

2016 Prescription Drug Guide

Humana Abbreviated Formulary

Partial list of covered drugs

Humana Enhanced (PDP)

Region 15
States of Indiana and Kentucky



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

This abridged formulary was updated on 11/05/2016 and is not a complete list of drugs covered by our plan. For a complete listing, more recent information or other questions, please contact Humana at 1-800-281-6918 or, for TTY users, 711, 7 days a week, from 8 a.m. - 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from Feb. 15 - Sept. 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit Humana.com.

Instructions for getting information about all covered drugs are inside.

Humana®

Welcome to Humana!

Note to existing members: This formulary changes yearly. If you belonged to the plan in 2015, please review this document to make sure that it still contains the drugs you take.

What is the formulary?

A formulary is the list of covered drugs selected by Humana. Humana worked with a team of doctors and pharmacists to make a formulary that represents the prescription drugs we think you need for a quality treatment program. Humana will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Humana network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary, which means it includes only some of the drugs covered by Humana. To search the complete list of all prescription drugs Humana covers, you can visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

For help or a complete list of covered drugs, you can also call Humana Customer Care at **1-800-281-6918 (TTY: 711)**. You can call us seven days a week, from 8 a.m. - 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from Feb. 15 - Sept. 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

Can the formulary change?

Generally, we won't discontinue or reduce coverage of the drug during the 2016 coverage year if you take a drug that was covered at the beginning of the year. However, we may change the formulary when a new, less-expensive generic drug becomes available or when new information about the safety or effectiveness of a drug is released.

We'll notify you if you are affected by the following changes to our formulary:

- When we remove a drug from the formulary
- When we add prior authorization, quantity limits, or step-therapy restrictions on a drug
- When we move a drug to a higher cost-sharing tier

What if you're affected by a formulary change?

We'll notify you at least 60 days before one of these changes happens or when you request a refill of the affected drug.

If the Food and Drug Administration (FDA) decides a drug on our formulary is unsafe or the drug's manufacturer takes the drug off the market, we'll immediately remove the drug from our formulary and then notify you if you're taking the drug.

The enclosed formulary is current as of November 2016. We'll update our printed formularies each month and they'll be available on **Humana.com/medicaredruglist**.

How do I use the formulary?

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

Medical condition

The formulary starts on page 10. We've put the drugs into groups depending on the type of medical conditions that they're used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Drugs." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 10. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 5 for more information on Utilization Management Requirements).

Alphabetical listing

If you're not sure about your drug's category or group, you can look for your drug in the Index that begins on page 33. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you'll see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

Prescription drugs are grouped into one of five tiers.

Humana covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

- **Tier 1 - Preferred Generic:** Generic or brand drugs that are available at the lowest cost share for the plan
- **Tier 2 - Generic:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Preferred Generic drugs
- **Tier 3 - Preferred Brand:** Generic or brand drugs that the plan offers at a lower cost to you than Tier 4 Non-Preferred Brand drugs
- **Tier 4 - Non-Preferred Brand:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 3 Preferred Brand drugs
- **Tier 5 - Specialty Tier:** Some injectables and other high-cost drugs

How much will I pay for covered drugs?

Humana pays part of the costs for your covered drugs and you pay part of the costs, too.

The amount of money you pay depends on:

- Which tier your drug is on
- Whether you fill your prescription at a network pharmacy
- Your current drug payment stage - please read your Evidence of Coverage (EOC) for more information

If you qualified for extra help with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage (EOC) or call Customer Care to find out what your costs are.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These are called Utilization Management Requirements. These requirements and limits may include:

- **Prior Authorization (PA):** Humana requires you to get prior authorization for certain drugs to be covered under your plan. This means that you'll need to get approval from Humana before you fill your prescriptions. If you don't get approval, Humana may not cover the drug.
- **Quantity Limits (QL):** For some drugs, Humana limits the amount of the drug that we'll cover. Humana might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of tier placement.
- **Step Therapy (ST):** In some cases, Humana requires you to first try certain drugs to treat your medical condition before we'll cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Humana may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Humana will then cover Drug B.
- **Part B versus Part D (B vs D):** Some drugs may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted to Humana that describes the use and the place where you receive and take the drug so we can make the determination.

For drugs that need prior authorization or step therapy or drugs that fall outside of quantity limits, your doctor can fax information about your condition and need for those drugs to Humana at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 6 p.m.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 10.

You can also visit **Humana.com/medicaredruglist** to get more information about the restrictions applied to specific covered drugs.

You can ask Humana to make an exception to these restrictions or limits. See the section "**How do I request an exception to the formulary?**" on page 6 for information about how to request an exception.

Does healthcare reform impact my coverage?

Since 2011, Medicare has made changes to help with the cost of medicines while members are in the Prescription Drug Plan coverage gap, which is often called the "donut hole." The Centers for Medicare & Medicaid Services (CMS) work with the companies that make prescription drugs and health plans so you receive nearly 55 percent off the cost of many covered, brand-name drugs while you're in the coverage gap. Medicare members who receive the low-income subsidy ("Extra Help") or are covered by a qualified, commercial prescription plan through an employer won't get this discount.

What if my drug isn't on the formulary?

If your drug isn't included in this list of covered drugs, visit **Humana.com/medicaredruglist** to see if your plan covers your drug. You can also call Customer Care and ask if your drug is covered.

If Humana doesn't cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that Humana covers. Show the list to your doctor and ask him or her to prescribe a similar drug that is covered by Humana.
- You can ask Humana to make an exception and cover your drug. See below for information about how to request an exception.

Talk to your doctor to decide if you should switch to another drug that we cover or if you should request a formulary exception so that we'll cover your drug.

How do I request an exception to the formulary?

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

- **Formulary exception:** You can ask us to cover your drug if it's not on our formulary.
- **Utilization restriction exception:** You can ask us not to apply coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us to not apply the limit and to cover more doses of the drug.
- **Tier exception:** You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can ask us to cover it as preferred drug instead. This would lower how much money you must pay for your drug. Please remember that you can't ask us to provide a higher level of coverage for the drug if we grant your request to cover a drug that is not on our formulary.

Generally, Humana will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or other restrictions wouldn't be as effective in treating your health condition and/or would cause adverse medical effects.

You should contact us to ask for an initial coverage decision for a formulary, tier, or utilization restriction exception. When you ask for an exception, you should submit a statement from your doctor that supports your request. This is called a supporting statement.

Generally, we must make our decision within 72 hours of getting your doctor's supporting statement. You can request a quicker, or expedited, exception if you or your doctor thinks your health would seriously suffer if you wait as long as 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your doctor's supporting statement.

Will my plan cover my drugs if they are not on the formulary?

You may take drugs that your plan doesn't cover. Or, you may talk to your provider about taking a different drug that your plan covers, but that drug might have a Utilization Management Requirement, such as a Prior Authorization or Step Therapy, that keeps you from getting the drug right away. In certain cases, we may cover as much as a 30-day supply of your drug during the first 90 days you're a member of our plan.

Here is what we'll do for each of your current Part D drugs that aren't on our formulary, or if you have limited ability to get your drugs:

- We'll temporarily cover up to a 30-day supply of your medicine when you go to a pharmacy.
- We won't pay for these drugs after your first 30-day supply, even if you've been a member of the plan for less than 90 days, unless we have granted you a formulary exception.

If you're a resident of a long-term care facility and you take Part D drugs that aren't on our formulary, we'll cover up to a 31-day supply, plus refills for a maximum of a 91-98 day supply of your current drug therapy (unless you have a prescription written for fewer days). We'll cover more than one refill of these drugs for the first 90 days you're a member of our plan. We'll cover a 31-day emergency supply of your drug (unless you have a prescription for fewer days) while you ask for a formulary exception if:

- You need a drug that's not on our formulary *or*
- You have limited ability to get your drugs *and*
- You're past the first 90 days of membership in our plan

Throughout the plan year, you may have a change in your treatment setting (the place where you receive and take your medicine) because of how much care you need. These changes include:

- Members who are discharged from a hospital or skilled-nursing facility to a home setting
- Members who are admitted to a hospital or skilled-nursing facility from a home setting
- Members who transfer from one skilled-nursing facility to another and use a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit

- Members who give up Hospice Status and go back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, Humana will cover as much as a 31-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. Humana will review these requests for continuation of therapy on a case-by-case basis when you're on a stabilized drug regimen that, if changed, is known to have risks.

Transition extension

Humana will consider on a case-by-case basis an extension of the transition period if your exception request or appeal hasn't been processed by the end of your initial transition period. We'll continue to provide necessary drugs to you if your transition period is extended.

A Transition Policy is available on Humana's Medicare website, **Humana.com**, in the same area where the Prescription Drug Guides are displayed.

MyHumana - Your secure website

Register for MyHumana, your secure website on **Humana.com**, to find out more about your prescription drug plan. You can sign in to MyHumana to get details about your benefits, view your claims, and explore the Medicare tab. You can also use the Rx Calculator under "Pharmacy Tools" on MyHumana to:

- Estimate your monthly drug costs and how long it will take you to reach the various cost "stages" for your prescription drug plan
- Get information about pricing, coverage, usage, dosage, interactions, and other details on more than 10,000 drugs
- Find out if a generic alternative might save you money

For More Information

For more detailed information about your Humana prescription drug coverage, please read your Evidence of Coverage (EOC) and other plan materials.

If you have questions about Humana, please visit our website at **[Humana.com/medicaredruglist](https://www.humana.com/medicaredruglist)**. The Drug List Search tool lets you search for your drug by name or drug type.

You can also call Humana Customer Care at **1-800-281-6918 (TTY: 711)**. You can call us seven days a week, from 8 a.m. - 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from Feb. 15 to Sept. 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

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

Humana Formulary

The formulary that begins on the next page provides coverage information about some of the drugs covered by Humana. If you have trouble finding your drug in the list, turn to the Index that begins on page 33.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug isn't listed in this partial formulary, please visit our website at **Humana.com**. Our additional contact information is listed on the previous page.

How to read your formulary

The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand-name drugs are CAPITALIZED and generic drugs are listed in lower-case italics. Next to the drug name you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:

GB - Select brand drugs that are covered in the gap

SP - Medicines that are typically available through a specialty pharmacy. Please contact your specialty pharmacy to make sure your drug is available.

MO - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.

