

Welcome to Humana

In this collection you will find valuable information regarding your health plan coverage, benefits and value added services.

Important Information

Customer Service – TEL. 1-800-314-3121

Proof of coverage, Student's certification, Immunizations benefit letters, Duplicate Cards, Confirm Copayments and Coinsurance, status of reimbursements, status of pre-authorizations for additional services or any health plan assistance

Eligibility– FAX 1-888-899-9730 EMAIL: feo_group@humana.com

New enrollments, changes or terminations

Pre-authorizations – FAX 1-800-658-9457 EMAIL: umfax@humana.com

Request of prior authorization for tests

Reimbursements EMAIL: prclaimsreimbursements@humana.com

Mental Health– APS – TEL. 1-877-621-0885


Services related to Mental Health, including claims and authorizations.

Humana®



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-314-3121. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.humana.com or call 1-800-314-3121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Not applicable	This plan does not have a deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles specific services services.
What is the out-of-pocket limit for this plan ?	Network providers : Single \$6,350/Family \$12,700	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.humana.com or call 1-800-314-3121.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 copay /visit	Covered by reimbursement at contracted fee, less copay	Virtual consultation, less \$ 0 copay, visit www.mdlive.com/humanapr .
	Specialist visit	\$12 copay /specialist visit \$15 copay /sub-specialist visit	Covered by reimbursement at contracted fee, less copay	Nutritionist – Maximum of 6 visits. Sub-specialist - \$12 copay /visit
	Preventive care/screening/ immunization	No charge	Covered by reimbursement at contracted fee, less copay	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance /test	Covered by reimbursement at contracted fee, less coinsurance	Preauthorization is required for genetic testing. \$0 copay applies for diagnostic testing and treatment of COVID-19, in accordance to Law 43 of 2020.
	Imaging (CT/PET scans, MRIs)	25% coinsurance /test	Covered by reimbursement at contracted fee, less coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.humana.com/druglist	Generic drugs (Tier 1)	\$5 copay / retail \$10 copay / retail	Covered by reimbursement at 70% of the contracted fee, less copay	Formulary: RX3 Traditional
	Preferred Brand drugs (Tier 2)	25% coinsurance min.\$10 retail 25% coinsurance min.\$20 mail order	Covered by reimbursement at 70% of the contracted fee, less coinsurance	Chemotherapy 10% coinsurance OTC Drugs \$1 copay ; prescription order required. Subject to Humana's OTC list.
	Non-preferred brand drugs (Tier 3)	35% coinsurance min.\$45 retail 35% coinsurance min.\$90 mail order	Covered by reimbursement at 70% of the contracted fee, less coinsurance	Maximum allowable benefits \$4,000; then 50% applies to all drugs. Retail - Covers up to a 30-day supply. Mail Order – Covers up to 90-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
	Specialty drugs	45% coinsurance retail	Covered by reimbursement at 70% of the contracted fee, less coinsurance	MAC A Mandatory generic
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$12 copay /office \$35 copay /facility	Covered by reimbursement at contracted fee, less copay	Preauthorization is required for facility use.
	Physician/surgeon fees	No charge	Covered by reimbursement at contracted fee	Surgical assistance is covered less 25% coinsurance ; preauthorization is required.
If you need immediate medical attention	Emergency room care	\$70 copay /illness \$0 copay /accident	\$70 copay /illness \$0 copay /accident	None
	Emergency medical transportation	\$50 copay / trip	\$50 copay / trip	Maritime and air aerial transportation (within the territorial limits of P.R.) is covered after preauthorization , unless is a life or death situation.
	Urgent care	\$70 copay /illness \$0 copay /accident	\$70 copay /illness \$0 copay /accident	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$70 copay /stay	Covered by reimbursement at contracted fee	Preauthorization is required for admissions. If emergency, prior authorization is not required. Provider may contact Humana within the next days following the emergency admission. Exclusions: Hospitalizations for procedures which can be performed on an ambulatory basis; Hospitalization for diagnostic purposes only; custodial, rest or convalescence services; Expenses for custodial services, private nurses, personal commodity services such as telephone, television, etc. and all medical services or expenses in convalescence facilities.
	Physician/surgeon fees	No charge	Covered by reimbursement	Surgical assistance is covered less 25%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
			at contracted fee	coinsurance ; preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$12 copay /visit	Covered by reimbursement at contracted fee, less copay	None.
	Inpatient services	\$70 copay /stay	Covered by reimbursement at contracted fee, less copay	Preauthorization is required. Partial hospitalization is covered without cost share. Preauthorization is required.
If you are pregnant	Office visits	\$12 copay /visit	Covered by reimbursement at contracted fee, less copay	Cost sharing does not apply to certain preventive services . Depending on the type of services, copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Epidural anesthesia is not covered.
	Childbirth/delivery professional services	No charge	Covered by reimbursement at contracted fee	
	Childbirth/delivery facility services	\$70 copay /stay	Covered by reimbursement at contracted fee, less copay	
If you need help recovering or have other special health needs	Home health care	No copay /stay*	Covered by reimbursement at contracted fee, less applicable cost-share for specific services provided.	Preauthorization is required. Covered initially 40 days and if needed, 20 additional days. *Home health services include services described elsewhere in the SBC (i.e. specialist visit, physical therapy). Refer to the other sections of the SBC for details in cost-share.
	Rehabilitation services	\$5 copay /physical therapy visit. \$12 copay /visit all other therapy visits.	Covered by reimbursement at contracted fee, less copay	Physical therapy, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, unlimited. Speech therapy, when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of 40 therapies. Occupational therapy for the purpose of training and aiding in the restoration of
	Habilitation services	\$5 copay /physical therapy visit. \$12 copay /visit all other therapy visits.	Covered by reimbursement at contracted fee, less copay	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
				normal physical function and or prevent further deterioration of the same; resulting from illness, trauma, stroke or a surgical procedure while insured under this policy, unlimited. For autism, all therapies are covered unlimited when medically necessary.
	Skilled nursing care	\$70 copay /stay	Covered by reimbursement at contracted fee, less copay	Preauthorization is required. Limited to 60 days.
	Durable medical equipment	25% coinsurance	Covered by reimbursement at contracted fee, less copay	Preauthorization is required.
	Hospice services	\$70 copay /stay	Covered by reimbursement at contracted fee, less copay	Preauthorization is required. It must provide a program of treatment for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than 6 months as a result of that illness. All services must be received within a 12 month period.
If your child needs dental or eye care	Children's eye exam	\$15 copay /visit	Covered by reimbursement at contracted fee, less copay	1 refraction per member per policy year for children and adults.
	Children's glasses	By reimbursement	By reimbursement	Maximum allowable benefits \$150 per member per policy year, by reimbursement.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic Surgery• Dental	<ul style="list-style-type: none">• Long Term Care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Private Duty Nursing• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Bariatric Surgery• Chiropractic Care – 1 initial visit/1 subsequent –\$12 copay; 20 manipulations at 100%	<ul style="list-style-type: none">• Hearing Aid – Maximum benefits \$250 per member, per policy year, by reimbursement	<ul style="list-style-type: none">• Routine eye care (Adult) – 1 eye exam per contract year• Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is Employee Benefits Security Administration of Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage. For more information about individual insurance coverage, visit the Office of the Commissioner of Insurance of Puerto Rico, , <http://ocs.pr.gov/ocspr/>.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact our customer service department at 1-800-314-3121.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-314-3121.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-314-3121.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-314-3121.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-314-3121.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$75
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$5,100
---------------------------	----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$600

