2018

Prescription Drug Guide

Humana Abbreviated Formulary

Partial list of covered drugs

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

HumanaChoice (Regional PPO)

This abridged formulary was updated on 12/04/2018 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 1-800-457-4708 or, for TTY users, 711, 7 days a week, from 8 a.m. - 8 p.m. However, please note that the 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.

For a complete list of Contract/PBP numbers this document relates to, please see the final page of this document.

Humana®

Welcome to Humana!

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 Humana. When it refers to "plan" or "our plan," it means Humana . This document includes a partial list of the drugs (formulary) for our plan which is current as of December 2018. For a complete, updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1 of each year, and from time to time during the year.

What is the abridged Humana Medicare formulary?

A formulary is the entire list of covered drugs or medicines selected by Humana. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. 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 the 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 medicines, 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 call Humana Customer Care at **1-800-457-4708 (TTY: 711)**. You can call us seven days a week, from 8 a.m. - 8 p.m. However, please note that the 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, if you take a drug that was covered at the beginning of the year, that coverage will not be discontinued or reduced during the 2018 coverage year. However, a formulary may be changed when, for example, a new, more cost effective generic drug or new information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose your plan, except for cases in which you can save additional money or we can ensure your safety.

We'll notify members who are affected by the following changes to the formulary:

- When a drug is removed from the formulary
- When prior authorization, quantity limits, or step-therapy restrictions are added to a drug or made more restrictive
- When a drug is moved to a higher cost-sharing tier

What if you're affected by a Drug List change?

We'll notify you by mail at least 60 days before one of these changes happens or we will provide a 60-day refill of the affected medicine with notice of the change.

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

The enclosed formulary is current as of December 2018. We'll update the printed formularies each month and they'll be available on Humana.com.

How do I use the formulary?

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

Medical condition

The formulary starts on page 11. 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 11. 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 group, you should look for your drug in the Index that begins on page 35. 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 Drugs
- **Tier 4 - Non-Preferred Drug:** 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 is covered. 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 that you first try certain drugs to treat your medical condition before coverage is available for 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 a determination can be made.

For drugs that need prior authorization or step therapy, or drugs that fall outside of quantity limits, your health care provider 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. - 8 p.m.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 11.

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 drugs 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 65 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 health care provider to decide if you should switch to another drug that is covered or if you should request a formulary exception so that it can be considered for coverage.

How do I request an exception to the formulary?

You can ask Humana to make an exception to the coverage rules. There are several types of exceptions that you can ask to be made.

- **Formulary exception:** You can request that your drug be covered if it's not on the formulary.
- **Utilization restriction exception:** You can request coverage restrictions or limits not be applied to your drug. For example, if your drug has a quantity limit, you can ask for the limit not to be applied and to cover more doses of the drug.
- **Tier exception:** You can request a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can request it to be covered as a preferred drug instead. This would lower how much money you must pay for your drug. Please remember a higher level of coverage cannot be requested for the drug if approval was not made to cover a drug that was not on the 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 health care provider that supports your request. This is called a supporting statement.

Generally, we must make the decision within 72 hours of receiving your health care provider's supporting statement. You can request a quicker, or expedited, exception if you or your health care provider thinks your health would seriously suffer if you wait as long as 72 hours for a decision. Once an expedited request is received, we must give you a decision no later than 24 hours after we get your health care provider'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 the plan.

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

- We'll temporarily cover up to a 30-day supply of your drug when you go to a pharmacy.
- There will be no coverage for the drugs after your first 30-day supply, even if you've been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you're a resident of a long-term care facility and you take Part D drugs that aren't on the 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 request a formulary exception if:

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

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. 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 requests for continuation of therapy on a case-by-case basis understanding 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 account

Register for MyHumana, your secure account 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 "Tools & Resources" 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

Humana Pharmacy® makes it easy to manage your prescriptions with mail delivery solutions

You may be able to fill your medicines through Humana Pharmacy – Humana's mail-delivery pharmacy. You can have your maintenance medicines, specialty medicines, or supplies mailed to a place that's most convenient for you. You should get your new prescription by mail in 7 – 10 days after Humana Pharmacy has received your prescription and all the necessary information. Refills should arrive within 5 – 7 days. To get started or learn more, visit hprxweb.com. You can also call Humana Pharmacy at 1-855-899-3134 (TTY: 711) Monday – Friday, 8 a.m. to 11 p.m., and Saturday, 8 a.m. to 6:30 p.m., Eastern time.

Other pharmacies are available in our network.

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**. The Drug List Search tool lets you search for your drug by name or drug type.

You can also call Humana Customer Care at **1-800-457-4708 (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 the drugs covered by Humana. If you have trouble finding your drug in the list, turn to the Index that begins on page 35.

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:
DL - Dispensing Limit; Drugs that may be limited to a 30 day supply
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 5 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 health care provider 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-lamivudine-zidov tab **DL**	5	QL (60 per 30 days)
acyclovir 400 mg, 800 mg tablet **MO**	2	
ALBENZA 200 MG TABLET **DL**	5	
amoxicillin 250 mg, 500 mg capsule **MO**	1	
amox-clav 250-125 mg, 500-125 mg, 875-125 mg tablet **MO**	2	
aztreonam 1 gm vial **MO**	4	
baciim 50,000 unit intramuscular solution **MO**	4	
bacitracin 50,000 unit vial **MO**	2	
BETHKIS 300 MG/4 ML SOLUTION FOR NEBULIZATION **DL**	5	PA
BILTRICIDE 600 MG TABLET **MO**	4	
CANCIDAS 50 MG, 70 MG INTRAVENOUS SOLUTION **DL**	5	
CAYSTON 75 MG/ML SOLUTION FOR NEBULIZATION **DL**	5	PA,QL (84 per 28 days)
cefaclor 250 mg, 500 mg capsule **MO**	3	
cefdinir 300 mg capsule **MO**	2	
cefepime hcl 1 gm vial; cefepime hcl 1 gram, 2 gram vial **MO**	4	
cefotetan 1 gm vial; cefotetan 10 gm vial; cefotetan 2 gm vial **MO**	4	
cefoxitin 1 gm vial; cefoxitin 10 gm vial; cefoxitin 2 gm vial **MO**	4	
ceftriaxone 1 gm vial; ceftriaxone 1 gram, 10 gram, 2 gram, 250 mg, 500 mg vial; ceftriaxone 10 gm vial; ceftriaxone 2 gm add vial; ceftriaxone 2 gm vial **MO**	3	
cefuroxime axetil 250 mg, 500 mg tab **MO**	3	
cephalexin 250 mg, 500 mg capsule **MO**	2	
chloramphen na succ 1 gm vl **MO**	3	
ciprofloxacin hcl 250 mg, 500 mg, 750 mg tab **MO**	1	
clindamycin hcl 150 mg, 300 mg, 75 mg capsule **MO**	2	
clindamycin 150 mg/ml, 300 mg/2 ml, 600 mg/4 ml, 900 mg/6 ml addvan; clindamycin ph 900 mg/6 ml vl **MO**	3	
colistimethate 150 mg vial **MO**	4	
CRIXIVAN 200 MG CAPSULE **MO**	4	QL (450 per 30 days)
CRIXIVAN 400 MG CAPSULE **MO**	4	QL (270 per 30 days)
dapsone 100 mg, 25 mg tablet **MO**	3	
daptomycin 350 mg, 500 mg vial **DL**	5	
DARAPRIM 25 MG TABLET **DL**	5	
DESCOVY 200 MG-25 MG TABLET **DL**	5	QL (30 per 30 days)
dicloxacillin 250 mg, 500 mg capsule **MO**	2	
DIFICID 200 MG TABLET **DL**	5	ST,QL (20 per 10 days)
doxycycline hyclate 100 mg tab **MO**	3	