The second column lists the tier of the drug. See page 4 for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. Humana may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your doctor prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 5 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANTI-INFECTIVE AGENTS		
abacavir 300 mg tablet MO	4	QL (60 per 30 days)
abacavir-lamivudine-zidov tab MO	5	QL (60 per 30 days)
acyclovir 200 mg capsule; acyclovir 400 mg, 800 mg tablet MO	2	
acyclovir sodium 500 mg vial MO	2	
adefovir dipivoxil 10 mg tab SP	5	
amoxicillin 125 mg, 250 mg tab chew; amoxicillin 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml susp; amoxicillin 250 mg, 500 mg capsule; amoxicillin 500 mg, 875 mg tablet MO	1	
azithromycin 250 mg, 500 mg, 600 mg tablet MO	2	
bacitracin 50,000 units vial MO	3	
BETHKIS 300 MG/4 ML SOLUTION FOR NEBULIZATION SP	5	PA,QL (224 per 28 days)
cefaclor 250 mg, 500 mg capsule MO	2	
cefuroxime axetil 250 mg, 500 mg tab MO	3	
cephalexin 125 mg/5 ml, 250 mg/5 ml susp; cephalexin 250 mg, 500 mg capsule; cephalexin 250 mg, 500 mg tablet MO	2	
ciprofloxacin hcl 100 mg, 250 mg, 500 mg, 750 mg tab MO	1	
clarithromycin 125 mg/5 ml, 250 mg/5 ml sus; clarithromycin 250 mg, 500 mg tablet; clarithromycin er 500 mg tab MO	3	
clindamycin hcl 150 mg, 300 mg, 75 mg capsule MO	2	
CRIXIVAN 200 MG CAPSULE MO	4	QL (450 per 30 days)
CRIXIVAN 400 MG CAPSULE MO	4	QL (270 per 30 days)
famciclovir 125 mg, 250 mg, 500 mg tablet MO	3	QL (90 per 30 days)
HARVONI 90 MG-400 MG TABLET SP	5	PA,QL (28 per 28 days)
isoniazid 100 mg, 300 mg tablet; isoniazid 100 mg/ml, 50 mg/5 ml solution; isoniazid 100 mg/ml, 50 mg/5 ml vial MO	1	
levofloxacin 250 mg, 500 mg, 750 mg tablet MO	2	
metronidazole 250 mg, 500 mg tablet MO	2	
NORVIR 100 MG CAPSULE; NORVIR 100 MG TABLET MO	4	QL (360 per 30 days)
PEGINTRON 120 MCG/0.5 ML, 150 MCG/0.5 ML, 50 MCG/0.5 ML, 80 MCG/0.5 ML SUBCUTANEOUS KIT SP	5	PA,QL (2 per 28 days)
PEGINTRON REDIPEN 120 MCG/0.5 ML, 150 MCG/0.5 ML, 50 MCG/0.5 ML, 80 MCG/0.5 ML SUBCUTANEOUS KIT SP	5	PA,QL (2 per 28 days)
primaquine 26.3 mg tablet MO	3	
PYLERA 140 MG-125 MG-125 MG CAPSULE MO	4	QL (144 per 30 days)
quinine sulfate 324 mg capsule MO	4	PA,QL (42 per 7 days)
ribavirin 200 mg capsule; ribavirin 200 mg tablet MO	3	QL (168 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 9.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SOVALDI 400 MG TABLET ^{SP}	5	PA,QL (28 per 28 days)
<i>sulfamethoxazole-tmp ds tablet; sulfamethoxazole-tmp ss tablet</i> ^{MO}	1	
SUSTIVA 200 MG CAPSULE ^{SP}	5	QL (120 per 30 days)
SUSTIVA 50 MG CAPSULE ^{SP}	4	QL (480 per 30 days)
SUSTIVA 600 MG TABLET ^{SP}	5	QL (30 per 30 days)
<i>tinidazole 250 mg, 500 mg tablet</i> ^{MO}	3	
TRIZIVIR 300 MG-150 MG-300 MG TABLET ^{MO}	5	QL (60 per 30 days)
VIREAD 150 MG, 200 MG, 250 MG, 300 MG TABLET ^{SP}	5	QL (30 per 30 days)
VIREAD 40 MG/SCOOP (40 MG/GRAM) ORAL POWDER ^{SP}	5	QL (240 per 30 days)
ANTIHISTAMINE DRUGS		
<i>levocetirizine 5 mg tablet</i> ^{MO}	2	QL (30 per 30 days)
ANTINEOPLASTIC AGENTS		
<i>anastrozole 1 mg tablet</i> ^{MO}	1	QL (30 per 30 days)
<i>bicalutamide 50 mg tablet</i> ^{MO}	3	QL (30 per 30 days)
GILOTRIF 20 MG, 30 MG, 40 MG TABLET ^{SP}	5	PA,QL (30 per 30 days)
GLEEVEC 100 MG TABLET ^{SP}	5	PA,QL (180 per 30 days)
GLEEVEC 400 MG TABLET ^{SP}	5	PA,QL (60 per 30 days)
ICLUSIG 15 MG TABLET ^{SP}	5	PA,QL (60 per 30 days)
ICLUSIG 45 MG TABLET ^{SP}	5	PA,QL (30 per 30 days)
IMBRUVICA 140 MG CAPSULE ^{SP}	5	PA,QL (120 per 30 days)
INLYTA 1 MG TABLET ^{SP}	5	PA,QL (180 per 30 days)
INLYTA 5 MG TABLET ^{SP}	5	PA,QL (60 per 30 days)
<i>letrozole 2.5 mg tablet</i> ^{MO}	2	QL (30 per 30 days)
MEKINIST 0.5 MG TABLET ^{SP}	5	PA,QL (120 per 30 days)
MEKINIST 2 MG TABLET ^{SP}	5	PA,QL (30 per 30 days)
<i>methotrexate 2.5 mg tablet</i> ^{MO}	3	B vs D
REVLIMID 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG CAPSULE ^{SP}	5	PA,QL (28 per 28 days)
SPRYCEL 100 MG, 50 MG, 70 MG, 80 MG TABLET ^{SP}	5	PA,QL (60 per 30 days)
SPRYCEL 140 MG TABLET ^{SP}	5	PA,QL (30 per 30 days)
SPRYCEL 20 MG TABLET ^{SP}	5	PA,QL (90 per 30 days)
SUTENT 12.5 MG, 25 MG, 37.5 MG, 50 MG CAPSULE ^{SP}	5	PA,QL (28 per 28 days)
TAFINLAR 50 MG CAPSULE ^{SP}	5	PA,QL (180 per 30 days)
TAFINLAR 75 MG CAPSULE ^{SP}	5	PA,QL (120 per 30 days)
<i>tamoxifen 10 mg, 20 mg tablet</i> ^{MO}	2	
TARCEVA 100 MG, 150 MG TABLET ^{SP}	5	PA,QL (30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TARCEVA 25 MG TABLET SP	5	PA,QL (90 per 30 days)
TARGRETIN 75 MG CAPSULE SP	5	PA,QL (300 per 30 days)
TASIGNA 150 MG, 200 MG CAPSULE SP	5	PA,QL (120 per 30 days)
TREXALL 10 MG, 15 MG, 5 MG, 7.5 MG TABLET MO	4	B vs D
VOTRIENT 200 MG TABLET SP	5	PA,QL (120 per 30 days)
XALKORI 200 MG, 250 MG CAPSULE SP	5	PA,QL (60 per 30 days)
XTANDI 40 MG CAPSULE SP	5	PA,QL (120 per 30 days)
ZYDELIG 100 MG, 150 MG TABLET SP	5	PA,QL (60 per 30 days)
ZYKADIA 150 MG CAPSULE SP	5	PA,QL (150 per 30 days)
ZYTIGA 250 MG TABLET SP	5	PA,QL (120 per 30 days)
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES		
ZOSTAVAX (PF) 19,400 UNIT/0.65 ML SUBCUTANEOUS SUSPENSION MO	4	QL (0.65 per 365 days)
AUTONOMIC DRUGS		
albuterol 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml sol; albuterol 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml solution; albuterol sul 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml sol; albuterol sul 2.5 mg/3 ml soln MO	2	B vs D
albuterol sulf 2 mg/5 ml syrup MO	2	
albuterol sulfate 2 mg, 4 mg tab; albuterol sulfate er 4 mg, 8 mg tab MO	4	
alfuzosin hcl er 10 mg tablet MO	2	QL (30 per 30 days)
ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION MO	3	
ARCAPTA NEOHALER 75 MCG CAPSULE WITH INHALATION DEVICE MO	4	QL (30 per 30 days)
baclofen 10 mg, 20 mg tablet MO	2	
bethanechol 10 mg, 25 mg, 5 mg tablet MO	3	
bethanechol 50 mg tablet MO	4	
CHANTIX 0.5 MG, 1 MG TABLET MO	4	QL (56 per 28 days)
COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION MO	4	
donepezil hcl 10 mg tablet MO	1	QL (60 per 30 days)
donepezil hcl 10 mg, 5 mg, 5 mg tablet; donepezil hcl odt 10 mg, 5 mg, 5 mg tablet MO	1	QL (30 per 30 days)
EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR GB,MO	3	
EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR GB,MO	3	
EXELON PATCH 13.3 MG/24 HOUR, 4.6 MG/24 HR, 9.5 MG/24 HR TRANSDERMAL MO	4	QL (30 per 30 days)
FORADIL AEROLIZER 12 MCG CAPSULE WITH INHALATION DEVICE MO	3	QL (60 per 30 days)

