/Antibody-Drug Conjugates		
DARZALEX	5	NEDS SP
OPDIVO	5	NEDS SP
YERVOY	5	NEDS SP
Retinoids		
bexarotene caps	5	NEDS SP
bexarotene gel	5	PA NSO; NEDS SP
PANRETIN	5	NEDS SP
tretinoin caps 10mg	5	NEDS SP
Treatment Adjuncts		
mesna tabs	5	NEDS SP
MESNEX TABS	5	NEDS SP
VORANIGO TABS 40MG	5	PA NSO; NEDS SP
VORANIGO TABS 10MG	5	QL(60 EA per 30 days); PA NSO; NEDS SP
Antiparasitics		

Drug Name	Drug Tier	Requirements/Limits
Anthelmintics		
albendazole tabs	4	
ivermectin tabs	3	
praziquantel tabs	3	
Antiprotozoals		
atovaquone	4	
atovaquone/proguanil hcl tabs 62.5mg; 25mg	4	
atovaquone/proguanil hydrochloride	4	
chloroquine phosphate tabs 250mg	3	
chloroquine phosphate tabs 500mg	4	
COARTEM	4	QL(24 EA per 3 days)
hydroxychloroquine sulfate tabs 200mg	2	
mefloquine hydrochloride	3	
nitazoxanide	4	
pentamidine isethionate inj	4	
pentamidine isethionate inhalation solr	4	PA BvD
primaquine phosphate tabs	4	
pyrimethamine tabs	5	NEDS SP
quinine sulfate caps 324mg	4	PA
Antiparkinson Agents		
Anticholinergics		
benztropine mesylate tabs	2	
trihexyphenidyl hcl soln	3	
trihexyphenidyl hydrochloride	2	
Antiparkinson Agents, Other		
carbidopa/levodopa/entacapone	4	
entacapone	3	
Dopamine Agonists		
bromocriptine mesylate caps, tabs	4	
KYNMOBI	5	NEDS SP
pramipexole dihydrochloride	2	
ropinirole er	4	
ropinirole hcl tabs 0.5mg, 1mg, 2mg, 4mg, 5mg	2	
ropinirole hydrochloride tabs 0.25mg, 3mg	2	
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa	2	
carbidopa/levodopa er tbcr 25mg; 100mg	3	
carbidopa/levodopa er tbcr 50mg; 200mg	4	
carbidopa/levodopa odt	4	
carbidopa tabs	4	
Monoamine Oxidase B (MAO-B) Inhibitors		
rasagiline mesylate tabs	4	
selegiline hcl caps	3	

Drug Name	Drug Tier	Requirements/Limits
selegiline hcl tabs	4	
Antipsychotics		
1st Generation/Typical		
chlorpromazine hcl tabs	4	
chlorpromazine hydrochloride conc, tabs	4	
fluphenazine decanoate inj	4	
fluphenazine hcl conc	4	
fluphenazine hydrochloride	4	
haloperidol decanoate inj	3	
haloperidol lactate	4	
haloperidol conc, tabs	2	
loxapine	3	
molindone hydrochloride	3	
perphenazine tabs	3	
pimozide	4	
thioridazine hydrochloride	3	
thiothixene caps 10mg, 1mg, 2mg, 5mg	4	
trifluoperazine hcl tabs 10mg, 2mg, 5mg	4	
trifluoperazine hydrochloride tabs 1mg	4	
2nd Generation/Atypical		
ABILIFY ASIMTUFII	5	NEDS SP
ABILIFY MAINTENA	5	NEDS SP
ABILIFY MYCITE MAINTENANCE KIT TBPK 10MG	5	QL(30 EA per 30 days); PA NSO; NEDS SP
ABILIFY MYCITE STARTER KIT TBPK 15MG, 20MG, 2MG, 30MG, 5MG	5	QL(30 EA per 30 days); PA NSO; NEDS SP
aripiprazole odt	4	
aripiprazole tabs	2	
aripiprazole soln	3	
ARISTADA	5	NEDS SP
ARISTADA INITIO	5	NEDS SP
asenapine maleate sl	4	ST NSO
CAPLYTA	5	QL(30 EA per 30 days); PA NSO; NEDS SP
FANAPT	5	ST NSO; NEDS SP
FANAPT TITRATION PACK A	4	ST NSO
FANAPT TITRATION PACK B	4	ST NSO
FANAPT TITRATION PACK C	4	ST NSO
INVEGA HAFYERA	5	NEDS SP
INVEGA SUSTENNA INJ 39MG/0.25ML	4	
INVEGA SUSTENNA INJ 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML	5	NEDS SP
INVEGA TRINZA	5	NEDS SP
lurasidone hydrochloride tabs 120mg, 20mg, 40mg, 60mg	4	QL(30 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
lurasidone hydrochloride tabs 80mg	4	QL(60 EA per 30 days)
LYBALVI	5	PA NSO; NEDS SP
NUPLAZID CAPS	5	QL(60 EA per 30 days); PA NSO; NEDS SP
NUPLAZID TABS 10MG	5	QL(60 EA per 30 days); PA NSO; NEDS SP
olanzapine odt	3	
olanzapine tabs	2	
olanzapine inj	3	
OPIPZA	5	PA NSO; NEDS SP
paliperidone er	4	
PERSERIS	5	NEDS SP
quetiapine fumarate tabs 100mg, 150mg, 200mg, 300mg, 400mg	2	
quetiapine fumarate tabs 25mg, 50mg	2	QL(60 EA per 30 days)
REXULTI	5	NEDS SP
RISPERDAL CONSTA INJ 12.5MG, 25MG	4	
RISPERDAL CONSTA INJ 37.5MG, 50MG	5	NEDS SP
risperidone er inj 12.5mg, 25mg	4	
risperidone er inj 37.5mg, 50mg	5	NEDS SP
risperidone odt	3	
risperidone tabs	1	
risperidone soln	3	
SECUADO	5	NEDS SP
VRAYLAR CPPK	4	
VRAYLAR CAPS	5	NEDS SP
ziprasidone hcl	3	
ziprasidone mesylate	3	
ZYPREXA RELPREVV INJ 210MG	3	
ZYPREXA RELPREVV INJ 300MG, 405MG	5	NEDS SP
Treatment-Resistant		
clozapine odt	4	
clozapine tabs 100mg, 200mg, 25mg, 50mg	3	
VERSACLOZ	5	NEDS SP
Antispasticity Agents		
Antispasticity Agents		
baclofen tabs 10mg, 20mg, 5mg	2	
dantrolene sodium caps	4	
tizanidine hcl tabs 2mg	2	
tizanidine hydrochloride tabs 4mg	2	
Antivirals		
Anti-cytomegalovirus (CMV) Agents		
cidofovir	5	NEDS SP
LIVTENCITY	5	PA; NEDS SP

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You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document.

Drug Name	Drug Tier	Requirements/Limits
PREVYMIS TABS	5	PA; NEDS SP
PREVYMIS PACK 20MG	4	PA
PREVYMIS PACK 120MG	5	PA; NEDS SP
valganciclovir	3	
valganciclovir hydrochloride	5	NEDS SP
Anti-hepatitis B (HBV) Agents		
adefovir dipivoxil	4	
entecavir	4	
lamivudine tabs 100mg	3	
VEMLIDY	5	NEDS SP
Anti-hepatitis C (HCV) Agents		
MAVYRET	5	PA; NEDS SP
ribavirin caps	3	
ribavirin tabs 200mg	3	
sofosbuvir/velpatasvir	5	PA; NEDS SP
VOSEVI	5	PA; NEDS SP
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
BIKTARVY	5	NEDS SP
DOVATO	5	NEDS SP
GENVOYA	5	NEDS SP
ISENTRESS HD	5	QL(60 EA per 30 days); NEDS SP
ISENTRESS PACK	4	
ISENTRESS TABS	5	QL(120 EA per 30 days); NEDS SP
ISENTRESS CHEW 25MG	3	QL(720 EA per 30 days)
ISENTRESS CHEW 100MG	5	QL(180 EA per 30 days); NEDS SP
JULUCA	5	NEDS SP
STRIBILD	5	NEDS SP
TIVICAY PD	4	
TIVICAY TABS 10MG	3	
TIVICAY TABS 25MG, 50MG	5	NEDS SP
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
COMPLERA	5	NEDS SP
DELSTRIGO	5	NEDS SP
EDURANT	5	NEDS SP
EDURANT PED	5	NEDS SP
efavirenz	4	
efavirenz/emtricitabine/tenofovir disoproxil fumarate	3	NEDS SP
efavirenz/lamivudine/tenofovir disoproxil fumarate	5	NEDS SP
emtricitabine/rilpivirine/tenofovir disoproxil fumarate	5	NEDS SP
etravirine	5	NEDS SP
INTELENCE TABS 25MG	3	
nevirapine er tb24 100mg	2	
nevirapine er tb24 400mg	4	

Drug Name	Drug Tier	Requirements/Limits
nevirapine tabs	2	
nevirapine susp	4	
PIFELTRO	5	NEDS SP
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
abacavir sulfate/lamivudine	4	
abacavir tabs	3	
abacavir soln	4	
CIMDUO	5	NEDS SP
DESCOVY	5	NEDS SP
emtricitabine	4	
emtricitabine/tenofovir disoproxil	5	NEDS SP
emtricitabine/tenofovir disoproxil fumarate tabs 200mg; 300mg	4	
emtricitabine/tenofovir disoproxil fumarate tabs 100mg; 150mg, 133mg; 200mg	5	NEDS SP
EMTRIVA SOLN	4	
lamivudine/zidovudine	4	
lamivudine soln 10mg/ml	4	
lamivudine tabs 150mg, 300mg	3	
ODEFSEY	5	NEDS SP
tenofovir disoproxil fumarate	4	
TRIUMEQ	5	NEDS SP
TRIUMEQ PD	4	
TRIZIVIR	5	NEDS SP
VIREAD POWD	5	NEDS SP
VIREAD TABS 150MG, 200MG, 250MG	5	NEDS SP
zidovudine	3	
Anti-HIV Agents, Other		
FUZEON	5	NEDS SP
maraviroc tabs 300mg	5	QL(120 EA per 30 days); NEDS SP
maraviroc tabs 150mg	5	QL(60 EA per 30 days); NEDS SP
RUKOBIA	5	NEDS SP
SELZENTRY SOLN	3	QL(1800 ML per 30 days)
SELZENTRY TABS 25MG	4	
SELZENTRY TABS 75MG	5	NEDS SP
SUNLENCA TBPK	5	NEDS SP
SUNLENCA TABS	5	QL(24 EA per 168 days); NEDS SP
TYBOST	3	
Anti-HIV Agents, Protease Inhibitors (PI)		
APTIVUS CAPS	5	NEDS SP
atazanavir	4	
atazanavir sulfate caps 300mg	4	
darunavir	5	NEDS SP