Need more information about the indicators displayed by the drug names? Please go to page 10.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
doxycycline mono 100 mg, 50 mg cap MO	2	QL (60 per 30 days)
EPCLUSA 400 MG-100 MG TABLET DL	5	PA,QL (28 per 28 days)
ERYTHROCIN 500 MG INTRAVENOUS SOLUTION MO	1	
erythromycin 250 mg, 500 mg filmtab MO	4	
fluconazole 100 mg, 150 mg, 200 mg, 50 mg tablet MO	2	
flucytosine 250 mg, 500 mg capsule DL	5	
FUZEON 90 MG SUBCUTANEOUS SOLUTION DL	5	QL (60 per 30 days)
GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET DL	5	QL (30 per 30 days)
griseofulvin 125 mg/5 ml susp MO	3	
griseofulvin micro 500 mg tab MO	4	
griseofulvin ultra 125 mg, 250 mg tab MO	4	
HARVONI 90 MG-400 MG TABLET DL	5	PA,QL (28 per 28 days)
hydroxychloroquine 200 mg tab MO	1	
imipenem-cilastatin 250 mg, 500 mg vl MO	4	
ISENTRESS 400 MG TABLET DL	5	QL (120 per 30 days)
isoniazid 100 mg/ml vial MO	1	
ivermectin 3 mg tablet MO	3	
linezolid 100 mg/5 ml susp DL	5	QL (1800 per 30 days)
linezolid 600 mg/300 ml-d5w MO	4	
meropenem iv 1 gm vial; meropenem iv 1 gram, 500 mg vial MO	4	
metronidazole 250 mg, 500 mg tablet MO	2	
nafcillin 1 gm vial MO	4	
nitrofurantoin mcr 100 mg, 50 mg cap MO	4	QL (90 per 365 days)
nitrofurantoin mono-mcr 100 mg MO	4	QL (90 per 365 days)
nystatin 100,000 unit/ml susp MO	2	
nystatin 500,000 unit oral tab MO	3	
ODEFSEY 200 MG-25 MG-25 MG TABLET DL	5	QL (30 per 30 days)
oseltamivir phos 45 mg, 75 mg capsule MO	3	QL (56 per 365 days)
paromomycin 250 mg capsule MO	4	
PASER 4 GRAM GRANULES DELAYED-RELEASE PACKET MO	4	
PEGINTRON 50 MCG/0.5 ML SUBCUTANEOUS KIT DL	5	PA,QL (4 per 28 days)
PEGINTRON REDIPEN 120 MCG DL	5	PA,QL (4 per 28 days)
penicillin vk 125 mg/5 ml, 250 mg/5 ml soln MO	2	
penicillin vk 250 mg, 500 mg tablet MO	2	
piperacil-tazobact 13.5 gm vl; piperacil-tazobact 13.5 gram, 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram; piperacil-tazobact 2.25 gm vl; piperacil-tazobact 3.375 gm vl; piperacil-tazobact 4.5 gm vial MO	4	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
polymyxin b sulfate vial MO	3	
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)
RELENZA DISKHALER 5 MG/ACTUATION POWDER FOR INHALATION MO	4	QL (60 per 180 days)
ribavirin 200 mg capsule MO	3	QL (168 per 28 days)
RIFATER 50 MG-120 MG-300 MG TABLET MO	4	
rimantadine hcl 100 mg tablet MO	4	
SELZENTRY 300 MG, 75 MG TABLET DL	5	QL (120 per 30 days)
sulfamethoxazole-tmp ds tablet; sulfamethoxazole-tmp ss tablet MO	1	
SUPRAX 400 MG CAPSULE MO	4	
SUSTIVA 200 MG CAPSULE	5	QL (120 per 30 days)
SUSTIVA 50 MG CAPSULE MO	4	QL (480 per 30 days)
SYNAGIS 100 MG/ML, 50 MG/0.5 ML INTRAMUSCULAR SOLUTION DL	5	PA
SYNERCID 500 MG INTRAVENOUS SOLUTION DL	5	
TEFLARO 400 MG, 600 MG INTRAVENOUS SOLUTION MO	4	
terbinafine hcl 250 mg tablet MO	2	QL (90 per 365 days)
tetracycline 250 mg, 500 mg capsule MO	4	
tigecycline 50 mg vial DL	5	
TIVICAY 25 MG, 50 MG TABLET DL	5	QL (60 per 30 days)
TOBI PODHALER 28 MG CAPSULE WITH INHALATION DEVICE; TOBI PODHALER 28 MG CAPSULES FOR INHALATION DL	5	PA,QL (224 per 28 days)
TRUVADA 100 MG-150 MG TABLET; TRUVADA 133 MG-200 MG TABLET; TRUVADA 167 MG-250 MG TABLET; TRUVADA 200 MG-300 MG TABLET DL	5	QL (30 per 30 days)
vancomycin 1 gm vial; vancomycin 1,000 mg, 10 gram, 250 mg, 5 gram, 500 mg, 750 mg vial; vancomycin hcl 1,000 mg, 10 gram, 250 mg, 5 gram, 500 mg, 750 mg vial; vancomycin hcl 10 gm vial; vancomycin hcl 5 gm vial MO	3	
vancomycin hcl 125 mg capsule DL	5	QL (120 per 30 days)
XIFAXAN 200 MG TABLET DL	5	PA,QL (9 per 30 days)
XIFAXAN 550 MG TABLET DL	5	PA,QL (84 per 28 days)
ANTIHISTAMINE DRUGS		
cetirizine hcl 1 mg/ml soln MO	2	QL (300 per 30 days)
clemastine fum 2.68 mg tab MO	4	
cyproheptadine 2 mg/5 ml syrup MO	4	
cyproheptadine 4 mg tablet MO	4	
desloratadine 5 mg tablet MO	4	QL (30 per 30 days)
diphenhydramine 50 mg/ml vial MO	4	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
levocetirizine 5 mg tablet **MO**	1	QL (30 per 30 days)
promethazine 12.5 mg, 25 mg, 50 mg suppos; promethazine 12.5 mg, 25 mg, 50 mg suppository **MO**	4	PA
promethazine 12.5 mg, 25 mg, 50 mg tablet **MO**	4	PA
ANTINEOPLASTIC AGENTS		
anastrozole 1 mg tablet **MO**	1	QL (30 per 30 days)
bicalutamide 50 mg tablet **MO**	3	QL (30 per 30 days)
fluorouracil 2% topical soln; fluorouracil 5% topical soln **MO**	4	
IBRANCE 100 MG, 125 MG, 75 MG CAPSULE **DL**	5	PA,QL (21 per 28 days)
INLYTA 1 MG TABLET **DL**	5	PA,QL (180 per 30 days)
INLYTA 5 MG TABLET **DL**	5	PA,QL (60 per 30 days)
methotrexate 2.5 mg tablet **MO**	1	B vs D
PICATO 0.015 % TOPICAL GEL **MO**	4	QL (3 per 30 days)
PICATO 0.05 % TOPICAL GEL **MO**	4	QL (2 per 30 days)
SPRYCEL 100 MG, 50 MG, 70 MG, 80 MG TABLET **DL**	5	PA,QL (60 per 30 days)
SPRYCEL 140 MG TABLET **DL**	5	PA,QL (30 per 30 days)
SPRYCEL 20 MG TABLET **DL**	5	PA,QL (90 per 30 days)
SUTENT 12.5 MG, 25 MG, 37.5 MG, 50 MG CAPSULE **DL**	5	PA,QL (28 per 28 days)
TARGRETIN 1 % TOPICAL GEL **DL**	5	PA
TARGRETIN 75 MG CAPSULE **DL**	5	PA,QL (300 per 30 days)
XTANDI 40 MG CAPSULE **DL**	5	PA,QL (120 per 30 days)
ANTITOXINS,IMMUNE GLOB,TOXOIDS,VACCINES		
BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SUSPENSION **MO**	4	
GAMUNEX-C 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %) INJECTION SOLUTION **DL**	5	PA
HYPERRAB S/D (PF) 150 UNIT/ML INTRAMUSCULAR SOLUTION **DL**	5	B vs D
IMOGAM RABIES-HT (PF) 150 UNIT/ML INTRAMUSCULAR SOLUTION **MO**	4	B vs D
INFANRIX (DTAP) (PF) 25 LF UNIT-58 MCG-10 LF/0.5ML INTRAMUSCULAR SUSP **MO**	4	
IPOL 40 UNIT-8 UNIT-32 UNIT/0.5 ML SUSPENSION FOR INJECTION **MO**	4	
TYPHIM VI 25 MCG/0.5 ML INTRAMUSCULAR SOLUTION **MO**	4	
ZOSTAVAX (PF) 19,400 UNIT/0.65 ML SUBCUTANEOUS SUSPENSION **MO**	3	QL (1 per 365 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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
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	QL (60 per 30 days)
baclofen 10 mg, 20 mg tablet **MO**	2	
BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER **MO**	4	QL (10.7 per 30 days)
BROVANA 15 MCG/2 ML SOLUTION FOR NEBULIZATION **MO**	4	PA
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	QL (4 per 20 days)
cyclobenzaprine 10 mg, 5 mg tablet **MO**	4	PA
dantrolene sodium 100 mg, 25 mg, 50 mg cap **MO**	4	
dicyclomine 20 mg tablet **MO**	2	
dihydroergotamine 1 mg/ml amp **MO**	4	
donepezil hcl 10 mg tablet **MO**	1	QL (60 per 30 days)