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$75
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$4,900
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$1,000
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$170

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

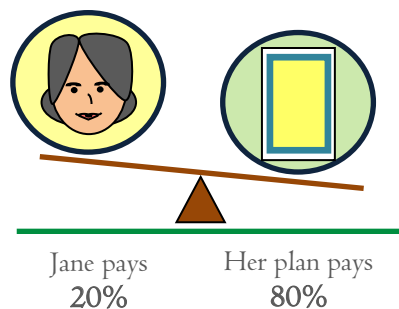
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

Cost Sharing

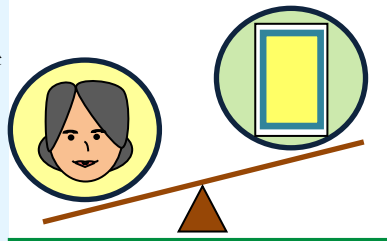
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100%
Her plan pays 0%
(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the [premium tax credit](#).

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

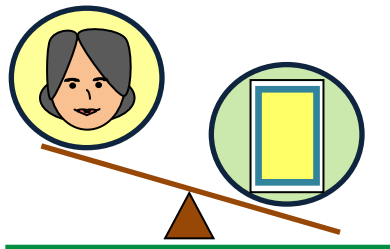
Out-of-network Provider (Non-Preferred Provider)

A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is *not* the same as “skilled care services,” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

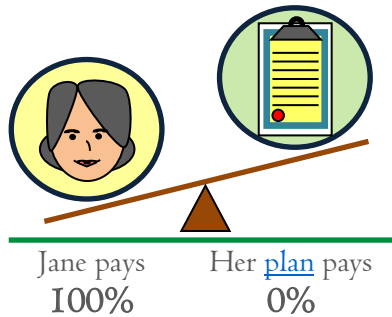
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



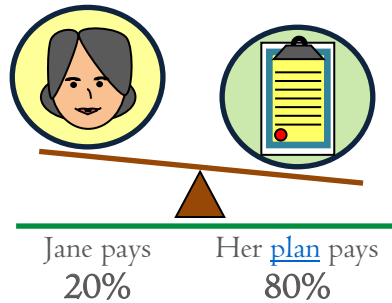
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



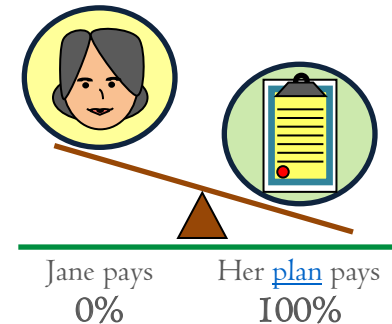
Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Humana Maximum 2000



New York Foundling PR	Humana Maximum 2000	Description of Benefits
-----------------------	---------------------	-------------------------