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
galantamine er 16 mg, 24 mg, 8 mg capsule ^{MO}	4	QL (30 per 30 days)
galantamine hbr 12 mg, 4 mg, 8 mg tablet ^{MO}	4	QL (60 per 30 days)
RAPAFLO 4 MG, 8 MG CAPSULE ^{MO}	3	QL (30 per 30 days)
rivastigmine 1.5 mg, 3 mg capsule ^{MO}	4	QL (90 per 30 days)
rivastigmine 4.5 mg, 6 mg capsule ^{MO}	4	QL (60 per 30 days)
SEREVENT DISKUS 50 MCG/DOSE POWDER FOR INHALATION ^{MO}	3	QL (60 per 30 days)
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION SOLUTION FOR INHALATION ^{MO}	3	
SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES ^{MO}	3	
tamsulosin hcl 0.4 mg capsule ^{MO}	2	QL (60 per 30 days)
TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED ^{MO}	4	
VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER ^{MO}	3	QL (36 per 30 days)
BLOOD FORMATION, COAGULATION, THROMBOSIS		
BRILINTA 90 MG TABLET ^{MO}	3	QL (60 per 30 days)
cilostazol 100 mg tablet ^{MO}	2	
cilostazol 50 mg tablet ^{MO}	2	
clopidogrel 300 mg tablet ^{MO}	2	QL (1 per 30 days)
clopidogrel 75 mg tablet ^{MO}	2	QL (30 per 30 days)
EFFIENT 10 MG TABLET ^{MO}	3	QL (30 per 30 days)
EFFIENT 5 MG TABLET ^{MO}	3	QL (30 per 30 days)
ELIQUIS 2.5 MG TABLET ^{MO}	3	QL (60 per 30 days)
ELIQUIS 5 MG TABLET ^{MO}	3	QL (74 per 30 days)
enoxaparin 100 mg/ml syringe ^{MO}	4	QL (28 per 28 days)
enoxaparin 120 mg/0.8 ml syr ^{MO}	4	QL (22.4 per 28 days)
enoxaparin 150 mg/ml syringe ^{MO}	4	QL (28 per 28 days)
enoxaparin 30 mg/0.3 ml syr ^{MO}	4	QL (16.8 per 28 days)
enoxaparin 300 mg/3 ml vial ^{MO}	4	QL (84 per 28 days)
enoxaparin 40 mg/0.4 ml syr ^{MO}	4	QL (11.2 per 28 days)
enoxaparin 60 mg/0.6 ml syr ^{MO}	4	QL (16.8 per 28 days)
enoxaparin 80 mg/0.8 ml syr ^{MO}	4	QL (22.4 per 28 days)
fondaparinux 2.5 mg/0.5 ml syr ^{MO}	4	QL (15 per 30 days)
fondaparinux 5 mg/0.4 ml syr ^{MO}	5	QL (12 per 30 days)
fondaparinux 7.5 mg/0.6 ml syr ^{MO}	5	QL (18 per 30 days)
NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE ^{SP}	5	PA,QL (7 per 30 days)
NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE ^{SP}	5	PA,QL (11.2 per 30 days)
NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION ^{SP}	5	PA,QL (22.4 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
PRADAXA 150 MG CAPSULE ^{MO}	4	QL (60 per 30 days)
PRADAXA 75 MG CAPSULE ^{MO}	4	QL (60 per 30 days)
PROCRT 10,000 UNIT/ML INJECTION SOLUTION ^{SP}	4	PA,QL (14 per 30 days)
PROCRT 2,000 UNIT/ML INJECTION SOLUTION ^{SP}	4	PA,QL (14 per 30 days)
PROCRT 20,000 UNIT/ML INJECTION SOLUTION ^{SP}	5	PA,QL (14 per 30 days)
PROCRT 3,000 UNIT/ML INJECTION SOLUTION ^{SP}	4	PA,QL (14 per 30 days)
PROCRT 4,000 UNIT/ML INJECTION SOLUTION ^{SP}	4	PA,QL (14 per 30 days)
PROCRT 40,000 UNIT/ML INJECTION SOLUTION ^{SP}	5	PA,QL (14 per 30 days)
warfarin sodium 1 mg tablet ^{MO}	1	
warfarin sodium 2 mg tablet ^{MO}	1	
warfarin sodium 2.5 mg tablet ^{MO}	1	
warfarin sodium 3 mg tablet ^{MO}	1	
warfarin sodium 4 mg tablet ^{MO}	1	
warfarin sodium 5 mg tablet ^{MO}	1	
warfarin sodium 6 mg tablet ^{MO}	1	
warfarin sodium 7.5 mg tablet ^{MO}	1	
XARELTO 10 MG TABLET ^{MO}	3	QL (35 per 60 days)
XARELTO 15 MG TABLET ^{MO}	3	QL (60 per 30 days)
XARELTO 20 MG TABLET ^{MO}	3	QL (30 per 30 days)
CARDIOVASCULAR DRUGS		
acebutolol 200 mg, 400 mg capsule ^{MO}	2	
amiodarone 150 mg/3 ml syringe; amiodarone 900 mg/18 ml vial; amiodarone hcl 200 mg tablet ^{MO}	2	
amiodarone hcl 100 mg, 400 mg tablet ^{MO}	4	
amlodipine besylate 10 mg, 2.5 mg, 5 mg tab ^{MO}	1	
amlodipine-atorvast 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg ^{MO}	4	QL (30 per 30 days)
amlodipine-benazepril 10-20 mg, 2.5-10 mg, 5-10 mg, 5-20 mg; amlodipine-benazepril 2.5-10 ^{MO}	3	QL (60 per 30 days)
amlodipine-benazepril 10-40 mg, 5-40 mg ^{MO}	3	QL (30 per 30 days)
amlodipine-valsartan 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg ^{MO}	4	QL (30 per 30 days)
amlod-valsalt-hctz 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg; amlod-valsalt-hctz 10-160-12.5mg ^{MO}	3	QL (30 per 30 days)
AMTURNIDE 150-5-12.5 MG, 300-10-12.5 MG, 300-10-25 MG, 300-5-12.5 MG, 300-5-25 MG TAB ^{MO}	3	QL (30 per 30 days)
atenolol 100 mg, 25 mg, 50 mg tablet ^{MO}	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg tablet ^{MO}	2	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
AZOR 10 MG-20 MG TABLET; AZOR 10 MG-40 MG TABLET; AZOR 5 MG-20 MG TABLET; AZOR 5 MG-40 MG TABLET MO	3	QL (30 per 30 days)
benazepril hcl 10 mg, 20 mg, 40 mg, 5 mg tablet MO	1	
benazepril-hctz 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg tab MO	2	
BENICAR 20 MG, 40 MG, 5 MG TABLET MO	3	QL (30 per 30 days)
BENICAR HCT 20 MG-12.5 MG TABLET; BENICAR HCT 40 MG-12.5 MG TABLET; BENICAR HCT 40 MG-25 MG TABLET MO	3	QL (30 per 30 days)
BIDIL 20 MG-37.5 MG TABLET MO	3	QL (180 per 30 days)
BYSTOLIC 10 MG TABLET MO	3	QL (120 per 30 days)
BYSTOLIC 2.5 MG, 5 MG TABLET MO	3	QL (30 per 30 days)
BYSTOLIC 20 MG TABLET MO	3	QL (60 per 30 days)
candesartan cilexetil 16 mg, 4 mg, 8 mg tab; candesartan cilexetil 16 mg, 4 mg, 8 mg tb MO	3	QL (60 per 30 days)
candesartan cilexetil 32 mg tb MO	3	QL (30 per 30 days)
candesartan-hctz 16-12.5 mg, 32-12.5 mg, 32-25 mg tab; candesartan-hctz 16-12.5 mg, 32-12.5 mg, 32-25 mg tb MO	3	QL (30 per 30 days)
captopril 100 mg, 12.5 mg, 25 mg, 50 mg tablet MO	2	
captopril-hctz 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg tablet MO	3	
cartia xt 120 mg, 180 mg, 240 mg capsule, extended release MO	2	QL (60 per 30 days)
cartia xt 300 mg capsule, extended release MO	2	QL (30 per 30 days)
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg tablet MO	1	
clonidine 0.1 mg/day patch; clonidine 0.2 mg/day patch; clonidine 0.3 mg/day patch MO	4	QL (4 per 28 days)
clonidine hcl 0.1 mg, 0.2 mg, 0.3 mg tablet MO	2	
COREG CR 10 MG, 20 MG, 40 MG, 80 MG CAPSULE, EXTENDED RELEASE MO	4	QL (30 per 30 days)
CRESTOR 10 MG, 20 MG, 40 MG, 5 MG TABLET MO	3	QL (30 per 30 days)
digoxin 0.05 mg/ml solution; digoxin 250 mcg tablet; digoxin 500 mcg/2 ml ampule MO	2	
digoxin 125 mcg tablet MO	2	QL (30 per 30 days)
dilt-xr 120 mg, 180 mg, 240 mg capsule, extended release MO	2	QL (60 per 30 days)
diltiazem 120 mg, 30 mg, 60 mg, 90 mg tablet; diltiazem 125 mg/25 ml vial; diltiazem 12hr er 120 mg, 60 mg, 90 mg cap MO	2	
diltiazem 24hr er 120 mg, 180 mg, 240 mg cap; diltiazem er 120 mg, 120 mg, 180 mg, 180 mg, 240 mg, 240 mg capsule; diltiazem hcl er 120 mg, 120 mg, 180 mg, 180 mg, 240 mg, 240 mg cap MO	2	QL (60 per 30 days)
diltiazem 24hr er 300 mg cap; diltiazem hcl er 300 mg, 360 mg, 420 mg cap MO	2	QL (30 per 30 days)
dipyridamole 25 mg, 50 mg, 75 mg tablet MO	4	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
doxazosin mesylate 1 mg, 2 mg, 4 mg, 8 mg tab ^{MO}	2	
EDARBI 40 MG, 80 MG TABLET ^{MO}	3	QL (30 per 30 days)
EDARBYCLOR 40 MG-12.5 MG TABLET; EDARBYCLOR 40 MG-25 MG TABLET ^{MO}	3	QL (30 per 30 days)
enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg tab; enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg tablet ^{MO}	1	
enalapril-hctz 10-25 mg, 5-12.5 mg tab; enalapril-hctz 10-25 mg, 5-12.5 mg tablet ^{MO}	2	
felodipine er 10 mg, 2.5 mg, 5 mg tablet ^{MO}	3	QL (30 per 30 days)
fenofibrate 160 mg tablet ^{MO}	2	QL (30 per 30 days)
fenofibrate 54 mg tablet ^{MO}	2	QL (60 per 30 days)
fenofibrate 134 mg, 200 mg capsule ^{MO}	3	QL (30 per 30 days)
fenofibrate 67 mg capsule ^{MO}	3	QL (60 per 30 days)
fenofibrate 145 mg tablet ^{MO}	4	QL (30 per 30 days)
fenofibrate 48 mg tablet ^{MO}	4	QL (60 per 30 days)
fenofibric acid dr 135 mg, 45 mg cap ^{MO}	4	QL (30 per 30 days)
fosinopril sodium 10 mg, 20 mg, 40 mg tab ^{MO}	2	
gemfibrozil 600 mg tablet ^{MO}	2	QL (60 per 30 days)
hydralazine 10 mg, 100 mg, 25 mg, 50 mg tablet; hydralazine 20 mg/ml vial ^{MO}	2	
irbesartan 150 mg, 300 mg, 75 mg tablet ^{MO}	1	QL (30 per 30 days)
irbesartan-hctz 150-12.5 mg, 300-12.5 mg tb ^{MO}	2	QL (30 per 30 days)
labetalol hcl 100 mg, 200 mg, 300 mg tablet; labetalol hcl 100 mg/20 ml vl; labetalol hcl 20 mg/4 ml syr ^{MO}	2	
LESCOL XL 80 MG TABLET,EXTENDED RELEASE ^{MO}	4	ST,QL (30 per 30 days)
LIPTRUZET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG TABLET ^{GB,MO}	4	QL (30 per 30 days)
lisinopril 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg tablet ^{MO}	1	
lisinopril-hctz 10-12.5 mg, 20-12.5 mg, 20-25 mg tab ^{MO}	1	
LIVALO 1 MG, 2 MG, 4 MG TABLET ^{MO}	3	ST,QL (30 per 30 days)
losartan potassium 100 mg, 25 mg, 50 mg tab ^{MO}	1	QL (60 per 30 days)
losartan-hctz 100-12.5 mg, 100-25 mg, 50-12.5 mg tab ^{MO}	1	QL (60 per 30 days)
lovastatin 10 mg, 20 mg, 40 mg tablet ^{MO}	1	QL (60 per 30 days)
methyldopa 250 mg, 500 mg tablet ^{MO}	3	
metoprolol succ er 100 mg, 200 mg, 25 mg, 50 mg tab ^{MO}	2	QL (60 per 30 days)
metoprolol-hctz 100-25 mg, 100-50 mg, 50-25 mg tab ^{MO}	3	
metoprolol 1 mg/ml carpject; metoprolol tart 5 mg/5 ml vial; metoprolol tartrate 100 mg, 25 mg, 50 mg tab ^{MO}	1	
minoxidil 10 mg, 2.5 mg tablet ^{MO}	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
MULTAQ 400 MG TABLET MO	3	QL (60 per 30 days)
niacin er 1,000 mg, 500 mg, 750 mg tablet MO	4	
nifedipine er 30 mg, 30 mg, 60 mg, 60 mg, 90 mg, 90 mg tablet MO	3	QL (60 per 30 days)
nitroglycerin 0.1 mg/hr, 0.2 mg/hr, 0.6 mg/hr patch MO	2	QL (30 per 30 days)
nitroglycerin 0.4 mg/hr patch MO	2	QL (60 per 30 days)
omega-3 ethyl esters 1 gm cap MO	4	QL (120 per 30 days)
PACERONE 100 MG, 400 MG TABLET MO	4	
pacerone 200 mg tablet MO	2	
pravastatin sodium 10 mg, 20 mg, 80 mg tab MO	2	QL (30 per 30 days)
pravastatin sodium 40 mg tab MO	2	QL (60 per 30 days)
propafenone hcl er 225 mg, 325 mg, 425 mg cap MO	4	
propranolol 1 mg/ml, 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml) vial; propranolol 10 mg, 20 mg, 40 mg, 60 mg, 80 mg tablet; propranolol 20 mg/5 ml soln; propranolol 40 mg/5 ml soln MO	2	
ramipril 1.25 mg, 10 mg, 2.5 mg, 5 mg capsule MO	1	
RANEXA 1,000 MG, 500 MG TABLET, EXTENDED RELEASE MO	3	ST, QL (120 per 30 days)
sildenafil 20 mg tablet MO	3	PA, QL (90 per 30 days)
simvastatin 10 mg, 20 mg, 40 mg, 5 mg, 80 mg tablet MO	1	QL (30 per 30 days)
sotalol 120 mg, 160 mg, 240 mg, 80 mg tablet; sotalol hcl 150 mg/10 ml vial MO	2	
spironolactone 100 mg, 25 mg, 50 mg tablet MO	2	
taztia xt 120 mg, 180 mg, 240 mg capsule, extended release MO	2	QL (60 per 30 days)
taztia xt 300 mg, 360 mg capsule, extended release MO	2	QL (30 per 30 days)
TEKAMLO 150 MG-10 MG TABLET; TEKAMLO 150 MG-5 MG TABLET; TEKAMLO 300 MG-10 MG TABLET; TEKAMLO 300 MG-5 MG TABLET MO	3	QL (30 per 30 days)
TEKTURNA 150 MG, 300 MG TABLET MO	3	QL (30 per 30 days)
TEKTURNA HCT 150 MG-12.5 MG TABLET; TEKTURN HCT 150 MG-25 MG TABLET; TEKTURN HCT 300 MG-12.5 MG TABLET; TEKTURN HCT 300 MG-25 MG TABLET MO	3	QL (30 per 30 days)
terazosin 1 mg, 10 mg, 2 mg, 5 mg capsule MO	1	
timolol maleate 10 mg, 20 mg, 5 mg tablet MO	2	
TRIBENZOR 20 MG-5 MG-12.5 MG TABLET; TRIBENZOR 40 MG-10 MG-12.5 MG TABLET; TRIBENZOR 40 MG-10 MG-25 MG TABLET; TRIBENZOR 40 MG-5 MG-12.5 MG TABLET; TRIBENZOR 40 MG-5 MG-25 MG TABLET MO	3	QL (30 per 30 days)
valsartan-hctz 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg tab MO	2	QL (30 per 30 days)
VASCEPA 1 GRAM CAPSULE MO	4	QL (120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
verapamil 120 mg, 40 mg, 80 mg tablet MO	1	
VYTORIN 10 MG-10 MG TABLET MO	4	QL (30 per 30 days)
VYTORIN 10 MG-20 MG TABLET MO	4	QL (30 per 30 days)
VYTORIN 10 MG-40 MG TABLET MO	4	QL (30 per 30 days)
VYTORIN 10 MG-80 MG TABLET MO	4	QL (30 per 30 days)
WELCHOL 3.75 GRAM ORAL POWDER PACKET; WELCHOL 625 MG TABLET MO	3	
ZETIA 10 MG TABLET MO	3	QL (30 per 30 days)
CENTRAL NERVOUS SYSTEM AGENTS		
ABILIFY MAINTENA 300 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE; ABILIFY MAINTENA 300 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE MO	5	QL (1.5 per 28 days)
ABILIFY MAINTENA 400 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE; ABILIFY MAINTENA 400 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE MO	5	QL (2 per 28 days)
acamprosate calc dr 333 mg tab MO	4	
acetaminophen-cod #2 tablet; acetaminophen-cod #3 tablet; acetaminophen-cod #4 tablet MO	3	QL (390 per 30 days)
alprazolam 0.25 mg, 0.5 mg tablet MO	2	QL (120 per 30 days)
alprazolam 1 mg tablet MO	2	QL (240 per 30 days)
alprazolam 2 mg tablet MO	2	QL (150 per 30 days)
amantadine 100 mg capsule; amantadine 100 mg tablet MO	4	
amitriptyline hcl 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tab MO	1	
amoxapine 100 mg, 150 mg, 25 mg, 50 mg tablet MO	2	
aripiprazole 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg tablet MO	4	QL (30 per 30 days)
AZILECT 0.5 MG, 1 MG TABLET MO	3	
bupropion hcl sr 150 mg, 150 mg, 300 mg tablet; bupropion hcl xl 150 mg, 150 mg, 300 mg tablet MO	3	QL (90 per 30 days)
bupropion hcl sr 200 mg tablet MO	3	QL (60 per 30 days)
buspirone hcl 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg tablet MO	2	
BUTISOL 30 MG, 50 MG TABLET; BUTISOL SODIUM 30 MG, 50 MG TABLET MO	4	
carbamazepine 100 mg tab chew MO	2	
carbamazepine 100 mg/5 ml susp; carbamazepine er 100 mg, 200 mg, 300 mg cap; carbamazepine er 100 mg, 200 mg, 400 mg tablet MO	4	
carbamazepine 200 mg tablet MO	3	
carbidopa-levo 10-100 mg, 25-100 mg, 25-250 mg odt MO	4	
carbidopa-levo er 25-100 tab; carbidopa-levo er 50-200 tab MO	3	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
carbidopa-levodopa 10-100 tab; carbidopa-levodopa 25-100 tab; carbidopa-levodopa 25-250 tab MO	2	
chlordiazepoxide 10 mg, 25 mg, 5 mg capsule MO	4	QL (120 per 30 days)
citalopram hbr 10 mg, 40 mg tablet MO	1	QL (30 per 30 days)
citalopram hbr 20 mg tablet MO	1	QL (60 per 30 days)
clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tab; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tablet; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg odt MO	4	
clonazepam 0.5 mg, 1 mg, 2 mg tablet MO	3	
clorazepate 15 mg, 3.75 mg, 7.5 mg tablet MO	4	
clozapine 100 mg, 200 mg, 25 mg, 50 mg tablet MO	3	
desipramine 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tablet MO	4	
dexmethylphenidate 10 mg, 2.5 mg, 5 mg tab MO	3	QL (60 per 30 days)
dexmethylphenidate er 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg cap; dexmethylphenidate er 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg cp MO	4	QL (30 per 30 days)
dextroamp-amphet er 10 mg, 15 mg, 5 mg cap MO	4	QL (30 per 30 days)
dextroamp-amphet er 20 mg, 25 mg, 30 mg cap MO	4	QL (60 per 30 days)
diazepam 10 mg tablet MO	4	QL (120 per 30 days)
diazepam 2 mg, 5 mg tablet MO	4	QL (90 per 30 days)
diclofenac-misoprost 50-200 tb; diclofenac-misoprost 75-200 tb MO	4	
duloxetine hcl dr 20 mg, 30 mg, 60 mg cap MO	3	QL (60 per 30 days)
endocet 10 mg-325 mg tablet; endocet 2.5 mg-325 mg tablet; endocet 5 mg-325 mg tablet; endocet 7.5 mg-325 mg tablet MO	3	QL (360 per 30 days)
entacapone 200 mg tablet MO	4	QL (300 per 30 days)
escitalopram 10 mg tablet MO	1	QL (45 per 30 days)
escitalopram 20 mg, 5 mg tablet MO	1	QL (30 per 30 days)
escitalopram oxalate 5 mg/5 ml MO	4	QL (600 per 30 days)
fentanyl 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour patch; fentanyl 37.5 mcg/hr patch; fentanyl 62.5 mcg/hr patch; fentanyl 87.5 mcg/hr patch MO	4	QL (20 per 30 days)
FLECTOR 1.3 % TRANSDERMAL 12 HOUR PATCH MO	4	PA,QL (60 per 30 days)
fluoxetine hcl 10 mg, 40 mg capsule MO	2	QL (60 per 30 days)
fluoxetine hcl 20 mg capsule MO	2	QL (120 per 30 days)
fluoxetine hcl 60 mg tablet MO	3	QL (30 per 30 days)
gabapentin 100 mg, 300 mg, 400 mg capsule MO	2	QL (270 per 30 days)
gabapentin 600 mg, 800 mg tablet MO	2	QL (180 per 30 days)
haloperidol 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg tablet MO	2	