donepezil hcl 10 mg, 5 mg tablet; donepezil hcl odt 10 mg, 5 mg tablet **MO**	1	QL (30 per 30 days)
EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR **MO**	3	QL (4 per 30 days)
EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR **MO**	3	QL (4 per 30 days)
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)
INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION **MO**	3	QL (30 per 30 days)
iprat-albut 0.5-3(2.5) mg/3 ml **MO**	2	B vs D
MESTINON TIMESPAN 180 MG TABLET,EXTENDED RELEASE **DL**	5	
midodrine hcl 10 mg, 2.5 mg, 5 mg tablet **MO**	3	
migergot 2 mg-100 mg rectal suppository	5	PA,QL (20 per 28 days)
PERFOROMIST 20 MCG/2 ML SOLUTION FOR NEBULIZATION **MO**	4	PA
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)
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	QL (4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES **MO**	3	QL (30 per 30 days)
STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO**	3	QL (4 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION SOLUTION FOR INHALATION MO	3	QL (4 per 30 days)
tamsulosin hcl 0.4 mg capsule MO	2	QL (60 per 30 days)
tizanidine hcl 2 mg, 4 mg tablet MO	1	
TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED MO	4	QL (1 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER MO	3	QL (36 per 30 days)
BLOOD FORMATION, COAGULATION, THROMBOSIS		
anagrelide hcl 0.5 mg, 1 mg capsule MO	3	
BRILINTA 60 MG, 90 MG TABLET MO	3	QL (60 per 30 days)
cilostazol 100 mg, 50 mg tablet MO	2	
clopidogrel 75 mg tablet MO	1	QL (30 per 30 days)
ELIQUIS 2.5 MG TABLET MO	3	QL (60 per 30 days)
ELIQUIS 5 MG, 5 MG (74 TABS) TABLET; ELIQUIS 5 MG, 5 MG (74 TABS) TABLETS IN A DOSE PACK MO	3	QL (74 per 30 days)
enoxaparin 100 mg/ml, 150 mg/ml syringe MO	4	QL (28 per 28 days)
enoxaparin 30 mg/0.3 ml, 60 mg/0.6 ml syr MO	4	QL (16.8 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 DL	5	QL (12 per 30 days)
NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE; NEULASTA 6 MG/0.6 ML, 6 MG/0.6ML WITH WEARABLE SUBCUTANEOUS INJECTOR DL	5	PA,QL (1.2 per 28 days)
NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE DL	5	PA,QL (7 per 30 days)
NEUPOGEN 300 MCG/ML INJECTION SOLUTION DL	5	PA,QL (14 per 30 days)
NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE DL	5	PA,QL (11.2 per 30 days)
NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION DL	5	PA,QL (22.4 per 30 days)
pentoxifylline er 400 mg tab MO	2	
PRADAXA 110 MG, 150 MG, 75 MG CAPSULE MO	4	QL (60 per 30 days)
PROCRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML INJECTION SOLUTION MO	4	PA,QL (14 per 30 days)
PROCRIT 20,000 UNIT/2 ML INJECTION SOLUTION MO	4	PA,QL (28 per 30 days)
PROCRIT 20,000 UNIT/ML, 40,000 UNIT/ML INJECTION SOLUTION DL	5	PA,QL (14 per 30 days)
tranexamic acid 1,000 mg/10 ml MO	4	PA
tranexamic acid 650 mg tablet MO	4	QL (30 per 5 days)
warfarin sodium 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg tablet MO	1	
XARELTO 10 MG, 20 MG TABLET MO	3	QL (30 per 30 days)
XARELTO 15 MG (42)-20 MG (9) TABLETS IN A STARTER PACK MO	3	QL (51 per 30 days)
XARELTO 15 MG, 2.5 MG TABLET MO	3	QL (60 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ZARXIO 300 MCG/0.5 ML INJECTION SYRINGE DL	5	PA,QL (7 per 30 days)
ZARXIO 480 MCG/0.8 ML INJECTION SYRINGE DL	5	PA,QL (11.2 per 30 days)
CARDIOVASCULAR DRUGS		
ADCIRCA 20 MG TABLET DL	5	PA,QL (60 per 30 days)
amiodarone hcl 200 mg tablet MO	2	
amlodipine-benazepril 10-20 mg, 2.5-10 mg, 5-10 mg, 5-20 mg; amlodipine-benazepril 2.5-10 MO	1	QL (60 per 30 days)
atenolol 100 mg, 25 mg, 50 mg tablet MO	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg tablet MO	1	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)
cartia xt 120 mg, 180 mg, 240 mg capsule,extended release MO	2	QL (60 per 30 days)
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	1	
COREG CR 10 MG, 20 MG, 40 MG, 80 MG CAPSULE, EXTENDED RELEASE MO	4	QL (30 per 30 days)
CORLANOR 5 MG, 7.5 MG TABLET MO	4	PA,QL (60 per 30 days)
digoxin 125 mcg tablet MO	2	QL (30 per 30 days)
digoxin 250 mcg tablet MO	4	QL (30 per 30 days)
diltiazem 24hr er 120 mg, 180 mg, 240 mg cap MO	2	QL (60 per 30 days)
dipyridamole 25 mg, 50 mg, 75 mg tablet MO	4	
dofetilide 125 mcg capsule MO	4	QL (240 per 30 days)
dofetilide 250 mcg capsule MO	4	QL (120 per 30 days)
doxazosin mesylate 1 mg, 2 mg, 4 mg, 8 mg tab MO	2	
ENTRESTO 24 MG-26 MG TABLET; ENTRESTO 49 MG-51 MG TABLET; ENTRESTO 97 MG-103 MG TABLET MO	3	PA,QL (60 per 30 days)
ezetimibe 10 mg tablet MO	3	QL (30 per 30 days)
fenofibrate 160 mg tablet MO	2	QL (30 per 30 days)
fenofibrate 145 mg tablet MO	3	QL (30 per 30 days)
gemfibrozil 600 mg tablet MO	2	QL (60 per 30 days)
hydralazine 10 mg, 100 mg, 25 mg, 50 mg tablet MO	2	
irbesartan 150 mg, 300 mg, 75 mg tablet MO	1	QL (30 per 30 days)
isosorbide mononit er 120 mg, 30 mg, 60 mg; isosorbide mononit er 120 mg, 30 mg, 60 mg tb MO	2	
lisinopril 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg tablet MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
metoprolol succ er 100 mg, 200 mg, 25 mg, 50 mg tab **MO**	1	QL (60 per 30 days)
metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg tab; metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg tb **MO**	1	
mexiletine 150 mg, 200 mg, 250 mg capsule **MO**	4	
moexipril-hctz 15-12.5 mg, 15-25 mg, 7.5-12.5 mg tab; moexipril-hctz 15-12.5 mg, 15-25 mg, 7.5-12.5 mg tablet **MO**	2	
MULTAQ 400 MG TABLET **MO**	3	QL (60 per 30 days)
niacin er 1,000 mg, 500 mg, 750 mg tablet **MO**	4	
niacor 500 mg tablet **MO**	2	
nifedipine er 30 mg, 60 mg, 90 mg tablet **MO**	3	QL (60 per 30 days)
NITROSTAT 0.3 MG, 0.4 MG, 0.6 MG SUBLINGUAL TABLET **MO**	3	
pacerone 200 mg tablet **MO**	2	
PRALUENT PEN 150 MG/ML, 75 MG/ML SUBCUTANEOUS PEN INJECTOR **DL**	5	PA,QL (2 per 28 days)
PRALUENT 75 MG/ML SYRINGE **DL**	5	PA,QL (2 per 28 days)
pravastatin sodium 40 mg tab **MO**	1	QL (60 per 30 days)
procainamide 100 mg/ml, 500 mg/ml vial **MO**	1	
propafenone hcl er 225 mg, 325 mg, 425 mg cap **MO**	4	
quinidine gluc 80 mg/ml vial **MO**	2	
quinidine sulfate 200 mg, 300 mg tab **MO**	2	
RANEXA 1,000 MG, 500 MG TABLET,EXTENDED RELEASE **MO**	3	ST,QL (120 per 30 days)
REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR **DL**	5	PA,QL (3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR **DL**	5	PA,QL (3 per 28 days)
REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE **DL**	5	PA,QL (3 per 28 days)