Deductibles		
Deductible Network Provider	Individual: \$0.00	Family: \$0.00
Deductible Out of Network Provider	Individual: \$0.00	Family: \$0.00
Maximum Out-Of-Pocket (MOOP)		
MOOP Network Provider	Individual: \$ 6,350	Familiar: \$12,700
MOOP Out of Network Provider	Individual: \$19,050	Familiar: \$38,100
Essential Benefits		
Ambulatory Services		
Generalists	Unlimited, less \$5 copayment	
Specialists	Unlimited, less \$12 copayment	
Sub-specialists	Unlimited, less \$15 copayment	
Chiropractic Services	One (1) initial visit, one (1) follow-up visit, less visit copayment and up to twenty (20) manipulations per member, per policy year.	
Nutritionist	Six (6) Nutritionist consultations per member per policy year, less \$12 copayment	
Laboratories and X-rays	Covered, less 25% coinsurance. Genetic tests require pre-certification, less 25%	
Electrocardiograms	Unlimited, less 25% coinsurance	
Computerized Tomography *	Unlimited, less 25% coinsurance Positron Emission Tomography (PET). Pre-authorization required	
Magnetic Resonance (including MRI and MRA)*	Unlimited, less 25% coinsurance	
Polysomnography	One (1) sleep study or polysomnography covered per member, per policy year, less 25% coinsurance	
Nuclear Medicine Tests	Unlimited, less 25% coinsurance	
Respiratory Therapy	Unlimited, less \$5 copayment	
Physical Therapy	Unlimited, as prescribed and under the supervision of an orthopedist or a physical medicine specialist, less \$5 copayment.	
Speech Therapy	Covered when ordered by a physician and rendered by a licensed speech therapist; up to a maximum of forty (40) therapies, per member per policy year, less \$12 copayment	
Occupational Therapy	Covered for the purpose of training and aiding in the restoration of normal physical function and or prevent further deterioration of the same; resulting illness, from trauma, stroke or a surgical procedure while member under this policy, unlimited, less \$12 copayment	
Ambulatory Surgery	Covered at ambulatory surgery facilities, less \$35 facility copayment	
Endoscopies	Diagnostic and therapeutic, less office copayment or less \$35 facility copayment	
Lithotripsy	Covered, unlimited, less \$35 ambulatory facility copayment per rendered service	
Vasectomy	Covered at physician's office, less \$12 copayment	

Humana Maximum 2000



Dialysis and hemodialysis	Acute and chronic services related to End Stage Renal Disease, such as dialysis, hemodialysis and complications directly related to the disease are covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed, less applicable copayment of ambulatory facility or hospital
Audiometry and tympanometry tests	When ordered by a physician, one (1) of each per member, per policy year, less 25% coinsurance
Allergy tests	Including allergenic and biological extracts, drugs, patches and provocative tests, up to a maximum of fifty (50) tests per member per policy year, less 25% coinsurance
Intra-articular injections	Unlimited, less \$12 office copayment
Diagnostic tests and treatments associated with hemophilia	Unlimited, less 25% coinsurance
Podiatrist	Treatment of diseases and disorders of the foot and ankle, including injections and surgical procedures, less visit copayment or facility copayment.
Eye refraction test	One (1) per member per policy year within the Humana Insurance network, less \$12 copayment
Ophthalmic Diagnostic Tests	Covered, less \$12
Mammography	when they are not presented as a preventive test required by ACA, but as a follow up to a diagnosis or treatment of a condition, less 25% coinsurance
Cervical Cryosurgery	Covered, less \$12 copayment
Naturopath visits	Unlimited visits according to Law 210 dated on December 14, 2007, less \$12 copayment
Nerve Conducting Velocity Test	Unlimited, less 25% coinsurance
Reduction Mammoplasty	When considered medically necessary, subject to Humana preauthorization, less \$35 facility copayment.
Hearing Aid	Maximum benefits \$250 per member per policy year, by reimbursement
Preventive Services	

Humana Maximum 2000



Annual preventive services are covered at **100%** (without copay) when provided within the Humana Provider Network and recommended by the *US Preventive Services Task Force (USPTF)*, the *Advisory Committee on Immunization Practices (ACIP)* of the *Centers for Disease Control and Prevention (CDC)*, and the *Health Resources and Services Administration*

Some of the covered preventive services include:

- a) Immunizations for infants, children, and adults in accord with accepted medical practice and as recommended by the Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and the American Academy of Pediatrics, as long as the individual is covered by this health insurance, including follow up (catch up).
 - Immunizations for Adults (21 years or older), including catch-ups – Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Tetanus/Diphtheria/Pertussis, Varicella
 - Immunizations for Children (less than 21 years old), including catch-ups – Haemophilus Influenzae Type b, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma Virus, Influenza (Flu Shot), Meningococcal, Measles/Mumps/Rubella, Pneumococcal, Rotavirus, Tetanus/Diphtheria/Pertussis, Varicella, , inactivated poliovirus
- b) Cervical cancer screening, Human papillomavirus (HPV) testing; and the HPV vaccine as required by the Food and Drug Administration (FDA) to achieve immunization.
- c) Breast cancer mammography screenings every one (1) to two (2) years for member over 40 years, biannual for member between fifty (50) and seventy-four (74) years. This includes guidance and advice regarding chemoprevention, and the chemoprevention of breast cancer in women when indicated.
- d) Pap Smear
- e) Prostatic Specific Antigen test (PSA) for men

For more information and updated about the recommended preventive services, visit:

<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>.