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hydrocodon-acetaminoph 2.5-325; hydrocodon-acetaminoph 7.5-325; hydrocodon-acetaminophen 5-325; hydrocodon-acetaminophn 10-325 MO	3	QL (360 per 30 days)
hydroxyzine 10 mg/5 ml, 25 mg/ml, 50 mg/ml soln; hydroxyzine 10 mg/5 ml, 25 mg/ml, 50 mg/ml vial; hydroxyzine hcl 10 mg, 25 mg, 50 mg tablet MO	3	
ibuprofen 100 mg/5 ml susp; ibuprofen 400 mg, 600 mg, 800 mg tablet MO	1	
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML INTRAMUSCULAR SYRINGE MO	5	QL (1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML INTRAMUSCULAR SYRINGE MO	5	QL (1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML, 78 MG/0.5 ML INTRAMUSCULAR SYRINGE MO	4	QL (1.5 per 28 days)
LAMICTAL ODT 100 MG, 200 MG, 25 MG, 50 MG DISINTEGRATING TABLET MO	4	
lamotrigine 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (35) tablet; lamotrigine 25 mg tb start kit; lamotrigine 25 mg, 5 mg disper tab; lamotrigine 25 mg, 5 mg disper tablet MO	2	
lamotrigine er 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg tablet; lamotrigine odt 100 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14) tablet; lamotrigine odt kit (blue); lamotrigine odt kit (green); lamotrigine odt kit (orange) MO	4	
LATUDA 120 MG, 20 MG, 40 MG, 60 MG TABLET MO	5	PA,QL (30 per 30 days)
LATUDA 80 MG TABLET MO	5	PA,QL (60 per 30 days)
levetiracetam 1,000 mg, 250 mg, 500 mg, 750 mg tablet; levetiracetam 100 mg/ml soln; levetiracetam er 500 mg, 750 mg tablet MO	2	
lithium carbonate 150 mg, 300 mg, 600 mg cap; lithium carbonate 300 mg tab; lithium carbonate er 300 mg, 450 mg tb MO	2	
lorazepam 0.5 mg, 1 mg tablet MO	2	QL (90 per 30 days)
lorazepam 2 mg tablet MO	2	QL (150 per 30 days)
LYRICA 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG CAPSULE MO	4	QL (90 per 30 days)
LYRICA 20 MG/ML ORAL SOLUTION MO	4	QL (900 per 30 days)
LYRICA 225 MG, 300 MG CAPSULE MO	4	QL (60 per 30 days)
meloxicam 15 mg tablet MO	1	QL (30 per 30 days)
meloxicam 7.5 mg tablet MO	1	QL (60 per 30 days)
mirtazapine 15 mg, 30 mg, 45 mg odt MO	4	QL (30 per 30 days)
mirtazapine 15 mg, 30 mg, 45 mg tablet MO	2	QL (30 per 30 days)
mirtazapine 7.5 mg tablet MO	2	
modafinil 100 mg, 200 mg tablet MO	4	PA,QL (60 per 30 days)
morphine sulf 10 mg, 20 mg, 30 mg, 5 mg suppos; morphine sulf er 100 mg tablet; morphine sulfate ir 15 mg, 30 mg tab MO	3	QL (180 per 30 days)
morphine sulf er 15 mg, 30 mg, 60 mg tablet MO	3	QL (120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<i>nabumetone 500 mg, 750 mg tablet</i> MO	2	
NAMENDA 2 MG/ML ORAL SOLUTION MO	3	PA,QL (360 per 30 days)
NAMENDA XR 14 MG, 21 MG, 28 MG, 7 MG CAPSULE SPRINKLE,EXTENDED RELEASE MO	3	PA,QL (30 per 30 days)
NAMENDA XR 7 MG-14 MG-21 MG-28 MG CAPSULE,SPRINKLE,ER 24HR,DOSE PACK MO	3	PA,QL (28 per 28 days)
<i>naproxen 250 mg, 375 mg, 375 mg, 500 mg, 500 mg tablet; naproxen dr 250 mg, 375 mg, 375 mg, 500 mg, 500 mg tablet</i> MO	2	
<i>naratriptan hcl 1 mg, 2.5 mg tablet</i> MO	3	QL (9 per 30 days)
NEUPRO 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH MO	4	QL (30 per 30 days)
<i>nortriptyline hcl 10 mg, 25 mg, 50 mg, 75 mg cap</i> MO	2	
NUDEXTA 20 MG-10 MG CAPSULE MO	3	QL (60 per 30 days)
NUVIGIL 150 MG, 200 MG, 250 MG TABLET MO	3	PA,QL (30 per 30 days)
NUVIGIL 50 MG TABLET MO	3	PA,QL (60 per 30 days)
<i>olanzapine 10 mg vial; olanzapine 15 mg, 20 mg tablet</i> MO	3	QL (60 per 30 days)
<i>olanzapine 10 mg, 2.5 mg, 5 mg, 7.5 mg tablet</i> MO	3	QL (30 per 30 days)
<i>olanzapine odt 10 mg, 5 mg tablet</i> MO	4	QL (30 per 30 days)
<i>olanzapine odt 15 mg, 20 mg tablet</i> MO	4	QL (60 per 30 days)
ONFI 10 MG, 20 MG TABLET MO	4	PA,QL (60 per 30 days)
OPANA ER 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 5 MG, 7.5 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE MO	3	QL (60 per 30 days)
<i>oxazepam 10 mg, 15 mg, 30 mg capsule</i> MO	4	
<i>oxycodone hcl 10 mg, 15 mg, 20 mg, 30 mg, 5 mg tablet; oxycodone hcl 5 mg capsule</i> MO	3	QL (360 per 30 days)
<i>oxycodon-acetaminophen 2.5-325; oxycodon-acetaminophen 7.5-325; oxycodone-acetaminophen 10-325; oxycodone-acetaminophen 5-325</i> MO	3	QL (360 per 30 days)
<i>phenobarbital 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg tablet</i> MO	3	QL (90 per 30 days)
<i>phenobarbital 15 mg, 60 mg tablet</i> MO	3	QL (120 per 30 days)
<i>phenobarbital 20 mg/5 ml elix</i> MO	3	QL (1500 per 30 days)
<i>phenobarbital 30 mg tablet</i> MO	3	QL (300 per 30 days)
PHENYTEK 200 MG, 300 MG CAPSULE MO	4	
<i>phenytoin 100 mg/4 ml, 125 mg/5 ml susp; phenytoin 50 mg tablet chew</i> MO	2	
<i>phenytoin sod ext 100 mg, 200 mg, 300 mg cap</i> MO	2	
POTIGA 200 MG, 300 MG, 400 MG TABLET MO	5	PA
POTIGA 50 MG TABLET MO	4	PA
<i>pramipexole 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg tablet</i> MO	2	