sildenafil 20 mg tablet **MO**	4	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)
spironolactone-hctz 25-25 tab **MO**	2	
spironolactone 100 mg, 25 mg, 50 mg tablet **MO**	2	
TEKTURNA 150 MG, 300 MG TABLET **MO**	3	QL (30 per 30 days)
TEKTURNA HCT 150 MG-12.5 MG TABLET; TEKTURNA HCT 150 MG-25 MG TABLET; TEKTURNA HCT 300 MG-12.5 MG TABLET; TEKTURNA HCT 300 MG-25 MG TABLET **MO**	3	QL (30 per 30 days)
telmisartan 20 mg, 40 mg tablet **MO**	2	QL (30 per 30 days)
telmisartan-hctz 40-12.5 mg, 80-25 mg tab; telmisartan-hctz 40-12.5 mg, 80-25 mg tb **MO**	4	ST,QL (30 per 30 days)
terazosin 1 mg, 10 mg, 2 mg, 5 mg capsule **MO**	1	
valsartan-hctz 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg tab **MO**	1	QL (30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
VASCEPA 0.5 GRAM CAPSULE MO	4	QL (240 per 30 days)
VASCEPA 1 GRAM CAPSULE MO	4	QL (120 per 30 days)
verapamil er 120 mg, 180 mg, 240 mg tablet MO	2	
VYTORIN 10 MG-10 MG TABLET MO	4	PA,QL (30 per 30 days)
WELCHOL 3.75 GRAM ORAL POWDER PACKET MO	3	
WELCHOL 625 MG TABLET MO	3	
ZETIA 10 MG TABLET MO	4	PA,QL (30 per 30 days)
CENTRAL NERVOUS SYSTEM AGENTS		
ABILIFY MAINTENA 300 MG, 400 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE DL	5	QL (1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE DL	5	QL (1 per 28 days)
acamprosate calc dr 333 mg tab MO	4	
alprazolam 0.25 mg, 0.5 mg, 1 mg tablet MO	2	QL (120 per 30 days)
amantadine 100 mg capsule MO	4	
amantadine 100 mg tablet MO	4	
amitriptyline hcl 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tab MO	3	PA
amoxapine 100 mg, 150 mg, 25 mg, 50 mg tablet MO	4	PA
ARISTADA 1,064 MG/3.9 ML SUSPENSION, EXTEND.REL. IM SYRINGE	5	QL (3.9 per 56 days)
ARISTADA 441 MG/1.6 ML SUSPENSION, EXTEND.REL. IM SYRINGE DL	5	QL (1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, EXTEND.REL. IM SYRINGE DL	5	QL (2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, EXTEND.REL. IM SYRINGE DL	5	QL (3.2 per 28 days)
AZILECT 0.5 MG, 1 MG TABLET MO	4	PA
BELSOMRA 10 MG, 15 MG, 20 MG, 5 MG TABLET MO	3	
benztropine mes 0.5 mg, 1 mg, 2 mg tab; benztropine mes 0.5 mg, 1 mg, 2 mg tablet MO	3	PA
bromocriptine 2.5 mg tablet MO	4	
bupap 50 mg-300 mg tablet MO	4	PA,QL (180 per 30 days)
buprenorphine 2 mg, 8 mg tablet sl MO	3	QL (90 per 30 days)
bupropion hcl sr 150 mg tablet MO	3	QL (90 per 30 days)
bupropion hcl xl 300 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	
butorphanol 1 mg/ml vial DL	4	QL (960 per 30 days)
carbidopa-levo er 25-100 tab; carbidopa-levo er 50-200 tab MO	3	
carbidopa-levodopa 10-100 tab; carbidopa-levodopa 25-100 tab; carbidopa-levodopa 25-250 tab MO	1	
celecoxib 100 mg, 200 mg, 400 mg, 50 mg capsule MO	4	QL (60 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
CELONTIN 300 MG CAPSULE MO	4	
citalopram hbr 20 mg tablet MO	1	QL (60 per 30 days)
clonazepam 0.5 mg, 1 mg, 2 mg tablet MO	3	
CYCLOSET 0.8 MG TABLET MO	4	PA,QL (180 per 30 days)
desipramine 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tablet MO	4	PA
dexmethylphenidate 10 mg, 2.5 mg, 5 mg tab MO	3	QL (60 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	3	QL (120 per 30 days)
diclofenac sod ec 50 mg, 75 mg tab MO	2	
duloxetine hcl dr 20 mg, 30 mg, 60 mg cap MO	3	QL (60 per 30 days)
EMBEDA 100 MG-4 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 20 MG-0.8 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 30 MG-1.2 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 50 MG-2 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 60 MG-2.4 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 80 MG-3.2 MG CAPSULE, EXTEND RELEASE, ORAL ONLY DL	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 DL	3	QL (360 per 30 days)
entacapone 200 mg tablet MO	3	QL (300 per 30 days)
ethosuximide 250 mg capsule MO	4	
fluoxetine hcl 10 mg, 40 mg capsule MO	1	QL (60 per 30 days)
fluphenazine 2.5 mg/5 ml elix MO	4	
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	
hydrocodone-ibuprofen 7.5-200 DL	3	QL (150 per 30 days)
hydroxyzine hcl 10 mg, 25 mg, 50 mg tablet MO	3	
ibuprofen 400 mg, 600 mg, 800 mg tablet MO	1	
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML INTRAMUSCULAR SYRINGE DL	5	QL (1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML INTRAMUSCULAR SYRINGE DL	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)
INVEGA TRINZA 273 MG/0.875 ML INTRAMUSCULAR SYRINGE	5	QL (0.87 per 90 days)
INVEGA TRINZA 410 MG/1.315 ML INTRAMUSCULAR SYRINGE	5	QL (1.31 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML INTRAMUSCULAR SYRINGE	5	QL (1.75 per 90 days)
INVEGA TRINZA 819 MG/2.625 ML INTRAMUSCULAR SYRINGE	5	QL (2.62 per 90 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
lithium carbonate 150 mg, 300 mg, 600 mg cap MO	1	
lithium carbonate er 300 mg, 450 mg tb MO	2	
loxapine 10 mg, 25 mg, 5 mg, 50 mg capsule MO	2	
LYRICA 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG CAPSULE MO	3	QL (90 per 30 days)
LYRICA 20 MG/ML ORAL SOLUTION MO	3	QL (900 per 30 days)
LYRICA 225 MG, 300 MG CAPSULE MO	3	QL (60 per 30 days)
meloxicam 7.5 mg tablet MO	1	QL (60 per 30 days)
modafinil 100 mg, 200 mg tablet MO	3	PA,QL (60 per 30 days)
naloxone 0.4 mg/ml vial MO	2	
naltrexone 50 mg tablet MO	2	
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)
NAMZARIC 14 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 21 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 28 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 7 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE MO	3	QL (30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG CAPSULE,SPRINKLE,ER 24HR,DOSE PACK MO	3	QL (28 per 28 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)
NUEDEXTA 20 MG-10 MG CAPSULE MO	3	PA,QL (60 per 30 days)
phenelzine sulfate 15 mg tab MO	3	
phenobarbital 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg tablet MO	3	PA,QL (90 per 30 days)
PHENYTEK 200 MG, 300 MG CAPSULE MO	4	
phenytoin sod ext 100 mg, 200 mg, 300 mg cap MO	2	
pimozide 1 mg, 2 mg tablet MO	4	
pramipexole 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg tablet MO	2	
primidone 250 mg, 50 mg tablet MO	2	
quetiapine fumarate 200 mg, 25 mg, 50 mg tab MO	2	QL (120 per 30 days)
rasagiline mesylate 0.5 mg, 1 mg tab MO	4	
riluzole 50 mg tablet MO	4	
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML INTRAMUSCULAR SYRINGE MO	4	QL (2 per 28 days)
RISPERDAL CONSTA 50 MG/2 ML INTRAMUSCULAR SYRINGE DL	5	QL (2 per 28 days)
