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.

Humana Gold Plus SNP-DE (HMO SNP)
Humana Community HMO SNP-DE (HMO SNP)
Humana Cleveland Clinic Preferred SNP-DE (HMO SNP)

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) |

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| 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) |

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| 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 | |

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| 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) |

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| 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) |

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| 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) |

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|---|---|---|
| *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) |

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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 |
|---|---|---|
| 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 | |

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| 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 | |

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| 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) |

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| 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 | |

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| 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) |

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| 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) |

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| 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 | |

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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 |
|---|---|---|
| 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) |

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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 |
|---|---|---|
| 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) |

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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 |
|---|---|---|
| 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) |

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| 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 |

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| 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) |

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| 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 | |

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## Discrimination is Against the Law

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

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**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**

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# 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 Coordinated Care plan with a Medicare contract and a contract with the AL, CA, FL, GA, IN, KY, LA, ME, MS, MO, MT, NE, NY, NC, OH, PA, SC, TN, TX, VA, and WA Medicaid program. 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)**.

H0028-007; H1036-167, 168, 222, 235, 241, 243, 245, 249; H1951-032, 033, 034, 041; H2649-028, 048, 050; H3533-002, 004; H4141-003; H4461-022; H5619-003, 038, 054, 067, 075, 076, 082, 093; H6622-008, 015, 018, 024, 027, 038, 048

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