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
PRISTIQ 100 MG, 25 MG, 50 MG TABLET,EXTENDED RELEASE ^{MO}	4	QL (30 per 30 days)
quetiapine fumarate 100 mg, 300 mg, 400 mg tab ^{MO}	2	QL (90 per 30 days)
quetiapine fumarate 200 mg, 25 mg, 50 mg tab ^{MO}	2	QL (120 per 30 days)
riluzole 50 mg tablet ^{SP}	4	
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML INTRAMUSCULAR SYRINGE ^{MO}	4	QL (4 per 28 days)
RISPERDAL CONSTA 50 MG/2 ML INTRAMUSCULAR SYRINGE ^{MO}	5	QL (4 per 28 days)
risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg odt ^{MO}	4	QL (60 per 30 days)
risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg tablet ^{MO}	1	QL (60 per 30 days)
risperidone 0.5 mg odt ^{MO}	4	QL (120 per 30 days)
risperidone 0.5 mg tablet ^{MO}	1	QL (120 per 30 days)
rizatriptan 10 mg, 5 mg odt ^{MO}	4	QL (12 per 30 days)
rizatriptan 10 mg, 5 mg tablet ^{MO}	3	QL (12 per 30 days)
ropinirole hcl 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg tablet ^{MO}	2	
ropinirole hcl er 12 mg, 2 mg, 4 mg, 6 mg, 8 mg tablet ^{MO}	4	QL (90 per 30 days)
SAVELLA 100 MG, 12.5 MG, 12.5 MG (5)-25 MG(8)-50 MG(42), 25 MG, 50 MG TABLET; SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK ^{MO}	3	QL (60 per 30 days)
SEROQUEL XR 150 MG TABLET,EXTENDED RELEASE ^{MO}	3	QL (90 per 30 days)
SEROQUEL XR 200 MG TABLET,EXTENDED RELEASE ^{MO}	3	QL (30 per 30 days)
SEROQUEL XR 300 MG, 400 MG TABLET,EXTENDED RELEASE ^{MO}	3	QL (60 per 30 days)
SEROQUEL XR 50 MG TABLET,EXTENDED RELEASE ^{MO}	3	QL (120 per 30 days)
sertraline hcl 100 mg tablet ^{MO}	1	QL (60 per 30 days)
sertraline hcl 25 mg, 50 mg tablet ^{MO}	1	QL (90 per 30 days)
SILENOR 3 MG, 6 MG TABLET ^{MO}	4	QL (30 per 30 days)
SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM; SUBOXONE 4 MG-1 MG SUBLINGUAL FILM; SUBOXONE 8 MG-2 MG SUBLINGUAL FILM ^{MO}	4	PA,QL (90 per 30 days)
sumatriptan 4 mg/0.5 ml, 6 mg/0.5 ml cart; sumatriptan 4 mg/0.5 ml, 6 mg/0.5 ml inject; sumatriptan 4 mg/0.5 ml, 6 mg/0.5 ml refill; sumatriptan 6 mg/0.5 ml syrng; sumatriptan 6 mg/0.5 ml vial ^{MO}	4	QL (6 per 30 days)
sumatriptan succ 100 mg, 25 mg, 50 mg tablet ^{MO}	2	QL (9 per 30 days)
temazepam 15 mg, 30 mg capsule ^{MO}	4	QL (30 per 30 days)
tiagabine hcl 2 mg, 4 mg tablet ^{MO}	4	
topiramate 100 mg, 200 mg, 50 mg tablet ^{MO}	2	QL (120 per 30 days)
topiramate 15 mg, 25 mg sprinkle cap ^{MO}	2	
topiramate 25 mg tablet ^{MO}	2	QL (90 per 30 days)
tramadol hcl 50 mg tablet ^{MO}	2	QL (240 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
trazodone 100 mg, 150 mg, 50 mg tablet ^{MO}	1	
trazodone 300 mg tablet ^{MO}	2	
venlafaxine hcl 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg tablet ^{MO}	2	
venlafaxine hcl er 150 mg cap ^{MO}	2	QL (60 per 30 days)
venlafaxine hcl er 150 mg, 225 mg, 37.5 mg tab ^{MO}	4	QL (30 per 30 days)
venlafaxine hcl er 37.5 mg cap ^{MO}	2	QL (30 per 30 days)
venlafaxine hcl er 75 mg cap ^{MO}	2	QL (90 per 30 days)
venlafaxine hcl er 75 mg tab ^{MO}	4	QL (60 per 30 days)
VIIBRYD 10 MG (7)-20 MG (23) TABLETS IN A DOSE PACK; VIIBRYD 10 MG, 10 MG (7)- 20 MG (23), 10 MG (7)-20 MG (7)-40 MG (16), 20 MG, 40 MG TABLET; VIIBRYD 10-20-40 MG STARTER PK ^{MO}	4	PA,QL (30 per 30 days)
VIMPAT 10 MG/ML ORAL SOLUTION ^{MO}	4	PA,QL (1395 per 30 days)
VOLTAREN 1 % TOPICAL GEL ^{MO}	4	
ziprasidone hcl 20 mg, 40 mg, 60 mg, 80 mg capsule ^{MO}	4	QL (60 per 30 days)
zolpidem tart er 12.5 mg, 6.25 mg tab ^{MO}	4	QL (90 per 365 days)
zolpidem tartrate 10 mg, 5 mg tablet ^{MO}	1	QL (90 per 365 days)
zonisamide 100 mg, 25 mg, 50 mg capsule ^{MO}	2	
ELECTROLYTIC, CALORIC, AND WATER BALANCE		
amiloride hcl 5 mg tablet ^{MO}	3	
bumetanide 0.25 mg/ml vial; bumetanide 0.5 mg, 1 mg, 2 mg tablet ^{MO}	2	
chlorothiazide 250 mg, 500 mg tablet ^{MO}	2	
furosemide 10 mg/ml syringe; furosemide 10 mg/ml, 10 mg/ml, 40 mg/5 ml (8 mg/ml) solution; furosemide 20 mg, 40 mg, 80 mg tablet; furosemide 40 mg/4 ml vial; furosemide 40 mg/5 ml soln ^{MO}	1	
hydrochlorothiazide 12.5 mg cp; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tab; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tb ^{MO}	1	
K-TAB 10 MEQ, 20 MEQ, 8 MEQ TABLET,EXTENDED RELEASE ^{MO}	4	
KLOR-CON 10 MEQ TABLET,EXTENDED RELEASE ^{MO}	2	
KLOR-CON 8 MEQ TABLET,EXTENDED RELEASE ^{MO}	2	
KLOR-CON M15 MEQ TABLET,EXTENDED RELEASE ^{MO}	2	
klor-con m20 meq tablet,extended release ^{MO}	2	
metolazone 10 mg, 2.5 mg, 5 mg tablet ^{MO}	2	
potassium cl 10% (20 meq/15 ml, 40 meq/15 ml; potassium cl 20% (20 meq/15 ml, 40 meq/15 ml; potassium cl er 10 meq, 20 meq tablet; potassium cl er 10 meq, 20 meq, 8 meq tablet; potassium cl er 10 meq, 8 meq capsule ^{MO}	2	
potassium citrate er 10 meq (1,080 mg), 15 meq, 5 meq (540 mg) tb; potassium citrate er 10 meq tb; potassium citrate er 5 meq tab ^{MO}	3	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
REVELA 0.8 GRAM, 2.4 GRAM ORAL POWDER PACKET ^{MO}	3	
REVELA 800 MG TABLET ^{MO}	3	QL (540 per 30 days)
sodium lactate 5 meq/ml vial ^{MO}	1	
torsemide 10 mg, 100 mg, 20 mg, 5 mg tablet; torsemide 20 mg/2 ml vial; torsemide 50 mg/5 ml vial ^{MO}	2	
triamterene-hctz 37.5-25 mg, 50-25 mg cap; triamterene-hctz 37.5-25 mg, 50-25 mg cp ^{MO}	2	
triamterene-hctz 37.5-25 mg, 75-50 mg tab; triamterene-hctz 37.5-25 mg, 75-50 mg tb ^{MO}	1	
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
acetazolamide 125 mg, 250 mg tablet ^{MO}	2	
ALPHAGAN P 0.1 %, 0.15 % EYE DROPS ^{MO}	3	
AZASITE 1 % EYE DROPS ^{MO}	3	
AZOPT 1 % EYE DROPS,SUSPENSION ^{MO}	3	
BEPREVE 1.5 % EYE DROPS ^{MO}	4	
BESIVANCE 0.6 % EYE DROPS,SUSPENSION ^{MO}	3	
brimonidine 0.2% eye drop; brimonidine tartrate 0.15% drp ^{MO}	3	
COMBIGAN 0.2 %-0.5 % EYE DROPS ^{MO}	3	
dorzolamide hcl 2% eye drops ^{MO}	2	QL (10 per 30 days)
dorzolamide-timolol eye drops ^{MO}	2	QL (10 per 30 days)
DUREZOL 0.05 % EYE DROPS ^{MO}	3	
DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY ^{MO}	3	
ILEVRO 0.3 % EYE DROPS,SUSPENSION ^{MO}	3	
LUMIGAN 0.01 % EYE DROPS ^{MO}	3	QL (2.5 per 25 days)
NASONEX 50 MCG/ACTUATION SPRAY ^{MO}	3	
OMNARIS 50 MCG NASAL SPRAY ^{MO}	3	
PATADAY 0.2 % EYE DROPS ^{MO}	3	
PAZEO 0.7 % EYE DROPS ^{MO}	3	QL (2.5 per 25 days)
prednisolone ac 1% eye drop ^{MO}	4	
QNASL 40 MCG/ACTUATION, 80 MCG/ACTUATION NASAL AEROSOL SPRAY ^{MO}	4	
RESTASIS 0.05 % EYE DROPS IN A DROPPERETTE ^{MO}	3	QL (60 per 30 days)
timolol 0.25% eye drops; timolol 0.5% eye drops ^{MO}	2	
timolol 0.25% gel-solution; timolol 0.5% gel-solution ^{MO}	3	
tobramycin-dexameth ophth susp ^{MO}	4	
TRAVATAN Z 0.004 % EYE DROPS ^{MO}	3	QL (2.5 per 25 days)
VERAMYST 27.5 MCG/ACTUATION NASAL SPRAY,SUSPENSION ^{MO}	4	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
VIGAMOX 0.5 % EYE DROPS ^{MO}	4	
ZETONNA 37 MCG/ACTUATION NASAL HFA INHALER ^{MO}	3	
GASTROINTESTINAL DRUGS		
AMITIZA 24 MCG, 8 MCG CAPSULE ^{MO}	3	
APRISO 0.375 GRAM CAPSULE,EXTENDED RELEASE ^{MO}	3	QL (120 per 30 days)
<i>balsalazide disodium 750 mg cp</i> ^{MO}	4	
CANASA 1,000 MG RECTAL SUPPOSITORY ^{MO}	3	QL (30 per 30 days)
<i>cimetidine 200 mg, 300 mg, 400 mg, 800 mg tablet</i> ^{MO}	2	
CREON 12,000-38,000-60,000 UNIT CAPSULE,DELAYED RELEASE; CREON 24,000-76,000-120,000 UNIT CAPSULE,DELAYED RELEASE; CREON 3,000-9,500-15,000 UNIT CAPSULE,DELAYED RELEASE; CREON 36,000-114,000-180,000 UNIT CAPSULE,DELAYED RELEASE; CREON 6,000-19,000-30,000 UNIT CAPSULE,DELAYED RELEASE ^{MO}	3	
DEXILANT 30 MG, 60 MG CAPSULE, DELAYED RELEASE ^{MO}	4	QL (30 per 30 days)
<i>esomeprazole mag dr 20 mg, 40 mg cap</i> ^{MO}	3	QL (30 per 30 days)
<i>famotidine 20 mg, 40 mg tablet; famotidine 40 mg/4 ml vial</i> ^{MO}	2	
<i>lansoprazole dr 30 mg capsule</i> ^{MO}	3	QL (30 per 30 days)
LIALDA 1.2 GRAM TABLET,DELAYED RELEASE ^{MO}	3	QL (120 per 30 days)
LINZESS 145 MCG, 290 MCG CAPSULE ^{MO}	3	QL (30 per 30 days)
<i>metoclopramide 10 mg, 5 mg tablet</i> ^{MO}	1	
<i>misoprostol 100 mcg, 200 mcg tablet</i> ^{MO}	3	
<i>omeprazole dr 10 mg, 20 mg, 40 mg capsule</i> ^{MO}	2	QL (60 per 30 days)
<i>pantoprazole sod dr 20 mg, 40 mg tab</i> ^{MO}	1	QL (60 per 30 days)
PENTASA 250 MG CAPSULE,CONTROLLED RELEASE ^{MO}	4	QL (150 per 30 days)
PENTASA 500 MG CAPSULE,CONTROLLED RELEASE ^{MO}	4	QL (300 per 30 days)
<i>prochlorperazine 25 mg supp</i> ^{MO}	3	
<i>ranitidine 15 mg/ml syrup; ranitidine 150 mg, 300 mg tablet; ranitidine hcl 50 mg/2 ml vial</i> ^{MO}	2	
<i>ranitidine 150 mg, 300 mg capsule</i> ^{MO}	3	
SANCUSO 3.1 MG/24 HOUR TRANSDERMAL PATCH ^{MO}	4	QL (4 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION MO	3	
ZENPEP 10,000-34,000-55,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 15,000-51,000-82,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 20,000-68,000-109,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 25,000-85,000-136,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 3,000-10,000-16,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 40,000-136,000-218,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 5,000-17,000-27,000 UNIT CAPSULE,DELAYED RELEASE MO	4	