ropinirole hcl 0.5 mg, 1 mg, 2 mg tablet MO	2	QL (90 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
selegiline hcl 5 mg capsule MO	3	
sumatriptan succ 100 mg, 25 mg, 50 mg tablet MO	2	QL (9 per 30 days)
thioridazine 10 mg, 100 mg, 25 mg, 50 mg tablet MO	3	
thiothixene 1 mg, 10 mg, 2 mg, 5 mg capsule MO	4	
tolcapone 100 mg tablet MO	4	PA
tranylcypromine sulf 10 mg tab MO	4	
trazodone 100 mg, 150 mg, 50 mg tablet MO	1	
trihexyphenidyl 2 mg/5 ml elx MO	3	PA
TRINTELLIX 10 MG, 20 MG, 5 MG TABLET MO	4	ST,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)
VOLTAREN 1 % TOPICAL GEL MO	4	
XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG CAPSULE SPRINKLE DL	3	QL (60 per 30 days)
ziprasidone hcl 20 mg, 40 mg, 60 mg, 80 mg capsule MO	4	QL (60 per 30 days)
zolpidem tartrate 10 mg, 5 mg tablet MO	2	
ZUBSOLV 0.7 MG-0.18 MG SUBLINGUAL TABLET; ZUBSOLV 1.4 MG-0.36 MG SUBLINGUAL TABLET; ZUBSOLV 2.9 MG-0.71 MG SUBLINGUAL TABLET; ZUBSOLV 5.7 MG-1.4 MG SUBLINGUAL TABLET MO	3	QL (90 per 30 days)
ZUBSOLV 11.4 MG-2.9 MG SUBLINGUAL TABLET MO	3	QL (30 per 30 days)
ZUBSOLV 8.6 MG-2.1 MG SUBLINGUAL TABLET MO	3	QL (60 per 30 days)
DEVICES		
BD INSULIN SYR 0.5 ML 29GX1/2"; BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64" MO	1	
BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2" MO	1	
NOVOFINE 30G X 1/3" NEEDLES MO	1	
NOVOFINE 32 32 GAUGE X 1/4" NEEDLE MO	1	
NOVOFINE AUTOCOVER 30 GAUGE X 1/3" NEEDLE MO	1	
NOVOFINE PLUS 32 GAUGE X 1/6" NEEDLE MO	1	
NOVOTWIST 32 GAUGE X 1/5" NEEDLE MO	1	
VGO 20 DEVICE MO	4	
VGO 30 DEVICE MO	4	
VGO 40 DEVICE MO	4	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
DIAGNOSTIC AGENTS		
ACTHAR H.P. 80 UNIT/ML INJECTION GEL **DL**	5	PA,QL (30 per 30 days)
ELECTROLYTIC, CALORIC, AND WATER BALANCE		
AURYXIA 210 MG IRON TABLET **MO**	4	QL (360 per 30 days)
bumetanide 0.5 mg, 1 mg, 2 mg tablet **MO**	2	
chlorthalidone 25 mg, 50 mg tablet **MO**	2	
CLINIMIX 5 % IN 20 % DEXTROSE (SULFITE-FREE) INTRAVENOUS SOLUTION **MO**	4	B vs D
CLINIMIX E 2.75 % IN 10 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION **MO**	4	B vs D
furosemide 20 mg, 40 mg, 80 mg tablet **MO**	1	
generlac 10 gram/15 ml oral solution **MO**	2	
hydrochlorothiazide 12.5 mg cp **MO**	1	
hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tab; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tb **MO**	1	
indapamide 1.25 mg, 2.5 mg tablet **MO**	1	
kionex powder **MO**	3	
KLOR-CON 10 MEQ TABLET,EXTENDED RELEASE **MO**	2	
klor-con m10 meq tablet,extended release **MO**	2	
lactated ringers irrigation **MO**	2	
lactulose 10 gm/15 ml solution; lactulose 20 gm/30 ml solution **MO**	2	
LITHOSTAT 250 MG TABLET **MO**	4	
metolazone 10 mg, 2.5 mg, 5 mg tablet **MO**	2	
PHYSIOLYTE 140 MEQ-5 MEQ-3 MEQ-98 MEQ/L IRRIGATION SOLUTION **MO**	1	
potassium cl er 10 meq, 20 meq tablet **MO**	2	
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	
probenecid 500 mg tablet **MO**	3	
probenecid-colchicine tabs **MO**	3	
RENVELA 0.8 GRAM ORAL POWDER PACKET **MO**	3	QL (540 per 30 days)
RENVELA 2.4 GRAM ORAL POWDER PACKET **MO**	3	QL (180 per 30 days)
RENVELA 800 MG TABLET **MO**	3	QL (540 per 30 days)
SAMSCA 15 MG, 30 MG TABLET **DL**	5	QL (60 per 30 days)
sodium lactate 5 meq/ml vial **MO**	1	
SPS (WITH SORBITOL) 15 GRAM-20 GRAM/60 ML ORAL SUSPENSION **MO**	3	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
triamterene-hctz 37.5-25 mg cp MO	1	
triamterene-hctz 37.5-25 mg, 75-50 mg tab; triamterene-hctz 37.5-25 mg, 75-50 mg tb MO	1	
ENZYMES		
CEREZYME 400 UNIT INTRAVENOUS SOLUTION DL	5	PA
ELELYSO 200 UNIT INTRAVENOUS SOLUTION DL	5	PA,QL (70 per 30 days)
ELITEK 1.5 MG, 7.5 MG INTRAVENOUS SOLUTION DL	5	PA
STRENSIQ 100 MG/ML SUBCUTANEOUS SOLUTION DL	5	PA,QL (38.4 per 28 days)
STRENSIQ 40 MG/ML SUBCUTANEOUS SOLUTION DL	5	PA
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
acetazolamide er 500 mg cap MO	4	
ALPHAGAN P 0.1 % EYE DROPS MO	3	
atropine 1% eye drops MO	2	
azelastine 0.1% (137 mcg) spry MO	3	QL (30 per 25 days)
AZOPT 1 % EYE DROPS,SUSPENSION MO	3	QL (10 per 28 days)
BEPREVE 1.5 % EYE DROPS MO	4	QL (5 per 25 days)
BESIVANCE 0.6 % EYE DROPS,SUSPENSION MO	3	
brimonidine 0.2% eye drop; brimonidine tartrate 0.15% drp MO	3	
chlorhexidine 0.12% rinse MO	1	
COMBIGAN 0.2 %-0.5 % EYE DROPS MO	3	QL (5 per 25 days)
dorzolamide hcl 2% eye drops MO	1	QL (10 per 30 days)
DUREZOL 0.05 % EYE DROPS MO	3	
epinastine hcl 0.05% eye drops MO	3	QL (5 per 25 days)
fluticasone prop 50 mcg spray MO	2	QL (16 per 30 days)
ILEVRO 0.3 % EYE DROPS,SUSPENSION MO	3	
IOPIDINE 1 % EYE DROPS IN A DROPPERETTE MO	4	
ipratropium 0.03% spray MO	2	QL (30 per 30 days)
ipratropium 0.06% spray MO	2	QL (45 per 30 days)
ketorolac 0.4% ophth solution; ketorolac 0.5% ophth solution MO	2	
latanoprost 0.005% eye drops MO	1	QL (5 per 25 days)
lidocaine viscous 2 % mucosal solution MO	2	
LOTEMAX 0.5 % EYE DROPS,SUSPENSION; LOTEMAX 0.5 % EYE GEL DROPS MO	4	
LOTEMAX 0.5 % EYE OINTMENT MO	4	
LUMIGAN 0.01 % EYE DROPS MO	3	QL (2.5 per 25 days)
NATACYN 5 % EYE DROPS,SUSPENSION MO	4	
NEVANAC 0.1 % EYE DROPS,SUSPENSION MO	4	ST
PAZEO 0.7 % EYE DROPS MO	3	QL (2.5 per 25 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
periogard 0.12 % mouthwash MO	1	
PHOSPHOLINE IODIDE 0.125 % EYE DROPS MO	4	
pilocarpine 1% eye drops; pilocarpine 2% eye drops; pilocarpine 4% eye drops MO	3	
prednisolone ac 1% eye drop MO	4	
proparacaine 0.5% eye drops MO	1	
RESTASIS 0.05 % EYE DROPS IN A DROPPERETTE MO	3	QL (60 per 30 days)
timolol maleate 0.25% eye drop; timolol maleate 0.5% eye drops MO	1	
tobramycin-dexameth ophth susp MO	4	
TRAVATAN Z 0.004 % EYE DROPS MO	3	QL (2.5 per 25 days)
trifluridine 1% eye drops MO	3	
VIGAMOX 0.5 % EYE DROPS MO	4	
XIIDRA 5 % EYE DROPS IN A DROPPERETTE MO	4	PA,QL (60 per 30 days)
ZIRGAN 0.15 % EYE GEL MO	4	QL (5 per 30 days)
GASTROINTESTINAL DRUGS		
AMITIZA 24 MCG, 8 MCG CAPSULE MO	3	QL (60 per 30 days)
aprepitant 125 mg, 40 mg capsule MO	4	B vs D,QL (2 per 28 days)
APRISO 0.375 GRAM CAPSULE,EXTENDED RELEASE MO	3	QL (120 per 30 days)
balsalazide disodium 750 mg cp MO	4	
CANASA 1,000 MG RECTAL SUPPOSITORY MO	3	QL (30 per 30 days)
CARAFATE 100 MG/ML ORAL SUSPENSION MO	4	
cimetidine 200 mg, 300 mg, 400 mg, 800 mg tablet 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 UNIT-9,500 UNIT-15,000 UNIT CAPSULE,DELAYED RELEASE; CREON 36,000 UNIT-114,000 UNIT-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)