Preventive services covered at **100%** (without copay) during and immediately following pregnancy when provided within the Humana Provider Network and recommended by the US Preventive Services Task Force (USPTF) and the Health Resources and Services Administration. For this service, member has to call the Humana Beginnings program at 1-866-488-5992, for screening process. Humana recommends participating in the Humana Beginnings Program starting the first trimester of gestation.

- Support for breastfeeding with guidance and counseling and the necessary supplies, including the breast pump with prescription.

Screening for Human Immunodeficiency Virus (HIV) covered at **100%** (without co-payment or coinsurance), according to the recommendation of the Centers for Disease Control and Prevention (CDC) and in compliance to the Act No. 45 of May 16, 2016, as part of the routine testing of a medical evaluation at least once every five (5) years, based on the clinical criteria for adolescents and adults between the ages of thirteen (13) and Sixty-five (65) years of age at low risk. For people of high risk between the ages of thirteen (13) and sixty-five (65) is covered annually.

Hospitalization Services	
Benefits includes in per diem	Semi-private room or similar facility up to a maximum of 365 days; Specialized units for critical care services including: intensive care unit (ICU), intermediate care unit, coronary care unit (CCU), neonatal intensive care unit (NICU), and pediatric intensive care unit (PICU); Operating, recovery, and maternity rooms; Oxygen and its administration; Laboratory and radiology; Drugs prescribed by physician during hospital stay that are included in the per diem; Disposable supplies; Special and regular diets; Regular hospital nursing service, less \$70 admission copayment.
Hyper alimentation Services	Covered as part of the hospital admission copayment
Surgical Procedures	Covered as part of the hospital admission copayment
Sonogram	Covered as part of the hospital admission copayment
Magnetic Resonance, including MRI & MRA	Covered, as medically necessary, as part of the hospital admission copayment
Electrocardiogram	Covered, as medically necessary, as part of the hospital admission copayment
Blood and Plasma	Covered, as medically necessary, as part of the hospital admission copayment
Physical Therapy	Covered, maximum of twenty (20) therapy sessions per member, per hospital stay

Humana Maximum 2000



Dialysis and Hemodialysis	Covered up to a maximum of ninety (90) days starting on the date on which the disease is diagnosed.
Morbid Obesity	Treatment and services for morbid obesity as medically necessary. One (1) bariatric surgery per lifetime.
Chemotherapy and radiotherapy	Covered, as medically necessary, as part of the hospital admission copayment
Assistant surgeon	Covered, less 25% coinsurance. Pre-authorization is required.
Transplant or Graft	
Bone, skin and cornea transplant or graft services received by the member person will be covered, less \$70 copayment; pre-authorization is required.	
Home Health Services	
This benefit will be covered for forty (40) days initially, and an additional twenty (20) days, subject to medical necessity certification. No additional copayment applies. Copayment and/or coinsurance apply based on the service given.	
Nurse Care	Care by a nurse or under the supervision of a graduate nurse
Collection of Samples	Covered. For Lab test, less 25% coinsurance.
Care and maintenance of catheters	Covered, authorized by the provider and Humana, under the supervision of graduate nurse
Respiratory Therapy Care	Covered, less \$5 copayment
Administration of intravenous antibiotics	Covered, subject to Humana's Case Management program
Ulcer care	Covered through Humana's case management program
Physical therapies	Covered, unlimited, less \$5 copayment
Hyper alimentation services	Covered, less 25% coinsurance
Skilled Nursing Facility	
Skilled nursing facility covered up to a maximum of sixty (60) days per member per policy year, less \$70 admission copayment. These services will be covered if they begin within the fourteen (14) days following the release from the hospital due to a hospitalization of at least three (3) days, and if they are rendered because of the same condition or in relation to the condition leading to the hospitalization. Pre-authorization is required.	
Durable Medical Equipment and Prosthesis	
Durable Medical Equipment	The purchase or rental of medically necessary Durable Medical Equipment, less 25% coinsurance. Required pre-authorization. The cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than a member would pay to buy it, Humana will covered up to the amount of the purchased equipment. We do not pay for equipment or devices not specifically designed and intended for the treatment of an injury or sickness. Including glucometer and insulin pump mention, less 25% coinsurance. Require pre-authorization.
Prosthesis	Initial placement of a medically necessary prosthesis and its supportive device, except for those excluded. We will also cover the replacement of such prosthesis if it is determined by the member person's physician to be necessary because of growth or change, less 25% coinsurance. Required pre-authorization