HORMONES AND SYNTHETIC SUBSTITUTES		
acarbose 100 mg, 25 mg, 50 mg tablet MO	3	
ANDROGEL 1.62 % (20.25 MG/1.25 GRAM) TRANSDERMAL GEL PACKET MO	3	QL (37.5 per 30 days)
ANDROGEL 1.62 % (40.5 MG/2.5 GRAM) TRANSDERMAL GEL PACKET MO	3	QL (150 per 30 days)
ANDROGEL 20.25 MG/1.25 GRAM (1.62 %) TRANSDERMAL GEL PUMP MO	3	
AVANDIA 2 MG, 4 MG TABLET MO	4	QL (60 per 30 days)
AVANDIA 8 MG TABLET MO	4	QL (30 per 30 days)
budesonide ec 3 mg capsule MO	5	
calcitonin-salmon 200 units sp MO	3	
danazol 100 mg, 200 mg, 50 mg capsule MO	4	
desmopressin 0.1 mg/ml sol; desmopressin ac 0.1 mg/ml (refrigerate), 4 mcg/ml vial; desmopressin acetate 0.1 mg, 0.2 mg tb MO	4	
dexamethasone 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg tablet; dexamethasone 0.5 mg/5 ml elx; dexamethasone 0.5 mg/5 ml liq MO	2	
estropipate 0.625(0.75 mg, 1.5 mg, 3 mg) tab; estropipate 1.25(0.75 mg, 1.5 mg, 3 mg) tab; estropipate 2.5(0.75 mg, 1.5 mg, 3 mg) tab MO	3	
FORTEO 20 MCG/DOSE (600 MCG/2.4 ML) SUBCUTANEOUS PEN INJECTOR SP	4	ST
FORTICAL 200 UNITS NASAL SPRAY MO	4	
glimepiride 1 mg, 2 mg, 4 mg tablet MO	1	
glipizide 10 mg, 5 mg tablet MO	1	
glipizide er 10 mg, 2.5 mg, 5 mg tablet MO	2	
glipizide-metformin 2.5-250 mg, 2.5-500 mg, 5-500 mg MO	2	
GLUCAGEN HYPOKIT 1 MG INJECTION MO	4	
GLUMETZA 500 MG TABLET,EXTENDED RELEASE GB,MO	4	QL (120 per 30 days)
glyburide 1.25 mg, 2.5 mg, 5 mg tablet MO	2	
glyburide micro 1.5 mg, 3 mg, 6 mg tab; glyburide micro 1.5 mg, 3 mg, 6 mg tablet MO	2	
glyburid-metformin 1.25-250 mg, 2.5-500 mg, 5-500 mg; glyburide-metformin 1.25-250 mg, 2.5-500 mg, 5-500 mg MO	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET MO	3	QL (30 per 30 days)
HUMALOG 100 UNIT/ML SUBCUTANEOUS CARTRIDGE; HUMALOG 100 UNIT/ML SUBCUTANEOUS SOLUTION MO	3	
HUMALOG KWIKPEN 100 UNIT/ML, 200 UNIT/ML (3 ML) SUBCUTANEOUS MO	3	
HUMALOG MIX 50-50 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO	3	
HUMALOG MIX 50-50 KWIKPEN 100 UNIT/ML SUBCUTANEOUS PEN MO	3	
HUMALOG MIX 75-25 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO	3	
HUMALOG MIX 75-25 KWIKPEN 100 UNIT/ML SUBCUTANEOUS INSULIN PEN MO	3	
HUMULIN 70/30 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO	3	
HUMULIN N 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO	3	
HUMULIN R 100 UNIT/ML INJECTION SOLUTION MO	3	
HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML SUBCUTANEOUS SOLN MO	3	
INVOKAMET 150 MG-1,000 MG TABLET; INVOKAMET 150 MG-500 MG TABLET; INVOKAMET 50 MG-1,000 MG TABLET; INVOKAMET 50 MG-500 MG TABLET MO	3	QL (60 per 30 days)
INVOKANA 100 MG, 300 MG TABLET MO	3	QL (30 per 30 days)
JANUMET 50 MG-1,000 MG TABLET; JANUMET 50 MG-500 MG TABLET MO	3	QL (60 per 30 days)
JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE MO	3	QL (30 per 30 days)
JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE; JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE MO	3	QL (60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG TABLET MO	3	QL (30 per 30 days)
JARDIANCE 10 MG, 25 MG TABLET MO	3	QL (30 per 30 days)
JENTADUETO 2.5 MG-1,000 MG TABLET; JENTADUETO 2.5 MG-500 MG TABLET; JENTADUETO 2.5 MG-850 MG TABLET MO	3	QL (60 per 30 days)
KAZANO 12.5 MG-1,000 MG TABLET; KAZANO 12.5 MG-500 MG TABLET MO	4	QL (60 per 30 days)
KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE MO	4	QL (60 per 30 days)
KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE; KOMBIGLYZE XR 5 MG-500 MG TABLET,EXTENDED RELEASE MO	4	QL (30 per 30 days)
LANTUS 100 UNIT/ML SUBCUTANEOUS SOLUTION MO	3	
LANTUS SOLOSTAR 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN MO	3	
LEVEMIR 100 UNIT/ML SUBCUTANEOUS SOLUTION MO	3	
LEVEMIR FLEXTOUCH 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN MO	3	
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg tablet MO	1	
LEVOXYL 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG TABLET GB,MO	3	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
metformin hcl 1,000 mg, 500 mg, 850 mg tablet ^{MO}	1	
metformin hcl er 500 mg tablet ^{MO}	1	QL (120 per 30 days)
metformin hcl er 750 mg tablet ^{MO}	1	QL (60 per 30 days)
nateglinide 120 mg, 60 mg tablet ^{MO}	3	
NESINA 12.5 MG, 25 MG, 6.25 MG TABLET ^{MO}	4	QL (30 per 30 days)
NOVOLIN 70/30 100 UNIT/ML SUBCUTANEOUS SUSPENSION ^{MO}	3	
NOVOLIN N 100 UNIT/ML SUBCUTANEOUS SUSPENSION ^{MO}	3	
NOVOLIN R 100 UNIT/ML INJECTION SOLUTION ^{MO}	3	
NOVOLOG 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MO}	3	
NOVOLOG FLEXPEN 100 UNIT/ML SUBCUTANEOUS ^{MO}	3	
NOVOLOG MIX 70-30 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MO}	3	
NOVOLOG MIX 70-30 FLEXPEN 100 UNIT/ML SUBCUTANEOUS PEN ^{MO}	3	
NOVOLOG PENFILL 100 UNIT/ML SUBCUTANEOUS CARTRIDGE ^{MO}	3	
ONGLYZA 2.5 MG, 5 MG TABLET ^{MO}	4	QL (30 per 30 days)
OSENI 12.5 MG-15 MG TABLET; OSENI 12.5 MG-30 MG TABLET; OSENI 12.5 MG-45 MG TABLET; OSENI 25 MG-15 MG TABLET; OSENI 25 MG-30 MG TABLET; OSENI 25 MG-45 MG TABLET ^{MO}	4	QL (30 per 30 days)
pioglitazone hcl 15 mg, 30 mg, 45 mg tablet ^{MO}	2	QL (30 per 30 days)
pioglitazone-glimepiride 30-2; pioglitazone-glimepiride 30-4 ^{MO}	4	QL (30 per 30 days)
pioglitazone-metformin 15-500; pioglitazone-metformin 15-850 ^{MO}	4	QL (90 per 30 days)
prednisone 1 mg, 10 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 5 mg, 50 mg tab dose pack; prednisone 1 mg, 10 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 5 mg, 50 mg tablet; prednisone 5 mg/5 ml solution ^{MO}	1	B vs D
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET; PREMARIN 25 MG SOLUTION FOR INJECTION ^{MO}	4	
PREMARIN 0.625 MG/GRAM VAGINAL CREAM ^{MO}	3	
repaglinide 0.5 mg, 1 mg, 2 mg tablet ^{MO}	4	
TOUJEO SOLOSTAR 300 UNIT/ML (1.5 ML) SUBCUTANEOUS INSULIN PEN ^{MO}	3	
TRADJENTA 5 MG TABLET ^{MO}	3	QL (30 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MO}	3	QL (2 per 28 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR ^{MO}	3	QL (9 per 30 days)
MISCELLANEOUS THERAPEUTIC AGENTS		
alendronate sodium 10 mg, 40 mg, 5 mg tab; alendronate sodium 10 mg, 40 mg, 5 mg tablet ^{MO}	1	QL (30 per 30 days)
alendronate sodium 35 mg, 70 mg tab ^{MO}	1	QL (4 per 28 days)
allopurinol 100 mg, 300 mg tablet ^{MO}	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
AMPYRA 10 MG TABLET,EXTENDED RELEASE ^{SP}	5	PA,QL (60 per 30 days)
ATELVIA 35 MG TABLET,DELAYED RELEASE ^{MO}	4	
AUBAGIO 14 MG, 7 MG TABLET ^{SP}	5	PA,QL (30 per 30 days)
AVODART 0.5 MG CAPSULE ^{MO}	4	PA,QL (30 per 30 days)
AVONEX 30 MCG/0.5 ML, 30 MCG/0.5 ML INTRAMUSCULAR PEN INJECTOR; AVONEX 30 MCG/0.5 ML, 30 MCG/0.5 ML INTRAMUSCULAR PEN KIT; AVONEX 30 MCG/0.5 ML, 30 MCG/0.5 ML INTRAMUSCULAR SYRINGE; AVONEX 30 MCG/0.5 ML, 30 MCG/0.5 ML INTRAMUSCULAR SYRINGE KIT ^{SP}	5	PA,QL (2 per 28 days)
AVONEX (WITH ALBUMIN) 30 MCG INTRAMUSCULAR KIT ^{SP}	5	PA,QL (4 per 28 days)
<i>azathioprine 50 mg tablet</i> ^{MO}	2	B vs D
BETASERON 0.3 MG SUBCUTANEOUS KIT; BETASERON 0.3 MG SUBCUTANEOUS SOLUTION ^{SP}	5	PA,QL (15 per 30 days)
BINOSTO 70 MG EFFERVESCENT TABLET ^{MO}	4	
CINRYZE 500 UNIT (5 ML) INTRAVENOUS SOLUTION ^{MO}	5	PA,QL (100 per 30 days)
COLCRYS 0.6 MG TABLET ^{MO}	3	QL (120 per 30 days)
COPAXONE 20 MG/ML SUBCUTANEOUS SYRINGE ^{SP}	5	PA,QL (30 per 30 days)
COPAXONE 40 MG/ML SUBCUTANEOUS SYRINGE ^{SP}	5	PA,QL (12 per 28 days)
<i>cyclosporine 100 mg, 25 mg capsule; cyclosporine 50 mg/ml ampul</i> ^{MO}	4	B vs D
<i>cyclosporine 100 mg/ml soln; cyclosporine modified 100 mg, 25 mg, 50 mg</i> ^{MO}	4	B vs D
ENBREL 25 MG (1 ML) SUBCUTANEOUS SOLUTION; ENBREL 50 MG/ML (0.98 ML) SUBCUTANEOUS SYRINGE ^{SP}	5	PA,QL (8 per 28 days)
ENBREL 25 MG/0.5 ML (0.51 ML) SUBCUTANEOUS SYRINGE ^{SP}	5	PA,QL (4.08 per 28 days)
<i>finasteride 5 mg tablet</i> ^{MO}	2	QL (30 per 30 days)
GILENYA 0.5 MG CAPSULE ^{SP}	5	PA,QL (30 per 30 days)
HUMIRA 10 MG/0.2 ML SUBCUTANEOUS SYRINGE KIT ^{SP}	5	PA,QL (0.4 per 28 days)
HUMIRA 20 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT ^{SP}	5	PA,QL (2.4 per 28 days)
HUMIRA 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT ^{SP}	5	PA,QL (4.8 per 28 days)
HUMIRA PEN CROHN'S-ULC COLITIS-HIDR SUP STARTER 40 MG/0.8 ML SUB-Q KIT ^{SP}	5	PA,QL (4.8 per 28 days)
<i>ibandronate sodium 150 mg tab</i> ^{MO}	3	QL (1 per 28 days)
JALYN 0.5 MG-0.4 MG CAPSULE, EXTENDED RELEASE ^{MO}	4	PA,QL (30 per 30 days)
<i>leflunomide 10 mg, 20 mg tablet</i> ^{MO}	2	QL (30 per 30 days)
<i>mycophenolate 250 mg capsule; mycophenolate 500 mg tablet</i> ^{MO}	3	B vs D
MYFORTIC 180 MG, 360 MG TABLET,DELAYED RELEASE ^{MO}	4	B vs D
PROLIA 60 MG/ML SUBCUTANEOUS SYRINGE ^{MO}	4	
REBIF (WITH ALBUMIN) 22 MCG/0.5 ML, 44 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{SP}	5	PA,QL (6 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 9.