Drug Name	Drug Tier	Requirements/Limits
EVOTAZ	5	NEDS SP
fosamprenavir calcium	5	NEDS SP
KALETRA SOLN	4	
LEXIVA SUSP	3	
lopinavir/ritonavir	4	
NORVIR SOLN	3	
NORVIR PACK	4	
PREZCOBIX	5	NEDS SP
PREZISTA SUSP	5	NEDS SP
PREZISTA TABS 75MG	4	
PREZISTA TABS 150MG	5	NEDS SP
REYATAZ PACK	5	NEDS SP
ritonavir	3	
SYMTUZA	5	NEDS SP
VIRACEPT TABS 250MG	3	
VIRACEPT TABS 625MG	5	NEDS SP
Anti-influenza Agents		
amantadine hcl caps, soln, tabs	3	
oseltamivir phosphate caps, susr	3	
RELENZA DISKHALER	3	
rimantadine hydrochloride	4	
XOFLUZA TBPK 40MG, 80MG	3	QL(1 EA per 7 days)
Antiherpetic Agents		
acyclovir sodium inj 50mg/ml	4	PA
acyclovir caps, tabs	2	
acyclovir susp	4	
famciclovir tabs	3	
valacyclovir hydrochloride	2	
Antiviral, Coronavirus Agents		
PAXLOVID TBPK 150MG; 100MG	3	QL(11 EA per 5 days)
PAXLOVID TBPK 150MG; 100MG	3	QL(20 EA per 5 days)
PAXLOVID TBPK 300MG; 100MG	3	QL(30 EA per 5 days)
Anxiolytics		
Anxiolytics, Other		
buspirone hcl tabs 15mg	2	
buspirone hydrochloride tabs 10mg, 30mg, 5mg, 7.5mg	2	
Benzodiazepines		
alprazolam	2	
alprazolam er	3	
clorazepate dipotassium tabs	4	
diazepam intensol	3	
diazepam tabs	2	
diazepam soln	3	
lorazepam intensol	2	

Drug Name	Drug Tier	Requirements/Limits
lorazepam tabs	2	
oxazepam	4	
Bipolar Agents		
Mood Stabilizers		
lithium	2	
lithium carbonate er	2	
lithium carbonate caps, tabs	2	
Blood Glucose Regulators		
Antidiabetic Agents		
acarbose tabs	1	
glimepiride tabs 1mg, 2mg, 4mg	1	
glipizide er	1	
glipizide/metformin hydrochloride	1	
glipizide tabs 10mg, 5mg	1	
glyburide micronized	1	
glyburide/metformin hydrochloride	1	
glyburide tabs 1.25mg, 2.5mg, 5mg	1	
GLYXAMBI	3	
JANUMET	3	
JANUMET XR	3	
JANUVIA	3	
JENTADUETO	3	
JENTADUETO XR	3	
metformin hydrochloride er tb24 500mg, 750mg	1	
metformin hydrochloride soln	1	
metformin hydrochloride tabs 1000mg, 500mg, 850mg	1	
miglitol	1	
MOUNJARO	3	PA
nateglinide	1	
OZEMPIC	3	PA
pioglitazone hcl-glimepiride	1	
pioglitazone hcl/metformin hcl	1	
pioglitazone hcl tabs 45mg	1	
pioglitazone hydrochloride tabs 15mg, 30mg	1	
repaglinide	1	
RYBELSUS	3	PA
saxagliptin hydrochloride	1	
saxagliptin hydrochloride/metformin hydrochloride er	1	
SYMLINPEN 120	5	NEDS SP
SYMLINPEN 60	5	NEDS SP
SYNJARDY	3	
SYNJARDY XR	3	
TRADJENTA	3	
TRULICITY	3	PA

Drug Name	Drug Tier	Requirements/Limits
XIGDUO XR	3	
Glycemic Agents		
BAQSIMI ONE PACK	3	
BAQSIMI TWO PACK	3	
diazoxide susp	4	
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	3	
GLUCAGON EMERGENCY KIT FOR LOW BLOOD SUGAR	3	
GVOKE HYPOPEN 1-PACK	3	
GVOKE HYPOPEN 2-PACK	3	
GVOKE KIT	3	
GVOKE PFS	3	
Insulins		
HUMALOG	3	
HUMALOG JUNIOR KWIKPEN	3	
HUMALOG KWIKPEN	3	
HUMALOG MIX 50/50	3	
HUMALOG MIX 50/50 KWIKPEN	3	
HUMALOG MIX 75/25	3	
HUMALOG MIX 75/25 KWIKPEN	3	
HUMULIN 70/30	3	
HUMULIN 70/30 KWIKPEN	3	
HUMULIN N	3	
HUMULIN N KWIKPEN	3	
HUMULIN R	3	
HUMULIN R U-500 (CONCENTRATED)	3	
HUMULIN R U-500 KWIKPEN	3	
INSULIN LISPRO	3	
INSULIN LISPRO JUNIOR KWIKPEN	3	
INSULIN LISPRO KWIKPEN	3	
INSULIN LISPRO PROTAMINE/INSULIN LISPRO KWIKPEN	3	
LANTUS	3	
LANTUS SOLOSTAR	3	
LEVEMIR FLEXTOUCH	3	
NOVOLIN 70/30	3	
NOVOLIN 70/30 FLEXPEN	3	
NOVOLIN N	3	
NOVOLIN N FLEXPEN	3	
NOVOLIN R	3	
NOVOLIN R FLEXPEN	3	
NOVOLOG	3	
NOVOLOG FLEXPEN	3	

Drug Name	Drug Tier	Requirements/Limits
NOVOLOG MIX 70/30	3	
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	3	
NOVOLOG PENFILL	3	
TOUJEO MAX SOLOSTAR	3	
TOUJEO SOLOSTAR	3	
TRESIBA	3	
TRESIBA FLEXTOUCH	3	
Blood Products and Modifiers		
Anticoagulants		
dabigatran etexilate	4	
ELIQUIS	3	
ELIQUIS STARTER PACK	3	
enoxaparin sodium inj 300mg/3ml	3	
enoxaparin sodium inj 100mg/ml, 120mg/0.8ml, 150mg/ml, 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml	4	
fondaparinux sodium inj 2.5mg/0.5ml	4	
fondaparinux sodium inj 10mg/0.8ml, 5mg/0.4ml, 7.5mg/0.6ml	5	NEDS SP
FRAGMIN INJ 10000UNIT/4ML, 2500UNIT/0.2ML, 5000UNIT/0.2ML	4	
FRAGMIN INJ 10000UNIT/ML, 12500UNIT/0.5ML, 15000UNIT/0.6ML, 18000UNT/0.72ML, 7500UNIT/0.3ML, 95000UNIT/3.8ML	5	NEDS SP
heparin sodium/d5w inj 5%; 40unit/ml	2	
heparin sodium inj 10000unit/ml, 1000unit/ml, 20000unit/ml, 5000unit/0.5ml, 5000unit/ml	3	
jantoven	1	
rivaroxaban susr	3	
warfarin sodium tabs	1	
XARELTO STARTER PACK	3	
XARELTO TABS	3	
Blood Products and Modifiers, Other		
anagrelide hydrochloride	3	
eltrombopag olamine	5	PA; NEDS SP
MOZOBIL	5	NEDS SP
NEULASTA	5	NEDS SP
NEULASTA ONPRO KIT	5	NEDS SP
plerixafor	5	NEDS SP
PROCRIT INJ 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	
PROCRIT INJ 20000UNIT/ML, 40000UNIT/ML	5	NEDS SP
PROMACTA	5	PA; NEDS SP
RETACRIT INJ 10000UNIT/ML, 20000UNIT/2ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	

Drug Name	Drug Tier	Requirements/Limits
RETACRIT INJ 40000UNIT/ML	5	NEDS SP
UDENYCA	5	NEDS SP
UDENYCA ONBODY	5	NEDS SP
ZARXIO	5	NEDS SP
Hemostasis Agents		
aminocaproic acid inj, oral soln	2	
aminocaproic acid tabs 500mg	2	
tranexamic acid tabs	3	
Platelet Modifying Agents		
aspirin/dipyridamole er	4	
BRILINTA	3	
CABLIVI	5	NEDS SP
cilostazol	2	
clopidogrel	1	
DOPTELET	5	PA; NEDS SP
prasugrel hydrochloride	3	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine	4	
clonidine hydrochloride tabs	1	
droxidopa	5	PA; NEDS SP
midodrine hydrochloride	3	
Alpha-adrenergic Blocking Agents		
prazosin hydrochloride caps	3	
Angiotensin II Receptor Antagonists		
candesartan cilexetil	1	
irbesartan	1	
losartan potassium tabs	1	
olmesartan medoxomil tabs	1	
telmisartan	1	
valsartan tabs	1	
Angiotensin-converting Enzyme (ACE) Inhibitors		
benazepril hydrochloride tabs	1	
captopril tabs	1	
enalapril maleate tabs	1	
fosinopril sodium	1	
lisinopril tabs	1	
moexipril hydrochloride	1	
perindopril erbumine	1	
quinapril hydrochloride	1	
ramipril	1	
trandolapril	1	
Antiarrhythmics		
amiodarone hydrochloride tabs 200mg	2	