Humana Maximum 2000



Ambulance Services	
Land transportation by an ambulance between facilities	Covered at 100% to a hospital or between health facilities, e.g. between a hospital and a radiology institute or between a skilled nursing facility and a hospital, and when ordered by a physician, including psychiatric emergencies.
Other land transportation by ambulance	Covered, unlimited, less \$50 copayment per trip. It includes land transportation to or from the member home.
Maritime and air transportation services by an ambulance	Covered within Puerto Rico, including Vieques and Culebra, less \$50 copayment per trip. Pre-authorization is required unless it is a life or death emergency.
Cancer Services and Treatments	
Chemotherapy and radiotherapy	Chemotherapy 10% coinsurance. Radiotherapy covered at 100% . Oral chemotherapy is covered through the pharmacy coverage.
Pain management injectable	Covered medically necessary oral and parenteral medication for pain management of patients suffering terminal cancer.
Stoma care and maintenance	Covered 100% as part of the office visit copayment or admission copayment
Maternity Services	
All female, including the wife or cohabitant and the dependent daughter of any employee covered by the insurance plan for families or couples, will have maternity benefit coverage.	
Hospitalization Services	Covered as part of the admission copayment: <ul style="list-style-type: none"> a. Delivery, including Cesarean Section. b. Delivery and recovery rooms. c. Nursery and incubator. d. Neonatal intensive care unit (NICU). e. Fetal monitoring during delivery. f. Postpartum sterilization before discharge.
Ambulatory services	<ul style="list-style-type: none"> a. Unlimited pre-natal and post-natal care, less \$12 copayment per visit. b. RhoGAM Vaccine, less 25% coinsurance. c. Genetic amniocentesis, less 25% coinsurance. d. Ambulatory sterilization. e. Spontaneous abortion. f. Ambulatory fetal monitoring, less 25% coinsurance. g. Biophysical profile covered for high-risk cases.
Pediatric Services	
Pediatrician	Unlimited visits, less \$12 copayment per visit
Well Child Care	Covered, less \$12 copayment per visit
Universal Neonatal Hearing Screening	Covered at 100%
Annual Exam	Covered, physical and mental evaluation, oral health, hearing and vision screening
Circumcision and Dilatation	Covered for newborns before discharge from the hospital , at ambulatory facility or physician office copayment
Immunizations	Covered at 100% according to established medical practices and as recommended by the American Academy of Pediatrics
Ventilators for Children	Coverage for technological equipment including eight (8) hours daily shift of a skilled nurse with knowledge in respiratory therapy or specialist in respiratory therapy.

Humana Maximum 2000



Care and treatment of congenital defects and anomalies	Covered when diagnosed by a doctor, without exclusion due to a preexisting condition. This covers newborns, recently adopted newborns or newborns recently placed for adoption. These services are subject to any copayment or coinsurance.
Synagis Immunization	Covered as per protocol approved by the Puerto Rico Department of Health.
Emergency Room Services	
Resulting from illness	Covered, less \$70 copayment
Resulting from accident	Covered at 100%
Urgent Care	
Resulting from illness	Covered, less \$70 copayment
Resulting from accident	Covered at 100%
Cardiovascular Procedures	
Diagnostic tests and treatment	Covered less 25% coinsurance
Physician Services	Covered, less \$12 copayment
Surgical Procedures	Covered, less \$35 facility copayment
Repair or replacement of heart valves, pacemaker and any other applicable device	Covered when medically necessary Pacemaker and defibrillator require pre-authorization.
Neurological Procedures	
Diagnostic tests and treatment	Covered less 25% coinsurance
Physician Services	Covered, less \$12 copayment
Surgical Procedures	Covered, less \$35 facility copayment
Repair or replacement of valves, and any other medically necessary device	Covered when medically necessary
Mental Health Services	
Professional Visits	Visits to professionals, psychiatrist, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer psychological health services, for adults, children and teens, less \$12 copayment.
Hospital Services	Covered, less \$70 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization
Psychiatric Emergency Transportation	Covered, less \$50 copayment
Group therapies	Covered, less \$12 copayment
Alcoholism & Substance Abuse Services	
Professional Visits	Visits to professionals, psychiatrist, psychology doctors and other providers who because of their education, training or experience, and the proper competency, are able to offer health services in substance abuse for adult, children and teens, less \$12 copayment.

Humana Maximum 2000



Therapies, Treatment and Follow-up	Covered at one or more service level
Residential Treatment	Covered, less \$12 copayment
Hospital Services	Covered, less \$70 admission copayment. Two (2) days of partial hospitalization are equivalent to one (1) day of regular hospitalization.
Autism	
Cover diagnostic and therapeutic services in persons diagnosed with disorders within the continuum of Autism. These services are subject to any applicable copayment or coinsurance. Services include but are not limited to: <ul style="list-style-type: none"> • Rehabilitation therapies (physical, speech and language, occupational) • Specialist office visits 	
Other Benefits	
Ambulatory Services	
SPECT Tests	Covered, less 25% coinsurance. Pre-authorization required.
Cardiovascular Rehabilitation Services	Rehabilitation program must include education and supervised exercises that lead to risk factor recognition and management and improved exercise capacity. Program must not exceed twelve (12) sessions in duration, less \$12 copayment. Pre-authorization required.
Orthopedic Devices	Covered, casts, splints, braces and crutches.
Laparoscopy	Covered at ambulatory facility or at hospital copayment per rendered service
Adult Circumcision	Covered, less office visit or facility copayment
Breast Biopsies	Covered, less facility or hospital copayment
Allergy Vaccines	Covered, up to a maximum of twenty (20) per member, policy year, less 25% coinsurance
Epidural Blocks	Covered for pain management administered by medically qualified and recognized specialist, one (1) per anatomical region per member per policy year, less applicable copayment.
Maxillofacial Surgery	Diagnostic and therapeutic services for accidental injuries, jaw fractures, neoplasms, injuries to natural teeth, including their replacement within a period of six months following an accident, provided the member was covered by this policy when the accident occurred, less applicable copayment. Pre-authorization required.
Reconstructive Surgery	For injuries due to an accident while the member is covered under this policy and is not covered under any other program (ACAA, FSE, etc.), less \$35 facility copayment.
Diagnostic tests and treatment associated with Hepatitis C	Covered, less 25% coinsurance
Diabetes paraphernalia	Lancets, syringes for insulin administration and glucometer strips up to a maximum of one hundred and fifty (150) of each one per month, less 25% coinsurance
Glucometer and insulin pump	Covered with no age limit, less 25% coinsurance. Pre-authorization required.
Nutritional Supplement free of phenylalanine	Covered at 100% the Nutritional Supplement free of phenylalanine, based on low phenylalanine protein hydrolysates for patients diagnosed with the genetic disorder Phenylketonuria (PKU), without age limits, and for other recommended diagnostic, prevention and treatment of people with innate metabolic errors.
Hospice	
Covered for a person who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than six (6) months as a result of that illness, less \$70 admission copayment. Pre-authorization required.	
Organ and Tissue Transplant	
Physician Benefits	Covered in centers of excellence contracted and coordinated by Humana. Pre-authorization required.
Hospitalization Services	Covered, less \$70 admission copayment.