diphenoxylat-atrop 2.5-0.025/5 MO	4	
diphenoxylate-atrop 2.5-0.025 MO	4	
dronabinol 10 mg, 2.5 mg, 5 mg capsule MO	4	B vs D,QL (120 per 30 days)
EMEND 125 MG, 40 MG CAPSULE MO	4	PA,QL (2 per 28 days)
lansoprazole dr 30 mg capsule 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, 72 MCG CAPSULE MO	3	QL (30 per 30 days)
meclizine 12.5 mg, 25 mg tablet MO	4	
metoclopramide 10 mg, 5 mg tablet MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
misoprostol 100 mcg, 200 mcg tablet **MO**	3	
omeprazole dr 10 mg, 20 mg, 40 mg capsule **MO**	1	QL (60 per 30 days)
ondansetron hcl 4 mg, 8 mg tablet **MO**	2	B vs D,QL (90 per 30 days)
polyethylene glycol 3350 powd **MO**	2	
prochlorperazine 25 mg supp **MO**	4	
ranitidine 150 mg, 300 mg tablet **MO**	2	
RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SOLUTION **MO**	4	QL (36 per 30 days)
RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SYRINGE **MO**	4	QL (36 per 28 days)
RELISTOR 150 MG TABLET **MO**	4	QL (90 per 30 days)
RELISTOR 8 MG/0.4 ML SUBCUTANEOUS SYRINGE **MO**	4	QL (12 per 30 days)
SANCUSO 3.1 MG/24 HOUR TRANSDERMAL PATCH **MO**	4	QL (4 per 30 days)
sucralfate 1 gm tablet **MO**	2	
SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION **MO**	3	
trilyte with flavor packets 420 gram oral solution **MO**	2	
ursodiol 250 mg tablet **MO**	3	
ursodiol 500 mg tablet **MO**	4	
VIBERZI 100 MG, 75 MG TABLET **MO**	4	PA,QL (60 per 30 days)
ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP DR 10,000 UNIT CAPSULE; ZENPEP DR 15,000 UNIT CAPSULE; ZENPEP DR 20,000 UNIT CAPSULE; ZENPEP DR 25,000 UNIT CAPSULE; ZENPEP DR 3,000 UNIT CAPSULE; ZENPEP DR 40,000 UNIT CAPSULE; ZENPEP DR 5,000 UNIT CAPSULE **MO**	4	
GOLD COMPOUNDS		
RIDAURA 3 MG CAPSULE **DL**	5	
HEAVY METAL ANTAGONISTS		
CUPRIMINE 250 MG CAPSULE	5	
SYPRINE 250 MG CAPSULE **DL**	5	
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)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANDROGEL 1.62 % (40.5 MG/2.5 GRAM), 20.25 MG/1.25 GRAM (1.62 %) TRANSDERMAL GEL PACKET; ANDROGEL 1.62 % (40.5 MG/2.5 GRAM), 20.25 MG/1.25 GRAM (1.62 %) TRANSDERMAL GEL PUMP **MO**	3	QL (150 per 30 days)
BYDUREON 2 MG SUBCUTANEOUS EXTENDED RELEASE SUSPENSION **MO**	4	QL (4 per 28 days)
BYDUREON 2 MG/0.65 ML SUBCUTANEOUS PEN INJECTOR **MO**	4	QL (4 per 28 days)
BYETTA 10 MCG/DOSE(250 MCG/ML)2.4 ML SUBCUTANEOUS PEN INJECTOR; BYETTA 5 MCG/DOSE (250 MCG/ML)1.2 ML SUBCUTANEOUS PEN INJECTOR **MO**	4	QL (2.4 per 30 days)
calcitonin-salmon 200 units sp **MO**	3	QL (3.7 per 28 days)
chorionic gonad 10,000 unit vl **MO**	4	PA
danazol 100 mg, 200 mg, 50 mg capsule **MO**	4	
desmopressin acetate 0.1 mg tb **MO**	4	QL (180 per 30 days)
desmopressin acetate 0.2 mg tb **MO**	4	
EGRIFTA 1 MG SUBCUTANEOUS SOLUTION **DL**	5	PA,QL (60 per 30 days)
ESTRACE 0.01% (0.1 MG/GRAM) VAGINAL CREAM **MO**	3	
ESTRING 2 MG (7.5 MCG/24 HOUR) VAGINAL RING **MO**	4	QL (1 per 90 days)
FARXIGA 10 MG, 5 MG TABLET **MO**	4	QL (30 per 30 days)
FORTEO 20 MCG/DOSE (600 MCG/2.4 ML) SUBCUTANEOUS PEN INJECTOR **MO**	4	PA,QL (2.4 per 28 days)
glipizide 10 mg, 5 mg tablet **MO**	1	
glipizide er 10 mg, 2.5 mg, 5 mg tablet **MO**	1	
GLUCAGEN HYPOKIT 1 MG INJECTION **MO**	3	
GLUMETZA 1,000 MG TABLET,EXTENDED RELEASE **MO**	4	QL (60 per 30 days)
GLUMETZA 500 MG TABLET,EXTENDED RELEASE **MO**	4	QL (120 per 30 days)
GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET **MO**	3	QL (30 per 30 days)
HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML SUBCUTANEOUS SOLN **DL**	5	
HUMULIN R U-500 (CONC) INSULIN KWIKPEN 500 UNIT/ML (3 ML) SUBCUTANEOUS **DL**	5	
INCRELEX 10 MG/ML SUBCUTANEOUS SOLUTION **DL**	5	PA
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)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE MO	3	QL (60 per 30 days)
JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE MO	3	QL (30 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)
KORLYM 300 MG TABLET DL	5	PA,QL (120 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO	3	
LANTUS U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION MO	3	
LEVEMIR FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO	3	
LEVEMIR U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION 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	
medroxyprogesterone 10 mg, 2.5 mg, 5 mg tab MO	2	
MENEST 0.3 MG, 0.625 MG, 1.25 MG TABLET MO	4	PA
metformin hcl 1,000 mg, 500 mg, 850 mg tablet MO	1	
methimazole 10 mg, 5 mg tablet MO	2	
METHITEST 10 MG TABLET MO	4	
methylprednisolone 4 mg dosepk MO	2	
MYALEPT 5 MG/ML (FINAL CONCENTRATION) SUBCUTANEOUS SOLUTION DL	5	PA,QL (30 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)
norg-ee 0.18-0.215-0.25/0.025; norg-ee 0.18-0.215-0.25/0.035; norg-ethin estra 0.25-0.035 mg MO	4	
nortrel 1/35 (21) 1 mg-35 mcg tablet MO	4	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO	3	
NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML SUBCUTANEOUS SUSP MO	3	
NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML INJECTION SOLUTION MO	3	
NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS MO	3	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION **MO**	3	
NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN **MO**	3	
NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS CARTRIDG **MO**	3	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS SOLUTION **MO**	3	
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) SUBCUTANEOUS CARTRIDGE **DL**	5	PA
OMNITROPE 5.8 MG SUBCUTANEOUS SOLUTION **DL**	5	PA
ONGLYZA 2.5 MG, 5 MG TABLET **MO**	4	QL (30 per 30 days)
ORTHO-NOVUM 7/7/7 (28) 0.5 MG/0.75 MG/1 MG-35 MCG TABLET **MO**	4	
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**	1	QL (30 per 30 days)
prednisone 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg tablet **MO**	1	B vs D
PREMARIN 0.625 MG/GRAM VAGINAL CREAM **MO**	3	
PROGLYCEM 50 MG/ML ORAL SUSPENSION **MO**	4	
propylthiouracil 50 mg tablet **MO**	3	
raloxifene hcl 60 mg tablet **MO**	3	QL (30 per 30 days)
repaglinide 0.5 mg, 1 mg, 2 mg tablet **MO**	3	
SENSIPAR 30 MG TABLET **MO**	3	QL (60 per 30 days)
SENSIPAR 60 MG TABLET	5	QL (60 per 30 days)
SENSIPAR 90 MG TABLET	5	QL (120 per 30 days)
SOMAVERT 10 MG, 15 MG, 20 MG SUBCUTANEOUS SOLUTION **DL**	5	PA,QL (60 per 30 days)
SYMLINPEN 120 2,700 MCG/2.7 ML SUBCUTANEOUS PEN INJECTOR **DL**	5	QL (10.8 per 30 days)