Drug Name	Drug Tier	Requirements/Limits
amiodarone hydrochloride tabs 100mg, 400mg	3	
digitek tabs 0.125mg, 0.25mg	2	
digoxin oral soln	2	
digoxin inj 0.25mg/ml	2	
digoxin tabs 125mcg, 250mcg	2	
dofetilide	3	
flecainide acetate	2	
mexiletine hydrochloride caps	3	
MULTAQ	3	
propafenone hcl	3	
propafenone hydrochloride	3	
propafenone hydrochloride er	4	
quinidine gluconate cr	4	
quinidine gluconate er	4	
quinidine sulfate tabs	3	
sorine	2	
sotalol hcl tabs 120mg, 160mg, 240mg	2	
sotalol hydrochloride (af)	2	
sotalol hydrochloride tabs 80mg	2	
Beta-adrenergic Blocking Agents		
acebutolol hydrochloride	3	
atenolol tabs	1	
bisoprolol fumarate tabs 10mg, 5mg	3	
carvedilol	1	
labetalol hydrochloride tabs 100mg, 200mg, 300mg	3	
metoprolol succinate er	2	
metoprolol tartrate tabs 100mg, 25mg, 37.5mg, 50mg	1	
metoprolol tartrate tabs 75mg	3	
nadolol tabs 20mg, 40mg, 80mg	2	
nebivolol hydrochloride	3	
pindolol tabs	4	
propranolol hcl soln 40mg/5ml	3	
propranolol hcl tabs 40mg	2	
propranolol hydrochloride er	3	
propranolol hydrochloride soln	3	
propranolol hydrochloride tabs 10mg, 20mg, 60mg, 80mg	2	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate tabs	1	
felodipine er	2	
nifedipine er	3	
nimodipine caps	4	
Calcium Channel Blocking Agents, Nondihydropyridines		
cartia xt	3	
dilt-xr	3	

Drug Name	Drug Tier	Requirements/Limits
diltiazem hcl cd	3	
diltiazem hcl er cp24 120mg, 180mg, 240mg, 420mg	3	
diltiazem hcl er cp12	4	
diltiazem hcl er tb24 300mg, 360mg, 420mg	4	
diltiazem hcl tabs 30mg, 60mg	2	
diltiazem hydrochloride er cp24	3	
diltiazem hydrochloride er tb24 120mg, 180mg, 240mg, 300mg, 360mg	4	
diltiazem hydrochloride tabs 120mg, 90mg	2	
matzim la	4	
taztia xt	3	
tiadylt er	3	
verapamil hcl er cp24 100mg, 120mg, 180mg, 240mg, 300mg	4	
verapamil hcl er tbcr 120mg	2	
verapamil hcl sr cp24	4	
verapamil hcl tabs 40mg, 80mg	2	
verapamil hydrochloride er cp24	4	
verapamil hydrochloride er tbcr 180mg, 240mg	2	
verapamil hydrochloride sr cp24 360mg	4	
verapamil hydrochloride tabs 120mg	2	
Cardiovascular Agents, Other		
aliskiren	1	
amiloride/hydrochlorothiazide	2	
amlodipine besylate/atorvastatin calcium	1	
amlodipine besylate/benazepril hydrochloride	1	
amlodipine besylate/valsartan	1	
amlodipine/olmesartan medoxomil	1	
amlodipine/valsartan/hydrochlorothiazide tabs 10mg; 12.5mg; 160mg, 10mg; 25mg; 160mg, 5mg; 12.5mg; 160mg, 5mg; 25mg; 160mg	1	
atenolol/chlorthalidone	3	
benazepril hydrochloride/hydrochlorothiazide	1	
bisoprolol fumarate/hydrochlorothiazide	3	
candesartan cilexetil/hydrochlorothiazide	1	
CORLANOR	4	
enalapril maleate/hydrochlorothiazide	1	
ENTRESTO	3	
fosinopril sodium/hydrochlorothiazide	3	
irbesartan/hydrochlorothiazide	1	
ivabradine hydrochloride	4	
lisinopril/hydrochlorothiazide	1	
losartan potassium/hydrochlorothiazide	1	
metoprolol/hydrochlorothiazide	3	
metyrosine	5	NEDS SP

Drug Name	Drug Tier	Requirements/Limits
olmesartan medoxomil/amlodipine/hydrochlorothiazide	1	
olmesartan medoxomil/hydrochlorothiazide	1	
pentoxifylline er	4	
quinapril/hydrochlorothiazide	1	
ranolazine er	3	
sacubitril/valsartan	3	
spironolactone/hydrochlorothiazide	2	
TEKTURNA HCT TABS 150MG; 12.5MG, 300MG; 12.5MG, 300MG; 25MG	3	
telmisartan/amlodipine	1	
telmisartan/hydrochlorothiazide	1	
trandolapril/verapamil hcl er	1	
triamterene/hydrochlorothiazide caps 25mg; 37.5mg	1	
triamterene/hydrochlorothiazide tabs	1	
valsartan/hydrochlorothiazide	1	
Diuretics, Loop		
bumetanide inj	2	
bumetanide tabs	3	
ethacrynic acid tabs	4	
furosemide tabs	1	
furosemide oral soln	2	
furosemide inj	4	
torsemide tabs	3	
Diuretics, Potassium-sparing		
amiloride hcl tabs	2	
triamterene caps	4	
Diuretics, Thiazide		
chlorthalidone tabs 25mg, 50mg	2	
hydrochlorothiazide caps, tabs	1	
indapamide tabs	2	
metolazone	2	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate micronized caps 134mg, 200mg, 67mg	3	
fenofibrate caps 130mg, 43mg	3	
fenofibrate caps 150mg, 50mg	4	
fenofibrate tabs 145mg, 160mg, 48mg, 54mg	2	
fenofibric acid dr	3	
gemfibrozil tabs	3	
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium	1	
FLOLIPID	3	
fluvastatin	1	
fluvastatin sodium er	1	
lovastatin tabs	1	

Drug Name	Drug Tier	Requirements/Limits
pitavastatin calcium	1	
pravastatin sodium	1	
rosuvastatin calcium tabs	1	
simvastatin tabs	1	
Dyslipidemics, Other		
cholestyramine light powd	3	
cholestyramine light pack	4	
cholestyramine powd	3	
cholestyramine pack	4	
colestipol hydrochloride gran	2	
colestipol hydrochloride pack, tabs	4	
ezetimibe	2	
ezetimibe/simvastatin	1	
icosapent ethyl	4	
niacin er	4	
omega-3-acid ethyl esters	3	
PRALUENT	3	PA
prevalite powd	3	
prevalite pack	4	
REPATHA	3	PA
REPATHA PUSHTRONEX SYSTEM	3	PA
REPATHA SURECLICK	3	PA
Mineralocorticoid Receptor Antagonists		
eplerenone	3	
KERENDIA	4	PA
spironolactone tabs	2	
Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)		
FARXIGA	3	
JARDIANCE	3	
Vasodilators, Direct-acting Arterial/Venous		
isosorbide dinitrate tabs	3	
isosorbide mononitrate	2	
isosorbide mononitrate er	2	
nitroglycerin transdermal	3	
nitroglycerin soln 0.4mg/spray	4	
nitroglycerin subl 0.3mg, 0.4mg, 0.6mg	2	
VERQUVO	4	
Vasodilators, Direct-acting Arterial		
hydralazine hydrochloride tabs	2	
minoxidil tabs	2	
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine/dextroamphetamine tabs	2	
amphetamine/dextroamphetamine cp24	3	

Drug Name	Drug Tier	Requirements/Limits
dextroamphetamine sulfate er	4	
dextroamphetamine sulfate tabs 10mg, 15mg, 20mg, 30mg, 5mg	4	
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
atomoxetine hydrochloride caps 10mg, 25mg	4	QL(60 EA per 30 days)
atomoxetine caps 100mg, 80mg	4	QL(30 EA per 30 days)
atomoxetine caps 10mg, 18mg, 25mg, 40mg, 60mg	4	QL(60 EA per 30 days)
clonidine hydrochloride er	3	
dexmethylphenidate hcl er cp24 20mg, 35mg	4	
dexmethylphenidate hcl tabs 10mg, 5mg	2	
dexmethylphenidate hydrochloride er cp24 10mg, 15mg, 30mg, 40mg, 5mg	4	
dexmethylphenidate hydrochloride cp24	4	
dexmethylphenidate hydrochloride tabs 2.5mg	2	
guanfacine hydrochloride er	3	QL(90 EA per 90 days)
methylphenidate hydrochloride er (cd)	4	
methylphenidate hydrochloride er (la)	4	
methylphenidate hydrochloride er (osm) tbcr 18mg, 27mg, 36mg, 54mg	4	
methylphenidate hydrochloride er tb24	4	
methylphenidate hydrochloride er tbcr 10mg, 20mg	4	
methylphenidate hydrochloride tabs	2	
methylphenidate hydrochloride soln	3	
methylphenidate hydrochloride chew	4	
Central Nervous System, Other		
AUSTEDO	5	PA; NEDS SP
AUSTEDO XR PATIENT TITRATION KIT TEPK 0	5	QL(56 EA per 365 days); PA; NEDS SP
AUSTEDO XR PATIENT TITRATION KIT TEPK 0	5	QL(84 EA per 365 days); PA; NEDS SP
AUSTEDO XR TB24 6MG	5	QL(210 EA per 30 days); PA; NEDS SP
AUSTEDO XR TB24 18MG, 30MG, 36MG, 42MG, 48MG	5	QL(30 EA per 30 days); PA; NEDS SP
AUSTEDO XR TB24 24MG	5	QL(60 EA per 30 days); PA; NEDS SP
AUSTEDO XR TB24 12MG	5	QL(90 EA per 30 days); PA; NEDS SP
COBENFY	5	QL(60 EA per 30 days); PA NSO; NEDS SP
COBENFY STARTER PACK	5	QL(112 EA per 365 days); PA NSO; NEDS SP
INGREZZA	5	PA; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
NUEDEXTA	3	PA
RADICAVA ORS	5	PA; NEDS SP
RADICAVA ORS STARTER KIT	5	PA; NEDS SP
riluzole	4	
tetrabenazine	4	PA
VEOZAH	4	QL(30 EA per 30 days); PA
Fibromyalgia Agents		
SAVELLA	3	
SAVELLA TITRATION PACK	3	
Multiple Sclerosis Agents		
AVONEX PEN	5	NEDS SP
AVONEX INJ 30MCG/0.5ML	5	NEDS SP
BETASERON	5	NEDS SP
dalfampridine er	3	
dimethyl fumarate	4	
fingolimod hydrochloride	5	NEDS SP
glatiramer acetate inj 40mg/ml	5	QL(12 ML per 28 days); NEDS SP
glatiramer acetate inj 20mg/ml	5	QL(30 ML per 30 days); NEDS SP
KESIMPTA	5	PA; NEDS SP
MAYZENT	5	NEDS SP
MAYZENT STARTER PACK TBPK 0.25MG	4	
MAYZENT STARTER PACK TBPK 0.25MG	5	NEDS SP
PLEGRIDY	5	NEDS SP
PLEGRIDY STARTER PACK	5	NEDS SP
REBIF	5	ST; NEDS SP
REBIF REBIDOSE	5	ST; NEDS SP
REBIF REBIDOSE TITRATION PACK	5	ST; NEDS SP
REBIF TITRATION PACK	5	ST; NEDS SP
teriflunomide	4	
VUMERITY	5	NEDS SP
ZEPOSIA	5	NEDS SP
ZEPOSIA 7-DAY STARTER PACK	5	NEDS SP
ZEPOSIA STARTER KIT	5	NEDS SP
Dental and Oral Agents		
Dental and Oral Agents		
cevimeline hydrochloride	4	
chlorhexidine gluconate soln	1	
kourzeq	3	
lidocaine hydrochloride viscous	2	
lidocaine viscous	2	
oralone dental paste	3	
periogard	1	
pilocarpine hydrochloride tabs 5mg, 7.5mg	4	
sf 5000 plus	2	