Humana Maximum 2000



Emergency Services Outside Puerto Rico	
Emergency Services received in the United States	<p>Services received in contracted Humana or ChoiceCare facilities:</p> <ul style="list-style-type: none"> Covered, less \$70 emergency room copayment. If as part of the emergency the member needs to be admitted, then \$70 hospital admission copayment applies. <p>Services received outside of contracted Humana or ChoiceCare facilities:</p> <ul style="list-style-type: none"> Covered, less \$70 emergency room copayment. If as part of the emergency the member needs to be admitted, then \$70 hospital admission copayment applies.
Emergency Services received outside the United States or Puerto Rico	<p>The member will be reimbursed 100% of the contracted fee for similar services by a provider in Puerto Rico or, billed charges, whichever is less, less applicable copayment, as described in the policy. All claims for services rendered outside of Puerto Rico or the United States must be submitted to Humana with all supporting medical and financial records within a period of one (1) year from the date of service or date of discharge (whichever is later) to ensure reimbursement where applicable.</p>
Services not available in Puerto Rico but available in the United States of America	
<p>A) Humana will cover such services only if the following four conditions are met.</p> <ol style="list-style-type: none"> The Member must be eligible for coverage under the Plan and the services requested must be included under the Policy's schedule of benefits. The provider referring must demonstrate that the equipment, treatment or facilities required to provide medically necessary covered services to the member are unavailable in Puerto Rico. A service will not be deemed unavailable in Puerto Rico if the request for services to be provided outside of Puerto Rico involves a modification to the equipment, technique, or surgical approach available in Puerto Rico or is based on the reputation or recognition of any given provider. The service must be coordinated and pre-authorized with Humana in Puerto Rico at least five (5) working days prior to the date the service will be rendered. The service must be provided by Humana or ChoiceCare network providers/facilities. <p>All services covered under this Section are subject to the applicable copayments, coinsurances and deductibles.</p> <p>B) If the service or treatment is not authorized by and coordinated with Humana in Puerto Rico, the member will be responsible for the entire payment for such service or treatment. Humana will reimburse the patient based on the applicable Humana fee in Puerto Rico, less applicable copayments, coinsurances or deductibles, only if conditions A1, A2 are met. To receive reimbursement, the member must provide Humana with all supporting medical and financial information within one (1) year) days of service or discharge.</p>	
Ambulatory Services for Dependent Studying in the United States of America	
<p>Dependent studying in the United States of America, as included in the definition of direct dependent, can receive coverage for covered services provided by contracted providers in the United States. To receive coverage the following conditions must be met:</p> <ul style="list-style-type: none"> The dependent studying in the United States of America must be eligible for coverage under the Plan and the ambulatory services received in the United States must be covered services under the Humana PPO Policy. The member must coordinate and obtain prior authorization from Humana P.R. for the services unless the services meet criteria for urgent or emergency treatment as set forth in the Policy. Services provided by a provider in the Humana or ChoiceCare provider network shall be paid according to the benefits under the Policy. Any copays, coinsurance and/or deductibles set forth in the policy applicable to the benefits shall apply. If the service is rendered by a provider not participating in the Humana or ChoiceCare network, the service will be reimbursed based on contracted fees for similar services in Puerto Rico, less applicable copayments, coinsurances and deductibles. The member is responsible for the difference between the Humana contracted rate in Puerto Rico and the facility billed charges. 	

Humana Maximum 2000



Additional Benefits

Pharmacy Coverage

Rx3 Traditional	<p>Generic drugs (Level 1) - \$5 copayment retail / \$10 copayment mail order</p> <p>Preferred brand drugs (Level 2) - 25% coinsurance min. \$10 retail / 25% coinsurance min. \$20 mail order</p> <p>Non preferred brand drugs (Level 3) - 35% coinsurance min. \$40 retail / 35% coinsurance min. \$90 mail order</p> <p>Specialty drugs - 45% coinsurance retail</p> <p>Chemotherapy – 10% coinsurance</p> <p>OTC drugs - \$1 Covered certain medications. Prescription order required. Review the list of covered OTC drugs.</p> <p>Maximum allowable benefits \$4,000; then 50% applies to all drugs.</p> <p>*30-day supply retail and 90-day supply for mail-order. Specialized drugs apply 30-day supply even if requested by mail-order.</p>
------------------------	--

Vision

Maximum benefits \$150 per member per policy year, by reimbursement

Telemedicine

Virtual consultations, including video, with a primary care physician, unlimited, less \$0 copay. Available through www.mdlive.com/humanapr.