SYMLINPEN 60 1,500 MCG/1.5 ML SUBCUTANEOUS PEN INJECTOR **DL**	5	QL (10.5 per 28 days)
SYNAREL 2 MG/ML NASAL SPRAY **DL**	5	
SYNJARDY 12.5 MG-1,000 MG TABLET; SYNJARDY 12.5 MG-500 MG TABLET; SYNJARDY 5 MG-1,000 MG TABLET; SYNJARDY 5 MG-500 MG TABLET **MO**	3	QL (60 per 30 days)
SYNTHROID 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**	3	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) SUBCUTANEOUS PEN **MO**	3	
TRADJENTA 5 MG TABLET **MO**	3	QL (30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TRESIBA FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO	3	
TRESIBA FLEXTOUCH U-200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO	3	
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR MO	3	QL (2 per 28 days)
UNITHROID 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	3	
VICTOZA 2-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR MO	3	QL (9 per 30 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR MO	3	QL (9 per 30 days)
XIGDUO XR 10 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 10 MG-500 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-500 MG TABLET,EXTENDED RELEASE MO	4	QL (30 per 30 days)
XIGDUO XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE MO	4	QL (60 per 30 days)
MISCELLANEOUS THERAPEUTIC AGENTS		
ACTIMMUNE 100 MCG (2 MILLION UNIT)/0.5 ML SUBCUTANEOUS SOLUTION DL	5	PA
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)
allopurinol 100 mg, 300 mg tablet MO	1	
AMPYRA 10 MG TABLET,EXTENDED RELEASE DL	5	PA,QL (60 per 30 days)
BETASERON 0.3 MG SUBCUTANEOUS KIT DL	5	PA,QL (15 per 30 days)
BINOSTO 70 MG EFFERVESCENT TABLET MO	4	QL (4 per 28 days)
CERDELGA 84 MG CAPSULE DL	5	PA,QL (60 per 30 days)
CINRYZE 500 UNIT (5 ML) INTRAVENOUS SOLUTION DL	5	PA,QL (20 per 30 days)
COLCRYS 0.6 MG TABLET MO	3	QL (120 per 30 days)
COPAXONE 20 MG/ML SUBCUTANEOUS SYRINGE DL	5	PA,QL (30 per 30 days)
COPAXONE 40 MG/ML SUBCUTANEOUS SYRINGE DL	5	PA,QL (12 per 28 days)
cyclosporine modified 100 mg, 25 mg, 50 mg MO	4	B vs D
disulfiram 250 mg, 500 mg tablet MO	4	
dutasteride 0.5 mg capsule MO	3	QL (30 per 30 days)
ELMIRON 100 MG CAPSULE MO	4	QL (90 per 30 days)
ENBREL 25 MG (1 ML) SUBCUTANEOUS SOLUTION DL	5	PA,QL (8 per 28 days)
ENBREL 25 MG/0.5 ML (0.51 ML) SUBCUTANEOUS SYRINGE DL	5	PA,QL (4.08 per 28 days)
ENBREL 50 MG/ML (0.98 ML) SUBCUTANEOUS SYRINGE DL	5	PA,QL (7.84 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ENBREL SURECLICK 50 MG/ML (0.98 ML) SUBCUTANEOUS PEN INJECTOR DL	5	PA,QL (7.84 per 28 days)
finasteride 5 mg tablet MO	1	QL (30 per 30 days)
FIRAZYR 30 MG/3 ML SUBCUTANEOUS SYRINGE DL	5	PA,QL (18 per 30 days)
GILENYA 0.25 MG, 0.5 MG CAPSULE DL	5	PA,QL (30 per 30 days)
HUMIRA 10 MG/0.1 ML, 10 MG/0.2 ML SUBCUTANEOUS SYRINGE KIT DL	5	PA,QL (2 per 28 days)
HUMIRA 20 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.4 ML, 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT DL	5	PA,QL (6 per 28 days)
HUMIRA PEN 40 MG/0.4 ML, 40 MG/0.8 ML SUBCUTANEOUS KIT DL	5	PA,QL (6 per 28 days)
HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML, 80 MG/0.8 ML SUBCUT KIT DL	5	PA,QL (6 per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT; HUMIRA PEN PSORIASIS-UVEITIS STARTER 40 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SUBCUTANEOUS KIT DL	5	PA,QL (6 per 28 days)
leflunomide 10 mg, 20 mg tablet MO	2	QL (30 per 30 days)
leucovorin calcium 10 mg, 15 mg, 25 mg, 5 mg tab MO	2	
leucovorin calcium 100 mg, 200 mg, 350 mg, 50 mg, 500 mg vial; leucovorin calcium 100 mg, 200 mg, 350 mg, 50 mg, 500 mg vl MO	2	B vs D
mesna 1 gram/10 ml vial MO	4	B vs D
MESNEX 400 MG TABLET DL	5	
mycophenolate 250 mg capsule MO	3	B vs D
octreotide 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml vial; octreotide acet 0.05 mg/ml vl; octreotide acet 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml vl MO	4	PA
PROLIA 60 MG/ML SUBCUTANEOUS SYRINGE MO	4	QL (1 per 180 days)
REBIF (WITH ALBUMIN) 22 MCG/0.5 ML, 44 MCG/0.5 ML SUBCUTANEOUS SYRINGE DL	5	PA,QL (6 per 28 days)
REBIF REBIDOSE 22 MCG/0.5 ML, 44 MCG/0.5 ML SUBCUTANEOUS PEN INJECTOR DL	5	PA,QL (6 per 28 days)
REBIF REBIDOSE 8.8 MCG/0.2 ML-22 MCG/0.5 ML (6) SUBCUTANEOUS PEN INJ. DL	5	PA,QL (4.2 per 28 days)
REBIF TITRATION PACK 8.8 MCG/0.2 ML-22 MCG/0.5 ML SUBCUTANEOUS SYRINGE DL	5	PA,QL (4.2 per 28 days)
REMICADE 100 MG INTRAVENOUS SOLUTION DL	5	PA
SIMPONI 100 MG/ML SUBCUTANEOUS PEN INJECTOR DL	5	PA,QL (3 per 30 days)
SIMPONI 100 MG/ML SUBCUTANEOUS SYRINGE DL	5	PA,QL (3 per 30 days)
THALOMID 100 MG, 200 MG, 50 MG CAPSULE DL	5	PA,QL (30 per 30 days)
ULORIC 40 MG, 80 MG TABLET MO	3	ST,QL (30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
XELJANZ 10 MG, 5 MG TABLET DL	5	PA,QL (60 per 30 days)
XELJANZ XR 11 MG TABLET,EXTENDED RELEASE DL	5	PA,QL (30 per 30 days)
PHARMACEUTICAL AIDS		
GAUZE PADS, STERILE 2"X2" MO	1	
RESPIRATORY TRACT AGENTS		
acetylcysteine 10% vial; acetylcysteine 20% vial MO	3	B vs D
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL	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	QL (60 per 30 days)
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	QL (12 per 30 days)
ARALAST NP 1,000 MG, 500 MG INTRAVENOUS SOLUTION DL	5	PA
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION MO	3	QL (30 per 30 days)
BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION; BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION MO	3	QL (60 per 30 days)
cromolyn 100 mg/5 ml oral conc MO	4	
cromolyn 20 mg/2 ml neb soln MO	3	B vs D
DALIRESP 500 MCG TABLET MO	3	QL (30 per 30 days)
ESBRIET 267 MG CAPSULE DL	5	PA,QL (270 per 30 days)
ESBRIET 267 MG TABLET DL	5	PA,QL (270 per 30 days)
ESBRIET 801 MG TABLET DL	5	PA,QL (90 per 30 days)
FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION MO	3	QL (60 per 30 days)
FLOVENT HFA 110 MCG/ACTUATION, 220 MCG/ACTUATION AEROSOL INHALER MO	3	QL (24 per 30 days)
FLOVENT HFA 44 MCG/ACTUATION AEROSOL INHALER MO	3	QL (10.6 per 30 days)
GLASSIA 1 GRAM/50 ML (2 %) INTRAVENOUS SOLUTION DL	5	PA
KALYDECO 150 MG TABLET DL	5	PA,QL (60 per 30 days)
KALYDECO 50 MG, 75 MG ORAL GRANULES IN PACKET DL	5	PA,QL (56 per 28 days)
LETAIRIS 10 MG, 5 MG TABLET DL	5	PA,QL (30 per 30 days)
montelukast sod 10 mg tablet MO	1	QL (30 per 30 days)
montelukast sod 4 mg, 5 mg tab chew MO	2	QL (30 per 30 days)
OFEV 100 MG, 150 MG CAPSULE DL	5	PA,QL (60 per 30 days)
OPSUMIT 10 MG TABLET DL	5	PA,QL (30 per 30 days)
PULMOZYME 1 MG/ML SOLUTION FOR INHALATION DL	5	B vs D