Drug Name	Drug Tier	Requirements/Limits
sodium fluoride 5000 plus	2	
sodium fluoride 5000 ppm crea	2	
sodium fluoride crea	2	
triamcinolone acetonide dental paste	3	
Dermatological Agents		
Acne and Rosacea Agents		
accutane	4	
acitretin	4	
adapalene gel	4	PA
amnesteem	4	
avita	2	PA
azelaic acid	4	
claravis	4	
clindamycin phosphate/benzoyl peroxide gel 2.5%; 1.2%, 5%; 1.2%	4	
clindamycin/benzoyl peroxide	4	
isotretinoin caps	4	
metronidazole crea 0.75%	2	
metronidazole gel 0.75%, 1%	4	
metronidazole lotn 0.75%	4	
MYORISAN	4	
NEUAC	4	
rosadan crea	2	
rosadan gel	4	
tazarotene crea 0.1%	3	PA
tazarotene crea 0.05%	4	PA
tazarotene gel	4	PA
tretinoin microsphere	4	PA
tretinoin crea 0.025%, 0.05%, 0.1%	3	PA
ZENATANE	4	
Dermatitis and Pruritus Agents		
amcinonide crea	4	
ammonium lactate crea, lotn	2	
betamethasone dipropionate augmented crea, lotn	2	
betamethasone dipropionate augmented oint	3	
betamethasone dipropionate augmented gel	4	
betamethasone dipropionate crea, lotn	3	
betamethasone dipropionate oint	4	
betamethasone valerate crea, lotn, oint	3	
clobetasol propionate e	4	QL(240 GM per 30 days)
clobetasol propionate crea 0.05%	2	QL(240 GM per 30 days)
clobetasol propionate oint	2	QL(240 GM per 30 days)
clobetasol propionate soln	3	QL(200 ML per 30 days)
clobetasol propionate sham	3	QL(236 ML per 30 days)

Drug Name	Drug Tier	Requirements/Limits
clobetasol propionate gel	3	QL(240 GM per 30 days)
clodan	3	QL(236 ML per 30 days)
desonide crea, oint	3	
desoximetasone crea	4	
DESRX	4	
fluocinolone acetonide body	4	
fluocinolone acetonide scalp	4	
fluocinolone acetonide topical	4	
fluocinolone acetonide crea 0.01%, 0.025%	4	
fluocinolone acetonide oint 0.025%	3	
fluocinolone acetonide soln 0.01%	2	
fluocinonide	3	
fluocinonide emulsified base	4	
fluticasone propionate crea 0.05%	2	
fluticasone propionate oint 0.005%	3	
halobetasol propionate crea, oint	4	
hydrocortisone butyrate oint	3	
hydrocortisone valerate crea	3	
hydrocortisone valerate oint	4	
hydrocortisone crea 1%, 2.5%	1	
hydrocortisone lotn 2.5%	2	
hydrocortisone oint 1%	1	
hydrocortisone oint 2.5%	2	
mometasone furoate crea 0.1%	2	
mometasone furoate oint 0.1%	2	
mometasone furoate soln 0.1%	3	
pimecrolimus	4	
prednicarbate oint	2	
selenium sulfide	2	
tacrolimus oint 0.03%, 0.1%	4	
triamcinolone acetonide crea 0.025%, 0.1%, 0.5%	2	
triamcinolone acetonide lotn 0.025%, 0.1%	3	
triamcinolone acetonide oint 0.025%, 0.1%, 0.5%	2	
TRITOCIN	3	
Dermatological Agents, Other		
calcipotriene crea	3	QL(120 GM per 30 days)
calcipotriene oint	4	QL(120 GM per 30 days)
calcipotriene soln	4	QL(120 ML per 30 days)
calcitriol oint 3mcg/gm	4	
clotrimazole/betamethasone dipropionate crea	2	
clotrimazole/betamethasone dipropionate lotn	4	
diclofenac sodium gel 3%	3	QL(200 GM per 30 days)
fluorouracil crea 5%	3	
fluorouracil crea 0.5%	4	

Drug Name	Drug Tier	Requirements/Limits
fluorouracil soln	4	
imiquimod crea 5%	3	
imiquimod crea 3.75%	4	
nystatin/triamcinolone	2	
nystatin/triamcinolone acetonide oint	2	
OTEZLA TABS 20MG, 30MG	5	QL(60 EA per 30 days); PA; NEDS SP
podofilox	4	
PROCTOFOAM HC	4	
SANTYL	4	
silver sulfadiazine	2	
ssd	2	
Pediculicides/Scabicides		
malathion	4	
permethrin crea	3	
Topical Anti-infectives		
ciclopirox nail lacquer	3	
ciclopirox olamine	2	
ciclopirox gel, sham, susp	3	
clindamycin phosphate gel 1%	1	
clindamycin phosphate lotn 1%	3	
clindamycin phosphate external soln 1%	2	
ery	4	
erythromycin gel 2%	3	
erythromycin soln 2%	2	
MENTAX	4	
mupirocin oint	2	QL(44 GM per 30 days)
mupirocin crea	4	QL(180 GM per 30 days)
SULFAMYLON CREA	4	
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
AMINOSYN II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 405MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 750MG/100ML	3	PA BvD

Drug Name	Drug Tier	Requirements/Limits
AMINOSYN-PF 7% INJ 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 300MG/100ML; 570MG/100ML; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML	3	PA BvD
carglumic acid	5	PA; NEDS SP
CLINIMIX 6/5	3	PA BvD
CLINIMIX 8/10	3	PA BvD
CLINIMIX E 8/10	3	PA BvD
dextrose 10%	2	
dextrose 10%/sodium chloride 0.2%	2	
dextrose 10%/sodium chloride 0.45%	2	
dextrose 2.5%/sodium chloride 0.45%	2	
dextrose 5%	2	
dextrose 5%/sodium chloride 0.2%	2	
dextrose 5%/sodium chloride 0.3%	2	
dextrose 5%/sodium chloride 0.33%	2	
dextrose 5%/sodium chloride 0.45%	2	
dextrose 5%/sodium chloride 0.9%	2	
dextrose 50%	2	
dextrose 70%	2	
dextrose/sodium chloride	2	
effer-k tbef 25meq	1	
glucose (dextrose) 50%	2	
glucose (dextrose) 70%	2	
k-prime	1	
kcl 0.075%/d5w/nacl 0.45% inj 5%; 10meq/l; 0.45%	4	
kcl 0.15%/d5w/nacl 0.2%	4	
kcl 0.15%/d5w/nacl 0.45% inj 5%; 20meq/l; 0.45%	4	
kcl 0.15%/d5w/nacl 0.9% inj 5%; 20meq/l; 0.9%	4	
kcl 0.3%/d5w/nacl 0.45% inj 5%; 40meq/l; 0.45%	4	
kcl 0.3%/d5w/nacl 0.9% inj 5%; 40meq/l; 0.9%	4	
klor-con	3	
klor-con 10	2	
klor-con 8	2	
klor-con m10	2	
klor-con m15	2	
klor-con m20	2	
klor-con/ef	2	
lactated ringers inj 3meq/l; 109meq/l; 28meq/l; 4meq/l; 130meq/l	2	
magnesium sulfate inj 50%	4	

Drug Name	Drug Tier	Requirements/Limits
PLENAMINE	3	PA BvD
potassium chloride er tbcr	2	
potassium chloride er cpcr	3	
potassium chloride/dextrose/sodium chloride inj 5%; 20meq/l; 0.225%	2	
potassium chloride/dextrose/sodium chloride inj 5%; 10meq/l; 0.45%, 5%; 20meq/l; 0.45%, 5%; 20meq/l; 0.9%, 5%; 30meq/l; 0.45%, 5%; 40meq/l; 0.45%, 5%; 40meq/l; 0.9%	4	
potassium chloride pack, oral soln	3	
potassium chloride inj 10meq/50ml, 20meq/50ml	2	
potassium chloride inj 2meq/ml	4	
potassium citrate er	4	
PREMASOL INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML	3	PA BvD
PROSOL	3	PA BvD
sodium chloride 0.45% inj	2	
sodium chloride inj 0.9%, 3%, 5%	2	
sodium chloride inj 0.9%, 2.5meq/ml, 4meq/ml	4	
TRAVASOL INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML	3	PA BvD
TROPHAMINE INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML	3	PA BvD
Electrolyte/Mineral/Metal Modifiers		
CHEMET	5	NEDS SP
deferasirox pack	5	NEDS SP
deferasirox tabs 90mg	3	
deferasirox tabs 180mg, 360mg	4	
deferasirox tbso 125mg	4	
deferasirox tbso 250mg, 500mg	5	NEDS SP
penicillamine tabs	5	NEDS SP
trientine hydrochloride	5	NEDS SP