Take advantage of all that's available for your health

Humana wants to make sure your care grows with you as you change, and that you get access to all you need. Did you know that many services, medicines, and screenings are available to you, and at no extra cost out of your pocket, when they are treated as preventive? See throughout for all that's available to you.

Adult preventive services

Preventive office visits are covered, as well as the screenings, immunizations and counseling listed below.

Screenings

Abdominal aortic aneurysm	One-time screening for men of specified ages who have ever smoked*
Alcohol use	Screening for all adults
Blood pressure	Screening for high blood pressure for all adults
Cholesterol	Screening for adults certain ages or at higher risk*
Colorectal cancer	Screening for adults aged 45–75
Depression/suicide risk	Screening for all adults
Diabetes/prediabetes	Screening for adults aged 35–70 at higher risk*
Drug use	Screening questions for all adults
Hepatitis B	Screening for adults at higher risk*
Hepatitis C	Screening for adults aged 18–79
HIV	Screening for adults at higher risk*
Lung cancer	Annual screening for adults aged 50–80 who smoke or have quit within the past 15 years*
Obesity	Screening for all adults
Syphilis	Screening for adults at higher risk*
Tobacco use	Screening for all adults
Tuberculosis	Screening for latent infection for adults at higher risk*

Note: You may need to pay all or part of the costs when services are completed to diagnose, monitor or treat an illness, pregnancy or injury, rather than prevent an illness, pregnancy or injury.



Adult preventive services continued

Preventive office visits are covered, as well as the screenings, immunizations and counseling listed below.

Medications and supplements (covered with a doctor's prescription)

Colonoscopy preparation	Bowel preparation medications for adults aged 45–75
Tobacco smoking cessation	FDA-approved smoking cessation medications for members 18 years and older
Statin	Low- to moderate-dose statin use for adults aged 45–75 at higher risk*
HIV prevention	PrEP pre-exposure prophylaxis with effective antiretroviral therapy to persons at high risk of HIV infection*

Counseling

Alcohol use reduction	Behavioral counseling interventions to reduce unhealthy alcohol use
Obesity	Referral to intensive, multicomponent behavioral interventions for persons with a body mass index (BMI) of 30 kg/m or higher; counseling to prevent obesity
Sexually transmitted infections (STI)	Prevention counseling for adults at higher risk*
Tobacco smoking cessation	Cessation interventions for tobacco users

Other

Falls prevention	Exercise interventions for adults aged 65 or older at increased risk for falls
Skin cancer prevention	Counseling for adults through age 24 to minimize their exposure to ultraviolet radiation



DID YOU KNOW?

Preventive care can help catch potential health issues early—when they're easier to treat.



Immunizations

(vaccines for adults—doses, recommended ages and recommended populations vary)†

COVID-19

Hepatitis A

Hepatitis B

Human papillomavirus (HPV)

Influenza

Measles, mumps, rubella (MMR)

Meningococcal

Pneumococcal

Tetanus, diphtheria, pertussis (Tdap)

Varicella (chickenpox)

Zoster (shingles/herpes zoster)

Women preventive services (includes pregnant women)

Preventive office visits are covered, as well as the screenings and counseling listed below.

Counseling

Genetic counseling for women who have tested positive for BRCA

Breast cancer chemoprevention
Counseling for women at increased risk for breast cancer*

Domestic and interpersonal violence
Screening and counseling for intervention services

Healthy weight and weight gain
Behavioral counseling interventions to promote healthy weight in pregnancy

Perinatal depression
Counseling interventions for pregnant and postpartum women at increased risk*

Sexually transmitted infections (STIs)
Behavioral counseling to reduce the risk of STIs

Tobacco smoking cessation
Behavioral interventions and expanded counseling for pregnant tobacco users

Other services

Breastfeeding[‡]
Lactation support, education, counseling and equipment for pregnant and nursing women

Contraceptive methods and counseling[‡]

Screenings

Anemia Screening on a routine basis for pregnant women

Bacteriuria Urinary tract or other infection screening for pregnant women

BRCA Screening for women at higher risk*

Breast cancer mammography Screening every one to two years for women aged 40 or over

Cervical cancer Screening for women with a cervix, regardless of sexual history, at specified ages and intervals**

Chlamydia infection Screening for younger women and other women at higher risk*

Depression/suicide risk Screening for pregnant and postpartum women

Gestational diabetes Screening for women after 24 weeks of gestation

Gonorrhea Screening for all women at higher risk*

Hepatitis B Screening for all pregnant women

HIV Screening for all pregnant women

HPV-DNA test High risk testing every three years for women with normal cytology results who are aged 30 or older*

Osteoporosis (bone density) Screening for women aged 65 and over and women at higher risk*

Preeclampsia Screening for all pregnant women

Rh(D) incompatibility Blood typing/antibody testing for all pregnant women at the first prenatal visit and at 24–28 weeks' gestation

Syphilis Screening for all pregnant women

Medications and supplements (covered with a doctor's prescription)

Aspirin to prevent preeclampsia Low-dose aspirin after 12 weeks of gestation in women at high risk*

Breast cancer preventive medications For women at increased risk for breast cancer*

Contraception FDA-approved contraceptives or sterilization for women with reproductive capacity to prevent pregnancy

Prenatal vitamins/folic acid For women who are pregnant, may become pregnant or are capable of pregnancy

Child preventive services

Preventive office visits are covered, as well as the screenings, immunizations, counseling and supplements listed below.