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
REBIF TITRATION PACK 8.8 MCG/0.2 ML-22 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{SP}	5	PA,QL (4.2 per 28 days)
REMICADE 100 MG INTRAVENOUS SOLUTION ^{MO}	5	PA
<i>risedronate sod dr 35 mg tab</i> ^{MO}	4	
<i>risedronate sodium 30 mg, 5 mg tab; risedronate sodium 30 mg, 5 mg tablet</i> ^{MO}	4	QL (30 per 30 days)
<i>risedronate sodium 35 mg tab</i> ^{MO}	4	QL (4 per 28 days)
SENSIPAR 30 MG TABLET ^{MO}	3	QL (60 per 30 days)
SENSIPAR 60 MG TABLET ^{MO}	5	QL (60 per 30 days)
SENSIPAR 90 MG TABLET ^{MO}	5	QL (120 per 30 days)
SIMPONI 100 MG/ML SUBCUTANEOUS PEN INJECTOR; SIMPONI 100 MG/ML SUBCUTANEOUS SYRINGE ^{SP}	5	PA,QL (3 per 30 days)
TECFIDERA 120 MG (14)- 240 MG (46), 240 MG CAPSULE,DELAYED RELEASE; TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE ^{SP}	5	PA,QL (60 per 30 days)
TECFIDERA 120 MG CAPSULE,DELAYED RELEASE ^{SP}	5	PA,QL (14 per 30 days)
THALOMID 100 MG, 200 MG, 50 MG CAPSULE ^{SP}	5	PA,QL (30 per 30 days)
THALOMID 150 MG CAPSULE ^{SP}	5	PA,QL (60 per 30 days)
ULORIC 40 MG, 80 MG TABLET ^{MO}	3	ST,QL (30 per 30 days)
RESPIRATORY TRACT AGENTS		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET ^{SP}	5	PA,QL (90 per 30 days)
ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION ^{MO}	3	
ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER ^{MO}	3	
ALVESCO 160 MCG/ACTUATION, 80 MCG/ACTUATION AEROSOL INHALER ^{MO}	4	
ARALAST NP 1,000 MG, 500 MG INTRAVENOUS SOLUTION ^{MO}	5	PA
ASMANEX TWISTHALER 110 MCG (30 DOSES), 110 MCG (7 DOSES), 220 MCG (120 DOSES), 220 MCG (14 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES) BREATH ACTIVATED ^{MO}	3	
BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION; BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION ^{MO}	3	
<i>budesonide 0.25 mg/2 ml, 0.5 mg/2 ml susp</i> ^{MO}	4	B vs D
<i>cromolyn 20 mg/2 ml neb soln</i> ^{MO}	2	B vs D
DALIRESP 500 MCG TABLET ^{MO}	3	QL (30 per 30 days)
DULERA 100 MCG-5 MCG/ACTUATION HFA AEROSOL INHALER; DULERA 200 MCG-5 MCG/ACTUATION HFA AEROSOL INHALER ^{MO}	4	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION MO	3	
FLOVENT HFA 110 MCG/ACTUATION, 220 MCG/ACTUATION, 44 MCG/ACTUATION AEROSOL INHALER MO	3	
GLASSIA 1 GRAM/50 ML (2 %) INTRAVENOUS SOLUTION MO	5	PA
LETAIRIS 10 MG, 5 MG TABLET SP	5	PA,QL (30 per 30 days)
montelukast sod 10 mg tablet; montelukast sod 4 mg, 5 mg tab chew MO	2	QL (30 per 30 days)
montelukast sod 4 mg granules MO	4	QL (30 per 30 days)
OFEV 100 MG, 150 MG CAPSULE SP	5	PA,QL (60 per 30 days)
OPSUMIT 10 MG TABLET SP	5	PA,QL (30 per 30 days)
QVAR 40 MCG/ACTUATION, 80 MCG/ACTUATION METERED AEROSOL ORAL INHALER MO	3	
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER MO	3	
TRACLEER 125 MG, 62.5 MG TABLET SP	5	PA,QL (60 per 30 days)
zafirlukast 10 mg, 20 mg tablet MO	4	QL (60 per 30 days)
SKIN AND MUCOUS MEMBRANE AGENTS		
adapalene 0.1% cream; adapalene 0.1% gel MO	4	
betamethasone dp aug 0.05% crm; betamethasone dp aug 0.05% gel; betamethasone dp aug 0.05% lot; betamethasone dp aug 0.05% oin MO	3	
calcipotriene 0.005% cream MO	4	QL (120 per 30 days)
COSENTYX PEN 150 MG/ML SUBCUTANEOUS SP	5	PA,QL (2 per 28 days)
desonide 0.05% cream; desonide 0.05% lotion; desonide 0.05% ointment MO	4	
desoximetasone 0.05% cream; desoximetasone 0.05% gel; desoximetasone 0.05% ointment; desoximetasone 0.25% cream; desoximetasone 0.25% ointment MO	4	
diflorasone 0.05% cream; diflorasone 0.05% ointment MO	4	
fluorouracil 0.5% cream; fluorouracil 2% topical soln; fluorouracil 5% cream; fluorouracil 5% top solution MO	4	
fluticasone prop 0.005% oint; fluticasone prop 0.05% cream MO	2	
hydrocortisone buty 0.1% cream; hydrocortisone butyr 0.1% oint; hydrocortisone butyr 0.1% soln MO	3	
lidocaine 5% ointment MO	4	
lidocaine 5% patch MO	4	PA,QL (90 per 30 days)
mupirocin 2% cream MO	4	
PICATO 0.015 %, 0.05 % TOPICAL GEL MO	4	
RECTIV 0.4 % (W/W) OINTMENT MO	4	QL (30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9.