Drug Name	Drug Tier	Requirements/Limits
Phosphate Binders		
calcium acetate caps	4	
calcium acetate tabs 667mg	3	
sevelamer carbonate	4	
VELPHORO	5	NEDS SP
Potassium Binders		
LOKELMA	4	QL(90 EA per 30 days)
sodium polystyrene sulfonate powd	3	
sps	4	
Vitamins		
cyanocobalamin inj 1000mcg/ml	2	EC
folic acid tabs 1mg	1	EC
prenatal tabs 120mg; 0; 200mg; 10mcg; 2mg; 12mcg; 27mg; 1mg; 20mg; 10mg; 1200mcg; 3mg; 1.84mg; 10mg; 25mg	2	
vitamin d caps 1.25mg	1	EC
Gastrointestinal Agents		
Anti-Constipation Agents		
constulose	2	
enulose	2	
generlac	2	
lactulose soln	2	
LINZESS	3	
lubiprostone	4	
MOVANTIK	3	
OSMOPREP	4	
Anti-Diarrheal Agents		
alosetron hydrochloride tabs 0.5mg	4	PA
alosetron hydrochloride tabs 1mg	5	PA; NEDS SP
loperamide hydrochloride caps	3	
XERMELO	5	PA; NEDS SP
Antispasmodics, Gastrointestinal		
dicyclomine hcl soln	4	
dicyclomine hydrochloride caps	2	
dicyclomine hydrochloride tabs 20mg	2	
glycopyrrolate soln	3	
glycopyrrolate tabs 1mg, 2mg	3	
Gastrointestinal Agents, Other		
CLENPIQ	3	
gavilyte-c	3	
gavilyte-g	3	
gavilyte-n/flavor pack	3	
metoclopramide hcl inj, oral soln	2	
metoclopramide hydrochloride tabs	1	
nitroglycerin oint 0.4%	4	QL(30 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
opium	2	
opium tincture tinc 1%	2	
peg-3350/electrolytes	3	
peg-3350/electrolytes/ascorbate	4	
peg-3350/nacl/na bicarbonate/kcl	3	
peg-3350/sodium sulf/naclpotassium cl/na ascorbate/ascorbic	4	
RECTIV	4	QL(30 GM per 30 days)
sodium sulfate/potassium sulfate/magnesium sulfate	4	
ursodiol caps 300mg	3	
ursodiol tabs	4	
VOWST	5	PA; NEDS SP
XIFAXAN TABS 550MG	5	PA; NEDS SP
Histamine2 (H2) Receptor Antagonists		
cimetidine tabs	4	
famotidine tabs 20mg, 40mg	2	
Protectants		
misoprostol	3	
sucralfate tabs	3	
sucralfate susp	4	
Proton Pump Inhibitors		
DEXLANSOPRAZOLE	4	
esomeprazole magnesium cpdr	3	
esomeprazole magnesium pack 10mg, 20mg, 40mg	4	
lansoprazole cpdr	2	
omeprazole dr cpdr 10mg	2	
omeprazole cpdr 20mg, 40mg	2	
pantoprazole sodium tbec	2	
rabeprazole sodium	2	
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
betaine anhydrous	5	NEDS SP
CHOLBAM	5	PA; NEDS SP
CREON CPEP 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	3	
cromolyn sodium conc 100mg/5ml	4	
CYSTAGON	4	
dichlorphenamide	5	PA; NEDS SP
ENDARI	5	NEDS SP
l-glutamine	5	NEDS SP
miglustat	5	PA; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
nitisinone	5	PA; NEDS SP
PROLASTIN-C	5	PA; NEDS SP
PYRUKYND	5	PA; NEDS SP
PYRUKYND TAPER PACK	5	PA; NEDS SP
REVCOVI	5	NEDS SP
sapropterin dihydrochloride	5	PA; NEDS SP
sodium phenylbutyrate powd, tabs	5	NEDS SP
SUCRAID	5	NEDS SP
WELIREG	5	PA NSO; NEDS SP
yargesa	5	PA; NEDS SP
zelvysia	5	PA; NEDS SP
ZENPEP CPEP 105000UNIT; 25000UNIT; 79000UNIT, 14000UNIT; 3000UNIT; 10000UNIT, 168000UNIT; 40000UNIT; 126000UNIT, 24000UNIT; 5000UNIT; 17000UNIT, 252600UNIT; 60000UNIT; 189600UNIT, 42000UNIT; 10000UNIT; 32000UNIT, 63000UNIT; 15000UNIT; 47000UNIT, 84000UNIT; 20000UNIT; 63000UNIT	3	
Genitourinary Agents		
Antispasmodics, Urinary		
darifenacin hydrobromide er	4	
GEMTESA	4	
mirabegron er	3	
MYRBETRIQ	3	
oxybutynin chloride er	3	
oxybutynin chloride soln	2	
oxybutynin chloride tabs 5mg	2	
oxybutynin chloride tabs 2.5mg	3	
solifenacin succinate	3	
tolterodine tartrate	4	
tolterodine tartrate er	4	
trospium chloride	3	
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er	2	
doxazosin mesylate	2	
dutasteride/tamsulosin hydrochloride	4	
dutasteride caps	2	
finasteride tabs	2	
tadalafil tabs 10mg, 20mg	2	QL(4 EA per 30 days); EC
tadalafil tabs 2.5mg, 5mg	3	QL(30 EA per 30 days); PA
tamsulosin hydrochloride	2	
terazosin hcl caps 10mg, 1mg, 5mg	2	
terazosin hydrochloride caps 2mg	2	
Genitourinary Agents, Other		

Drug Name	Drug Tier	Requirements/Limits
acetic acid 0.25%	2	
bethanechol chloride tabs	3	
ELMIRON	4	
sildenafil citrate tabs 100mg, 25mg, 50mg	2	QL(4 EA per 30 days); EC
sildenafil tabs 25mg	2	QL(4 EA per 30 days); EC
tiopronin dr	5	NEDS SP
vardenafil hydrochloride	2	QL(4 EA per 30 days); EC
vardenafil hydrochloride odt	2	QL(4 EA per 30 days); EC
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
DEPO-MEDROL	3	
dexamethasone intensol	2	
dexamethasone sodium phosphate +rfid	2	
dexamethasone sodium phosphate inj 100mg/10ml, 10mg/ml, 120mg/30ml, 20mg/5ml, 4mg/ml	2	
dexamethasone elix, soln	2	
dexamethasone tabs 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg	2	
fludrocortisone acetate tabs	3	
hydrocortisone sodium succinate inj 100mg	4	
hydrocortisone tabs 10mg, 20mg, 5mg	3	
kenalog-10	2	
methylprednisolone acetate inj 40mg/ml, 50mg/ml, 80mg/ml	2	
methylprednisolone dose pack tbpk	2	
methylprednisolone tabs	2	
prednisolone sodium phosphate oral soln 15mg/5ml	2	
prednisolone sodium phosphate oral soln 5mg/5ml	3	
prednisolone sodium phosphate oral soln 10mg/5ml, 20mg/5ml, 25mg/5ml	4	
prednisolone soln, tabs	4	
prednisone tbpk	3	
prednisone soln	4	
prednisone tabs 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg	1	
SOLU-CORTEF INJ 100MG	4	
triamcinolone acetonide inj 10mg/ml, 40mg/ml	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
desmopressin acetate tabs	4	
desmopressin acetate soln 0.01%	2	
desmopressin acetate soln 0.01% (refrigerated)	4	
GENOTROPIN	5	PA; NEDS SP
GENOTROPIN MINIQUICK INJ 0.2MG	3	PA
GENOTROPIN MINIQUICK INJ 0.4MG, 0.6MG, 0.8MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 1MG, 2MG	5	PA; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
INCRELEX	5	PA; NEDS SP
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
Androgens		
danazol caps	4	
testosterone cypionate inj 100mg/ml, 200mg/ml	2	
testosterone enanthate inj	2	
testosterone pump gel 1.62%	3	
testosterone pump gel 1%	4	
testosterone gel 20.25mg/1.25gm, 40.5mg/2.5gm	3	
testosterone gel 25mg/2.5gm, 50mg/5gm	4	
Estrogens		
abigale	3	
abigale lo	3	
amabelz	3	
amethia	4	
apri	2	
ashlyna	4	
aviane	4	
azurette	4	
balziva	4	
briellyn	4	
conjugated estrogens	4	
desogestrel/ethinyl estradiol tabs 0; 0	4	
dotti	4	
drospirenone/ethinyl estradiol tabs 3mg; 0.03mg	3	
eluryng	4	
enilloring	4	
estradiol valerate inj	4	
estradiol/norethindrone acetate	3	
estradiol oral tabs	2	
estradiol crea, ptwk	3	
estradiol pttw, vaginal tabs	4	
ESTRING	4	
etonogestrel/ethinyl estradiol	3	
falmina	4	
FEIRZA 1.5/30	4	
FEIRZA 1/20	4	
finzala	3	
fyavolv tabs 5mcg; 1mg	3	
fyavolv tabs 2.5mcg; 0.5mg	4	
galbriela	4	
haloette	4	
iclevia	4	

Drug Name	Drug Tier	Requirements/Limits
IMVEXXY MAINTENANCE PACK	3	
IMVEXXY STARTER PACK	3	
introvale	4	
jaimiess	4	
jinteli	3	
joyeaux	4	
junel 1.5/30	4	
junel 1/20	4	
junel fe 1.5/30	4	
junel fe 1/20	4	
junel fe 24	4	
kariva	4	
kelnor 1/35	4	
larin 1.5/30	4	
larin 1/20	4	
larin fe 1.5/30	4	
larin fe 1/20	4	
lessina	4	
levonest	4	
levonorgestrel and ethinyl estradiol tabs 20mcg; 90mcg	4	
levonorgestrel/ethinyl estradiol	4	
levora 0.15/30-28	4	
lojaimiess	4	
marlissa	4	
mibelas 24 fe	3	
microgestin 1.5/30	4	
microgestin 1/20	4	
microgestin fe 1.5/30	4	
microgestin fe 1/20	4	
minzoya	4	
necon 0.5/35-28	4	
nikki	3	
norelgestromin/ethinyl estradiol	3	
norethindrone acetate/ethinyl estradiol/ferrous fumarate tabs 0; 75mg; 1mg	3	
norethindrone acetate/ethinyl estradiol tabs 5mcg; 1mg	3	
norethindrone acetate/ethinyl estradiol tabs 2.5mcg; 0.5mg	4	
nortrel 0.5/35 (28)	4	
nortrel 1/35	4	
nortrel 7/7/7	4	
portia-28	4	
PREMARIN CREA	3	
PREMARIN TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG	4	