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER MO	3	QL (10.2 per 30 days)
TRACLEER 125 MG, 62.5 MG TABLET DL	5	PA,QL (60 per 30 days)
VENTAVIS 10 MCG/ML, 20 MCG/ML SOLUTION FOR NEBULIZATION DL	5	PA
zafirlukast 10 mg, 20 mg tablet MO	4	QL (60 per 30 days)
SKIN AND MUCOUS MEMBRANE AGENTS		
acyclovir 5% ointment MO	4	PA
ALCOHOL 70% SWABS MO	1	
ammonium lactate 12% cream MO	2	
ammonium lactate 12% lotion MO	2	
ciclopirox 0.77% gel MO	4	
ciclopirox 8% solution MO	3	
CLEOCIN 100 MG VAGINAL SUPPOSITORY MO	4	
clotrimazole 10 mg troche MO	2	
COSENTYX 150 MG/ML SUBCUTANEOUS SYRINGE DL	5	PA,QL (32 per 365 days)
DENAVIR 1 % TOPICAL CREAM MO	4	PA
desonide 0.05% cream MO	4	
desoximetasone 0.25% cream MO	4	
ELIDEL 1 % TOPICAL CREAM MO	4	
lidocaine 5% patch MO	4	PA,QL (90 per 30 days)
lidocaine-prilocaine cream MO	4	
lindane 1% shampoo MO	4	
MENTAX 1 % TOPICAL CREAM MO	4	
methoxsalen 10 mg softgel DL	5	
metronidazole top 1% gel pump; metronidazole topical 0.75% gl; metronidazole topical 1% gel; metronidazole vaginal 0.75% gl MO	4	
mupirocin 2% ointment MO	2	
mupirocin 2% cream MO	4	
naftifine hcl 1% cream; naftifine hcl 2% cream MO	4	ST
nystatin 100,000 unit/gm oint MO	2	
nystatin-triamcinolone ointm MO	4	
nystop 100,000 unit/gram topical powder MO	2	
permethrin 5% cream MO	3	
RECTIV 0.4 % (W/W) OINTMENT MO	4	QL (30 per 30 days)
silver sulfadiazine 1% cream MO	2	
SULFAMYLON 50 GRAM TOPICAL PACKET MO	4	
TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION MO	3	QL (420 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
terconazole 0.4% cream; terconazole 0.8% cream **MO**	2	
tretinoin 0.01% gel; tretinoin 0.025% gel; tretinoin 0.05% gel **MO**	4	PA
tretinoin 0.025% cream; tretinoin 0.05% cream; tretinoin 0.1% cream **MO**	4	PA
triderm 0.1 %, 0.5 % topical cream **MO**	2	
ZYCLARA 2.5 % TOPICAL CREAM PUMP **MO**	4	QL (15 per 30 days)
ZYCLARA 3.75 % TOPICAL CREAM PACKET; ZYCLARA 3.75 % TOPICAL CREAM PUMP **MO**	4	
SMOOTH MUSCLE RELAXANTS		
MYRBETRIQ 25 MG, 50 MG TABLET,EXTENDED RELEASE **MO**	3	QL (30 per 30 days)
oxybutynin 5 mg tablet **MO**	2	
oxybutynin cl er 10 mg, 15 mg, 5 mg tablet **MO**	3	QL (60 per 30 days)
theophylline er 100 mg, 200 mg tablet **MO**	2	
TOVIAZ 4 MG, 8 MG TABLET,EXTENDED RELEASE **MO**	3	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 **MO**	2	
doxercalciferol 0.5 mcg, 1 mcg, 2.5 mcg cap; doxercalciferol 0.5 mcg, 1 mcg, 2.5 mcg capsule **MO**	4	
PRENATABS FA 29 MG-1 MG TABLET **MO**	4	

Need more information about the indicators displayed by the drug names? Please go to page 10.

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

Index

C

D

E

F

G

S

T

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-800-281-6918 or if you use a TTY, call 711.

If you believe that **Humana Inc. and its subsidiaries** have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-800-281-6918 or if you use a TTY, call 711.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019, 800-537-7697 (TDD)

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

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)**.

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'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-281-6918 (TTY: 711)**.

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

MLInsert_CustCare_Embedded

Notes

Notes

This abridged formulary was updated on 12/04/2018 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 1-800-457-4708 or, for TTY users, 711, 7 days a week, from 8 a.m. - 8 p.m. However, please note that the 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 Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana 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, premiums and/or co-payments/co-insurance may change on January 1 of each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary. You must generally use network pharmacies to use your prescription drug benefit.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-457-4708 (TTY: 711)**.

R0110-002, 003; R0865-003; R0923-002; R1390-002; R1532-002; R3392-002; R3887-002; R4182-003, 004; R4845-002; R5361-002; R5495-002; R5826-005, 074; R7220-002; R7315-002

Humana®

Humana.com