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SORIATANE 10 MG, 17.5 MG, 25 MG CAPSULE ^{MO}	5	
TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION ^{MO}	3	QL (420 per 30 days)
TARGRETIN 1 % TOPICAL GEL ^{SP}	5	PA
triamcinolone 0.025% cream; triamcinolone 0.025% oint; triamcinolone 0.1% cream; triamcinolone 0.1% ointment; triamcinolone 0.5% cream; triamcinolone 0.5% ointment ^{MO}	2	
ZYCLARA 2.5 %, 3.75 % TOPICAL CREAM PUMP ^{MO}	4	QL (15 per 30 days)
ZYCLARA 3.75 % TOPICAL CREAM PACKET ^{MO}	4	
SMOOTH MUSCLE RELAXANTS		
flavoxate hcl 100 mg tablet ^{MO}	3	
MYRBETRIQ 25 MG, 50 MG TABLET,EXTENDED RELEASE ^{MO}	4	QL (30 per 30 days)
oxybutynin 5 mg tablet; oxybutynin 5 mg/5 ml syrup ^{MO}	2	
oxybutynin cl er 10 mg, 15 mg, 5 mg tablet ^{MO}	3	QL (60 per 30 days)
tolterodine tartrate 1 mg, 2 mg tab ^{MO}	3	QL (60 per 30 days)
TOVIAZ 4 MG, 8 MG TABLET,EXTENDED RELEASE ^{MO}	3	QL (30 per 30 days)
trospium chloride 20 mg tablet ^{MO}	4	
trospium chloride er 60 mg cap ^{MO}	4	QL (30 per 30 days)
VESICARE 10 MG, 5 MG TABLET ^{MO}	4	QL (30 per 30 days)
VITAMINS		
calcitriol 0.25 mcg, 0.5 mcg capsule; calcitriol 1 mcg/ml ampul ^{MO}	2	

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Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-281-6918 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-281-6918 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-281-6918 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-281-6918 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-281-6918 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-281-6918 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-281-6918 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-281-6918 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-281-6918 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-281-6918 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-281-6918 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-281-6918 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-281-6918 (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-281-6918 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-281-6918 (TTY: 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-281-6918 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq, kojí' hódíłnih 1-800-281-6918 (TTY: 711).

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This abridged formulary was updated on 11/05/2016 and is not a complete list of drugs covered by our plan. For a complete listing, more recent information or other questions, please contact Humana at 1-800-281-6918 or, for TTY users, 711, 7 days a week, from 8 a.m. - 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from Feb. 15 - Sept. 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit Humana.com.

Humana is a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana PDP plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change (on January 1 of) each year. The Formulary may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call our customer service number at **1-800-281-6918 (TTY: 711)**.

Esta información está disponible sin costo en otros idiomas. Llame a nuestro departamento de Servicio al Cliente al **1-800-281-6918 (TTY: 711)**.

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