Drug Name	Drug Tier	Requirements/Limits
PREMPHASE	4	
rosyrah	4	
tarina fe 1/20 eq	4	
taysofy	2	
tri-sprintec	2	
trivora-28	4	
turqoz	4	
valtya 1/50	4	
velivet	4	
vyfemla	4	
XARAH FE	4	
xelria fe	4	
xulane	3	
yuvafem	4	
zafemy	3	
zovia 1/35	4	
Progestins		
camila	2	
deblitane	2	
DEPO-SUBQ PROVERA 104	3	
errin	2	
gallifrey	3	
heather	2	
LILETTA	3	
medroxyprogesterone acetate tabs	1	
medroxyprogesterone acetate inj	2	
megestrol acetate tabs	2	
megestrol acetate susp 40mg/ml	3	
megestrol acetate susp 625mg/5ml	4	
meleya	2	
NEXPLANON	3	
norethindrone acetate tabs	3	
orquidea	2	
progesterone caps	3	
sharobel	2	
Selective Estrogen Receptor Modifying Agents		
OSPHENA	4	
raloxifene hydrochloride	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
ADTHYZA TABS 120MG, 15MG, 30MG, 60MG, 90MG	4	
ARMOUR THYROID	4	
euthyrox tabs 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 50mcg, 75mcg, 88mcg	1	

Drug Name	Drug Tier	Requirements/Limits
levo-t	1	
levothyroxine sodium tabs	1	
levoxyl tabs 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 50mcg, 75mcg, 88mcg	1	
liomny	3	
liothyronine sodium tabs	3	
NIVA THYROID TABS 15MG	4	
niva thyroid tabs 120mg, 30mg, 60mg, 90mg	4	
np thyroid 120	2	
np thyroid 15	2	
np thyroid 30	2	
np thyroid 60	2	
np thyroid 90	2	
SYNTHROID TABS	4	
THYROID TABS 120MG, 15MG, 30MG, 60MG, 90MG	4	
unithroid	1	
Hormonal Agents, Suppressant (Adrenal or Pituitary)		
Hormonal Agents, Suppressant (Adrenal or Pituitary)		
cabergoline	3	
ELIGARD	4	
FIRMAGON INJ 80MG	4	
FIRMAGON INJ 120MG/VIAL	5	NEDS SP
KORLYM	5	QL(120 EA per 30 days); PA; NEDS SP
lanreotide acetate	5	NEDS SP
leuprolide acetate inj 1mg/0.2ml	4	
LUPRON DEPOT (1-MONTH)	5	NEDS SP
LUPRON DEPOT (3-MONTH)	5	NEDS SP
LUPRON DEPOT (4-MONTH)	5	NEDS SP
LUPRON DEPOT (6-MONTH)	5	NEDS SP
mifepristone tabs 300mg	5	QL(120 EA per 30 days); PA; NEDS SP
octreotide acetate inj 100mcg/ml, 50mcg/ml	2	
octreotide acetate inj 100mcg/ml, 200mcg/ml, 500mcg/ml, 50mcg/ml	4	
octreotide acetate inj 1000mcg/ml	5	NEDS SP
ORGOVYX	5	PA NSO; NEDS SP
SIGNIFOR	5	QL(60 ML per 30 days); PA; NEDS SP
SOMATULINE DEPOT	5	NEDS SP
SOMAVERT	5	PA; NEDS SP
SYNAREL	5	NEDS SP
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		

Drug Name	Drug Tier	Requirements/Limits
methimazole tabs 10mg, 5mg	2	
propylthiouracil tabs	3	
Immunological Agents		
Angioedema Agents		
BERINERT	5	PA; NEDS SP
HAEGARDA	5	PA; NEDS SP
icatibant acetate	5	QL(18 ML per 30 days); PA; NEDS SP
Immunoglobulins		
BIVIGAM INJ 10%, 5GM/50ML	5	PA BvD; NEDS SP; HI
CUVITRU	5	PA BvD; NEDS SP
FLEBOGAMMA DIF INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML	5	PA BvD; NEDS SP; HI
GAMMAGARD LIQUID INJ 10GM/100ML, 2.5GM/25ML, 20GM/200ML, 30GM/300ML, 5GM/50ML	5	PA BvD; NEDS SP; HI
GAMMAPLEX INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML	5	PA BvD; NEDS SP; HI
HIZENTRA	5	PA BvD; NEDS SP
OCTAGAM INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 30GM/300ML, 5GM/100ML, 5GM/50ML	5	PA BvD; NEDS SP; HI
PRIVIGEN	5	PA BvD; NEDS SP; HI
Immunological Agents, Other		
ARCALYST	5	PA; NEDS SP
BENLYSTA	5	PA; NEDS SP
COSENTYX	5	PA; NEDS SP
COSENTYX SENSOREADY PEN	5	PA; NEDS SP
COSENTYX UNOREADY	5	PA; NEDS SP
DUPIXENT	5	PA; NEDS SP
ORENCIA CLICKJECT	5	QL(4 ML per 28 days); PA; NEDS SP
ORENCIA INJ 50MG/0.4ML	5	QL(1.6 ML per 28 days); PA; NEDS SP
ORENCIA INJ 87.5MG/0.7ML	5	QL(2.8 ML per 28 days); PA; NEDS SP
ORENCIA INJ 125MG/ML	5	QL(4 ML per 28 days); PA; NEDS SP
OTEZLA TBPK 0	5	QL(110 EA per 365 days); PA; NEDS SP
RINVOQ	5	QL(30 EA per 30 days); PA; NEDS SP
RINVOQ LQ	5	QL(360 ML per 30 days); PA; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI PEN	5	QL(1 ML per 28 days); PA; NEDS SP
SKYRIZI INJ 600MG/10ML	5	PA; NEDS SP
SKYRIZI INJ 150MG/ML	5	QL(1 ML per 28 days); PA; NEDS SP
SKYRIZI INJ 180MG/1.2ML	5	QL(1.2 ML per 28 days); PA; NEDS SP
SKYRIZI INJ 360MG/2.4ML	5	QL(2.4 ML per 28 days); PA; NEDS SP
STEQEYMA INJ 45MG/0.5ML	3	QL(1 ML per 28 days); PA
STEQEYMA INJ 90MG/ML	5	QL(1 ML per 28 days); PA; NEDS SP
TAVNEOS	5	PA; NEDS SP
XELJANZ XR	5	QL(30 EA per 30 days); PA; NEDS SP
XELJANZ SOLN	5	QL(300 ML per 30 days); PA; NEDS SP
XELJANZ TABS	5	QL(60 EA per 30 days); PA; NEDS SP
XOLAIR	5	PA; NEDS SP
YESINTEK INJ 45MG/0.5ML	3	QL(1 ML per 28 days); PA
YESINTEK INJ 90MG/ML	5	QL(1 ML per 28 days); PA; NEDS SP
Immunostimulants		
ACTIMMUNE	5	NEDS SP
BESREMI	5	PA NSO; NEDS SP
PEGASYS INJ 180MCG/ML	5	QL(4 ML per 28 days); NEDS SP
Immunosuppressants		
azathioprine tabs 50mg	3	PA BvD
azathioprine tabs 100mg, 75mg	4	PA BvD
cyclosporine modified	4	PA BvD
cyclosporine caps 100mg, 25mg	4	PA BvD
ENBREL MINI	5	QL(8 ML per 28 days); PA; NEDS SP
ENBREL SURECLICK	5	QL(8 ML per 28 days); PA; NEDS SP
ENBREL INJ 50MG/ML	5	QL(8 ML per 28 days); PA; NEDS SP
ENBREL INJ 25MG/0.5ML	5	QL(8.16 ML per 28 days); PA; NEDS SP
ENVARSUS XR TB24 0.75MG, 1MG	4	PA BvD
ENVARSUS XR TB24 4MG	5	PA BvD; NEDS SP
everolimus tabs 0.25mg, 0.5mg, 0.75mg, 1mg	5	QL(60 EA per 30 days); PA BvD; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
GENGRAF SOLN	4	PA BvD
GENGRAF CAPS 100MG, 25MG	4	PA BvD
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJ 0, 80MG/0.8ML	5	PA; NEDS SP
HUMIRA PEN-CD/UC/HS STARTER	5	PA; NEDS SP
HUMIRA PEN-PEDIATRIC UC STARTER PACK	5	PA; NEDS SP
HUMIRA PEN-PS/UV STARTER	5	PA; NEDS SP
HUMIRA PEN INJ 80MG/0.8ML	5	QL(4 EA per 28 days); PA; NEDS SP
HUMIRA PEN INJ 40MG/0.4ML, 40MG/0.8ML	5	QL(6 EA per 28 days); PA; NEDS SP
HUMIRA INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML	5	QL(6 EA per 28 days); PA; NEDS SP
JYLAMVO	5	NEDS SP
leflunomide	2	
methotrexate sodium tabs	2	
methotrexate sodium inj 1gm/40ml, 250mg/10ml, 50mg/2ml	2	
methotrexate inj 50mg/2ml	2	
mycophenolate mofetil caps, tabs	3	PA BvD
mycophenolate mofetil susr	5	PA BvD; NEDS SP
mycophenolic acid dr	4	PA BvD
NULOJIX	5	NEDS SP
PEGASYS INJ 180MCG/0.5ML	5	QL(4 ML per 28 days); NEDS SP
PROGRAF PACK	4	PA BvD
REZUROCK	5	PA; NEDS SP
sirolimus tabs	4	PA BvD
sirolimus soln	5	PA BvD; NEDS SP
tacrolimus caps 0.5mg, 1mg, 5mg	4	PA BvD
TREXALL	4	
XATMEP	4	
Vaccines		
ABRYSVO	6	
ACTHIB INJ 0	6	
ADACEL	6	
AREXVY	6	
BCG VACCINE INJ 50MG	6	
BEXSERO	6	
BOOSTRIX	6	
DAPTACEL INJ 15LF/0.5ML; 23MCG/0.5ML; 5LF/0.5ML	6	
DENGVAXIA	6	
DIPHTHERIA/TETANUS TOXOIDS ADSORBED PEDIATRIC	6	
ENGERIX-B	6	PA BvD
GARDASIL 9	6	

Drug Name	Drug Tier	Requirements/Limits
HAVRIX INJ 1440UNIT/ML, 720ELU/0.5ML	6	
HEPLISAV-B	6	PA BvD
HIBERIX	6	
IMOVAX RABIES (H.D.C.V.)	6	
INFANRIX	6	
IPOL INACTIVATED IPV	6	
IXCHIQ	6	
IXIARO	6	
JYNNEOS	6	
KINRIX INJ 25LFU/0.5ML; 58MCG/0.5ML; 0; 10LFU/0.5ML	6	
M-M-R II	6	
MENACTRA	6	
MENQUADFI	6	
MENVEO	6	
MRESVIA	6	
PEDIARIX INJ 25LFU/0.5ML; 10MCG/0.5ML; 58MCG/0.5ML; 0; 10LFU/0.5ML	6	
PEDVAX HIB INJ 7.5MCG/0.5ML	6	
PENBRAYA	6	
PENMENVY	6	
PENTACEL	6	
PREHEVBRIO	6	PA BvD
PRIORIX	6	
PROQUAD	6	
QUADRACEL	6	
RABAVERT	6	
RECOMBIVAX HB	6	PA BvD
ROTARIX	6	
ROTATEQ SOLN	6	
SHINGRIX	6	
STAMARIL	6	
TDVAX	6	
TENIVAC	6	
TETANUS/DIPHTHERIA TOXOIDS-ADSORBED ADULT	6	
TICOVAC	6	
TRUMENBA	6	
TWINRIX	6	
TYPHIM VI	6	
VAQTA	6	
VARIVAX	6	
VAXCHORA	6	
VIMKUNYA	6	
VIVOTIF	6	

Drug Name	Drug Tier	Requirements/Limits
YF-VAX	6	
Inflammatory Bowel Disease Agents		
Aminosalicylates		
balsalazide disodium	4	
mesalamine dr	4	
mesalamine er	4	
mesalamine enem, kit, supp	4	
sulfasalazine tabs, tbec	2	
Glucocorticoids		
budesonide er	5	NEDS SP
budesonide cpep 3mg	4	
budesonide foam 2mg	4	
CORTIFOAM FOAM	4	
hydrocortisone crea 1%, 2.5%	2	
hydrocortisone enem 100mg/60ml	4	
procto-med hc	2	
proctosol hc	2	
proctozone-hc	2	
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
alendronate sodium soln	4	
alendronate sodium tabs 10mg, 35mg, 70mg	1	
BONSITY	5	PA; NEDS SP
calcitonin salmon inj	3	
calcitonin-salmon soln	3	
calcitriol caps 0.25mcg, 0.5mcg	2	
calcitriol soln 1mcg/ml	4	
cinacalcet hydrochloride	4	
paricalcitol caps	4	
PROLIA	4	PA
RAYALDEE	5	NEDS SP
risedronate sodium	3	
risedronate sodium dr	4	
teriparatide	5	PA; NEDS SP
XGEVA	5	PA; NEDS SP
zoledronic acid inj 4mg/100ml, 4mg/5ml, 5mg/100ml	2	
Miscellaneous Therapeutic Agents		
Miscellaneous Therapeutic Agents		
alcohol prep pads	2	
b-d insulin syringe ultrafine ii/0.3ml/31g x 5/16"	2	
bd insulin syringe safetyglide/1ml/29g x 1/2"	2	
bd insulin syringe ultra-fine/0.5ml/30g x 12.7mm	2	
bd insulin syringe ultra-fine/1ml/31g x 8mm	2	
bd insulin syringe/u-100/1ml/27g x 1/2"	2	

Drug Name	Drug Tier	Requirements/Limits
bd insulin syringe/u-500/0.5ml/31g x 6mm	2	
bd pen needle/original/ultra-fine/29g x 12.7mm	2	
curity gauze pads 2"x2" 12 ply	2	
droplet pen needles 29gx10mm	2	
gauze pads 2"x2"	2	
gnp insulin syringe/0.3ml/30g x 5/16"	2	
gnp insulin syringe/0.5ml/30g x 5/16"	2	
INTRALIPID INJ 20GM/100ML, 30GM/100ML	3	PA BvD
levocarnitine tabs	4	
NUTRILIPID	3	PA BvD
OMNIPOD 5 DEXCOM G7G6 INTRO KIT (GEN 5)	4	
OMNIPOD 5 DEXCOM G7G6 PODS (GEN 5)	4	
OMNIPOD 5 G7 INTRO KIT (GEN 5)	4	
OMNIPOD 5 G7 PODS (GEN 5)	4	
OMNIPOD 5 LIBRE2 PLUS G6 INTRO GEN 5	4	
OMNIPOD 5 LIBRE2 PLUS G6 PODS	4	
OMNIPOD CLASSIC PDM STARTER KIT (GEN 3)	4	
OMNIPOD CLASSIC PODS (GEN 3)	4	
OMNIPOD DASH INTRO KIT (GEN 4)	4	
OMNIPOD DASH PDM KIT (GEN 4)	4	
OMNIPOD DASH PODS (GEN 4)	4	
OMNIPOD GO 10 UNITS/DAY	4	
OMNIPOD GO 15 UNITS/DAY	4	
OMNIPOD GO 20 UNITS/DAY	4	
OMNIPOD GO 25 UNITS/DAY	4	
OMNIPOD GO 30 UNITS/DAY	4	
OMNIPOD GO 35 UNITS/DAY	4	
OMNIPOD GO 40 UNITS/DAY	4	
sodium chloride 0.9%	3	
sterile water for irrigation	2	
techlite insulin syringe u-100/0.5ml/30g x 1/2"	2	
trueplus insulin syringe /u-100/1ml/29g x 1/2"	2	
trueplus pen needles 29gx12mm	2	
Ophthalmic Agents		
Ophthalmic Agents, Other		
atropine sulfate soln 1%	4	
bacitracin/polymyxin b	2	
brimonidine tartrate/timolol maleate	4	
cyclopentolate hcl soln 2%	2	
cyclopentolate hydrochloride	2	
cyclosporine emul 0.05%	4	
CYSTARAN	5	NEDS SP
dorzolamide hcl/timolol maleate	2	
dorzolamide hydrochloride/timolol maleate pf	4	

Drug Name	Drug Tier	Requirements/Limits
neo-polycin	3	
neo-polycin hc	3	
neomycin/bacitracin/polymyxin	3	
neomycin/polymyxin/bacitracin zinc oint 400unit/gm; 3.5mg/gm; 10000unit/gm	3	
neomycin/polymyxin/bacitracin/hydrocortisone	3	
neomycin/polymyxin/dexamethasone susp	2	
neomycin/polymyxin/dexamethasone oint	3	
neomycin/polymyxin/gramicidin	3	
neomycin/polymyxin/hydrocortisone ophthalmic susp 1%; 3.5mg/ml; 10000unit/ml	4	
polycin	2	
polymyxin b sulfate/trimethoprim sulfate	2	
RESTASIS	3	
RESTASIS MULTIDOSE	3	
ROCKLATAN	3	
SIMBRINZA	3	
sulfacetamide sodium/prednisolone sodium phosphate	2	
TOBRADEX ST	3	
tobramycin/dexamethasone	3	
XIIDRA	4	
Ophthalmic Anti-allergy Agents		
ALOCRIL	4	
azelastine hcl ophthalmic soln 0.05%	2	
bepotastine besilate	4	
cromolyn sodium soln 4%	2	
epinastine hcl	4	
olopatadine hydrochloride	3	
Ophthalmic Anti-Infectives		
bacitracin	4	
BESIVANCE	4	
ciprofloxacin hydrochloride soln 0.3%	2	
erythromycin oint 5mg/gm	2	
gatifloxacin	4	
gentak oint	2	
gentamicin sulfate ophthalmic soln 0.3%	2	
levofloxacin ophthalmic soln 0.5%, 1.5%	3	
moxifloxacin hydrochloride soln 0.5%	2	
NATACYN	4	
ofloxacin ophthalmic soln 0.3%	2	
sulfacetamide sodium oint 10%	3	
sulfacetamide sodium soln 10%	3	
tobramycin	2	
trifluridine	4	

Drug Name	Drug Tier	Requirements/Limits
XDEMVY	5	PA; NEDS SP
ZIRGAN	4	
Ophthalmic Anti-inflammatories		
bromfenac	4	
bromfenac sodium soln 0.07%	3	
bromfenac sodium soln 0.075%	4	
BROMSITE	4	
dexamethasone sodium phosphate ophthalmic soln 0.1%	4	
diclofenac sodium ophthalmic soln 0.1%	2	
difluprednate	4	
FLAREX	3	
fluorometholone	4	
flurbiprofen sodium	4	
ILEVRO	3	
ketorolac tromethamine	2	
LOTEMAX OINT	4	
loteprednol etabonate	4	
prednisolone acetate	3	
prednisolone sodium phosphate ophthalmic soln 1%	3	
PROLENSA	3	
Ophthalmic Beta-Adrenergic Blocking Agents		
betaxolol hcl	4	
BETIMOL	4	
carteolol hcl	2	
levobunolol hcl soln 0.5%	3	
timolol hemihydrate	4	
timolol maleate ophthalmic gel forming	4	
timolol maleate soln 0.25%, 0.5%	1	
timolol maleate soln 0.5%	4	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
acetazolamide	2	
acetazolamide er	2	
ALPHAGAN P SOLN 0.1%	3	
apraclonidine	4	
brimonidine tartrate soln 0.2%	2	
brimonidine tartrate soln 0.1%	3	
brimonidine tartrate soln 0.15%	4	
brinzolamide	4	
dorzolamide hydrochloride	2	
methazolamide tabs	4	
PHOSPHOLINE IODIDE SOLR 0.125%	3	
pilocarpine hcl soln 1%, 2%, 4%	3	
pilocarpine hydrochloride soln 1%, 2%, 4%	3	
RHOPRESSA	3	

Drug Name	Drug Tier	Requirements/Limits
Ophthalmic Prostaglandin and Prostamide Analogs		
bimatoprost	4	
latanoprost soln	2	
LUMIGAN	3	
tafluprost	4	
travoprost	4	
VYZULTA	4	
Otic Agents		
Otic Agents		
acetic acid	2	
ciprofloxacin/dexamethasone	4	
ciprofloxacin soln 0.2%	4	
CORTISPORIN-TC	4	
flac	4	
fluocinolone acetonide oil 0.01%	3	
hydrocortisone/acetic acid	4	
neomycin/polymyxin/hc	4	
neomycin/polymyxin/hydrocortisone otic susp 1%; 3.5mg/ml; 10000unit/ml	4	
ofloxacin otic soln 0.3%	2	
Respiratory Tract/Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
budesonide susp 0.25mg/2ml, 0.5mg/2ml, 1mg/2ml	4	PA BvD
FLOVENT DISKUS AEPB 100MCG/BLIST	4	QL(180 EA per 90 days); ST
FLOVENT DISKUS AEPB 250MCG/BLIST	4	QL(720 EA per 90 days); ST
FLOVENT DISKUS AEPB 50MCG/BLIST	4	ST
flunisolide soln 0.025%	3	QL(150 ML per 90 days)
fluticasone propionate diskus aepb 100mcg/act	4	QL(180 EA per 90 days); ST
fluticasone propionate diskus aepb 250mcg/act	4	QL(720 EA per 90 days); ST
fluticasone propionate diskus aepb 50mcg/act	4	ST
fluticasone propionate hfa aero 44mcg/act	4	QL(63.6 GM per 90 days); ST
fluticasone propionate hfa aero 110mcg/act, 220mcg/act	4	QL(72 GM per 90 days); ST
fluticasone propionate susp 50mcg/act	1	QL(48 GM per 90 days)
mometasone furoate susp 50mcg/act	3	QL(102 GM per 90 days)
QVAR REDIHALER	3	QL(63.6 GM per 90 days)
Antihistamines		
azelastine hcl nasal soln 0.15%	2	QL(120 ML per 90 days)
azelastine hydrochloride soln 0.1%	2	QL(120 ML per 90 days)
cyproheptadine hcl syrp	4	
cyproheptadine hydrochloride tabs	2	
desloratadine	3	
diphenhydramine hydrochloride inj	2	
hydroxyzine hcl inj 25mg/ml	2	
hydroxyzine hcl tabs 50mg	2	

Drug Name	Drug Tier	Requirements/Limits
hydroxyzine hydrochloride syrp	2	
hydroxyzine hydrochloride tabs 10mg, 25mg	2	
hydroxyzine pamoate caps	2	
levocetirizine dihydrochloride tabs	2	
Antileukotrienes		
montelukast sodium chew, pack, tabs	2	
zafirlukast	4	
Bronchodilators, Anticholinergic		
atrovent hfa	4	QL(77.4 GM per 90 days)
INCRUSE ELLIPTA	3	QL(30 EA per 30 days)
ipratropium bromide inhalation soln	2	PA BvD
ipratropium bromide nasal soln 0.03%	3	QL(180 ML per 90 days)
ipratropium bromide nasal soln 0.06%	3	QL(90 ML per 90 days)
LONHALA MAGNAIR REFILL KIT	5	NEDS SP
LONHALA MAGNAIR STARTER KIT	5	NEDS SP
SPIRIVA RESPIMAT	3	QL(12 GM per 90 days)
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa aers 108mcg/act	2	QL(108 GM per 90 days)
albuterol sulfate hfa aers 108mcg/act	2	QL(40.2 GM per 90 days)
albuterol sulfate hfa aers 108mcg/act	2	QL(51 GM per 90 days)
albuterol sulfate nebu	2	PA BvD
albuterol sulfate syrp, tabs	4	
arformoterol tartrate	4	PA BvD
epinephrine inj 0.15mg/0.15ml, 0.15mg/0.3ml, 0.3mg/0.3ml	3	QL(2 EA per 1 days)
formoterol fumarate nebu	4	PA BvD
levalbuterol hcl nebu	4	PA BvD
levalbuterol hydrochloride nebu 0.63mg/3ml	4	PA BvD
levalbuterol nebu	4	PA BvD
PROAIR RESPICLICK	3	QL(6 EA per 90 days)
SEREVENT DISKUS	3	QL(180 EA per 90 days)
STRIVERDI RESPIMAT	3	QL(12 GM per 90 days)
Cystic Fibrosis Agents		
CAYSTON	5	PA; NEDS SP
KALYDECO	5	QL(56 EA per 28 days); PA; NEDS SP
ORKAMBI TABS	5	QL(112 EA per 28 days); PA; NEDS SP
ORKAMBI PACK	5	QL(56 EA per 28 days); PA; NEDS SP
PULMOZYME	5	PA BvD; NEDS SP
TOBI PODHALER	5	NEDS SP
Mast Cell Stabilizers		
cromolyn sodium nebu 20mg/2ml	3	PA BvD
Phosphodiesterase Inhibitors, Airways Disease		

Drug Name	Drug Tier	Requirements/Limits
elixophyllin	2	
roflumilast	4	
theophylline er tb24	3	
theophylline er tb12	4	
theophylline elix	2	
Pulmonary Antihypertensives		
ADEMPAS	5	PA; NEDS SP
alyq	4	PA
ambrisentan	5	PA; NEDS SP
bosentan	5	PA; NEDS SP
OPSUMIT	5	PA; NEDS SP
ORENITRAM TITRATION KIT MONTH 1	5	PA; NEDS SP
ORENITRAM TITRATION KIT MONTH 2	5	PA; NEDS SP
ORENITRAM TITRATION KIT MONTH 3	5	PA; NEDS SP
ORENITRAM TBCR 0.125MG, 0.25MG, 1MG, 2.5MG	4	PA
ORENITRAM TBCR 5MG	5	PA; NEDS SP
sildenafil citrate tabs 20mg	3	PA
tadalafil tabs 20mg	4	PA
TRACLEER TBSO	5	PA; NEDS SP
VENTAVIS	5	PA; NEDS SP
Pulmonary Fibrosis Agents		
OFEV	5	QL(60 EA per 30 days); PA; NEDS SP
pirfenidone caps	5	QL(270 EA per 30 days); PA; NEDS SP
pirfenidone tabs 534mg	5	QL(135 EA per 30 days); PA; NEDS SP
pirfenidone tabs 267mg	5	QL(270 EA per 30 days); PA; NEDS SP
pirfenidone tabs 801mg	5	QL(90 EA per 30 days); PA; NEDS SP
Respiratory Tract Agents, Other		
acetylcysteine soln	4	PA BvD
ANORO ELLIPTA	3	QL(180 EA per 90 days)
benzonatate	2	EC
BEVESPI AEROSPHERE	3	QL(10.7 GM per 30 days)
BREO ELLIPTA	3	QL(180 EA per 90 days)
BREYNA	4	QL(30.9 GM per 90 days)
BREZTRI AEROSPHERE	3	QL(32.1 GM per 90 days)
BRONCHITOL	5	NEDS SP
COMBIVENT RESPIMAT	3	QL(24 GM per 90 days)
FASENRA PEN	5	PA; NEDS SP
FASENRA INJ 10MG/0.5ML	4	PA
FASENRA INJ 30MG/ML	5	PA; NEDS SP

Drug Name	Drug Tier	Requirements/Limits
fluticasone propionate/salmeterol diskus	3	QL(180 EA per 90 days)
fluticasone propionate/salmeterol aepb 500mcg/act; 50mcg/act	3	QL(180 EA per 90 days)
fluticasone propionate/salmeterol aepb 113mcg/act; 14mcg/act, 232mcg/act; 14mcg/act, 55mcg/act; 14mcg/act	3	QL(3 EA per 90 days)
hydrocodone bitartrate/homatropine methylbromide tabs	2	EC
hydrocodone polistirex/chlorpheniramine polistirex	2	EC
ipratropium bromide/albuterol sulfate	2	PA BvD
promethazine vc/codeine	2	EC
promethazine/codeine soln	2	EC
promethazine/phenylephrine/codeine	2	EC
STIOLTO RESPIMAT	3	QL(12 GM per 90 days)
TRELEGY ELLIPTA	3	QL(180 EA per 90 days)
wixela inhub	3	QL(180 EA per 90 days)
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
cyclobenzaprine hydrochloride tabs	3	
Sleep Disorder Agents		
Sleep Promoting Agents		
BELSOMRA	3	
eszopiclone	2	
flurazepam hcl	2	
flurazepam hydrochloride	2	
ramelteon	4	QL(30 EA per 30 days)
tasimelteon	5	PA; NEDS SP
temazepam caps 15mg, 30mg, 7.5mg	2	
triazolam	3	
zaleplon	2	
zolpidem tartrate tabs	2	
Wakefulness Promoting Agents		
armodafinil	3	PA
modafinil tabs	2	PA
sodium oxybate	5	PA; NEDS SP

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You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document.

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kcl 0.15%/d5w/nacl 0.45%	40
kcl 0.15%/d5w/nacl 0.9%	40
kcl 0.3%/d5w/nacl 0.45%	40
kcl 0.3%/d5w/nacl 0.9%	40
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You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document.

TUFTS Health Plan

a Point32Health company

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Someone who speaks English can help you. This is a free service.

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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)。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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 quí vị cần thông dịch viên xin gọi 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-701-9000 (HMO)/1-866-623-0172 (PPO)**. هذه خدمة مجانية. سيقوم شخص ما يتحدث العربية بمساعدتك.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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 z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-701-9000 (HMO)/1-866-623-0172 (PPO). 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ございます。通訳をご用命になるには、1-800-701-9000 (HMO)/1-866-623-0172 (PPO)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。

This formulary was updated on 12/01/2025. For more recent information or other questions, please contact Tufts Medicare Preferred HMO Member Services at **1-800-701-9000** (TTY users should call 711), 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 to March 31 and Monday– Friday from April 1 to September 30, or visit **www.thpmp.org**.

TUFTS Health Plan
1 Wellness Way
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Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (TTY: 711).