Immunizations

(vaccines for children from birth to age 18—doses, ages and populations vary)[†]

COVID-19

Diphtheria, tetanus, and pertussis (DTaP/Tdap)

Haemophilus influenzae B (HiB)

Hepatitis A (Hep A)

Hepatitis B (Hep B)

Human papillomavirus (HPV)

Inactivated poliovirus (IPV)

Influenza (flu shot)

Measles, mumps, rubella (MMR)

Meningococcal

Pneumococcal conjugate

Rotavirus

Varicella (chickenpox)

Counseling

Obesity

Comprehensive, intensive behavioral interventions to promote improvements in weight status

Sexually transmitted infections (STIs)

Prevention counseling for adolescents at higher risk*

Skin cancer

Brief counseling for children and adolescents to minimize their exposure to ultraviolet radiation

Tobacco smoking cessation

Education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents

Screenings

Alcohol and drug use	Assessments for adolescents
Autism	Screening for children at 18–24 months
Behavioral	Assessments for children of all ages
Depression/suicide risk	Screening for adolescents aged 12–18
Developmental	Screening for children under age 3, and surveillance throughout childhood
Dyslipidemia	Screening for children at higher risk of lipid disorders*
Height, weight and body mass index	Measurements for children of all ages
Hearing/Vision	Screening for all children 3 years or older*
Hemoglobinopathies	Screening for sickle cell disease in newborns
Hepatitis B	Screening for adolescents at higher risk*
Hypothyroidism	Screening for newborns
HIV	Screening for adolescents at higher risk*
Lead	Screening for children at risk for exposure
Medical history	For all children throughout development
Obesity	Screening for children aged 6 or older
Oral health	Risk assessment for young children
Phenylketonuria (PKU)	Screening for newborns
Sexually transmitted infection (STI)	Screening for adolescents at higher risk*
Sudden cardiac arrest/death	Screening for adolescents ages 11–21 years old
Tuberculin	Testing for children at higher risk of tuberculosis*
Medications and supplements (covered with a doctor's prescription)	
Fluoride supplement	Oral supplements for children if primary water source is deficient in fluoride
Fluoride varnish	Application by a primary care clinician to primary teeth starting at tooth eruption through age 5
Gonorrhea	Preventive medicine for the eyes of all newborns
HIV pre-exposure prophylaxis (PrEP)	PrEP pre-exposure prophylaxis with effective antiretroviral therapy to persons at high risk of HIV acquisition*
Iron	Supplements for children ages 6–12 months at risk for anemia

Refer to your Certificate of Coverage for details about all the covered services and benefit levels.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write Humana, or your Humana insurance agent or broker. In the event of any disagreement between this communication and the plan document, the plan document will control.

Sources

* For more information on the definition of higher or increased risk and age recommendations, please see the US Preventive Guidelines at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/>.

† For more information on immunization recommendations, resources and schedules, please refer to the Centers for Disease Control and Prevention at www.cdc.gov/vaccines/schedules/index.html.

‡ On Aug. 1, 2011, the U.S. Department of Health and Human Services released new guidelines regarding coverage of preventive health services for women. The new guidelines state that non-grandfathered insurance plans with plan years beginning on or after Aug. 1, 2012, must include these services without cost sharing.

** Women 21–64: every three years with cervical cytology (Pap test) alone; OR women 30–65: every five years with hrHPV testing alone or cotesting. We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan. For complete details, refer to your plan's Certificate of Coverage.

\$0 preventive medication coverage



Humana makes it easier than ever to get the pharmacy preventive services you need to maintain your overall health. Our plans provide a range of preventive medications at no cost to members.*

The medications listed below will be covered **100%** when they're prescribed for preventive care purposes. This means no copayments, coinsurance or deductibles when prescriptions are filled by pharmacies in your plan's pharmacy network. You can locate pharmacies in your network by going to [Humana.com/PharmacyLocator](https://www.humana.com/PharmacyLocator).

Remember, preventive care keeps you healthy and may prevent illness.

Covered preventive medication (with a doctor's prescription)	Who's eligible
Aspirin	Adults 45–79 to prevent cardiovascular disease; pregnant women to prevent preeclampsia
Atorvastatin, lovastatin and simvastatin	Adults 40 and older to prevent cardiovascular disease
Colonoscopy bowel preparation medications	Adults 50–75 for preventive screening colonoscopy
Contraceptives	Adolescents and adult women with reproductive capacity
Fluoride	Children 6 months to 6 years whose primary water source is deficient in fluoride
Folic acid	Adolescents or women who plan to become pregnant or may become pregnant
Prevention of Human Immunodeficiency Virus (HIV) Infection: Pre-Exposure Prophylaxis [HIV PrEP]	Persons at risk of contracting HIV
Preventive vaccines	Children and adults as recommended by the Advisory Committee on Immunization Practices (ACIP)
Smoking-cessation medications	Adults 18 and older
Tamoxifen and raloxifene	Women who are at increased risk for breast cancer and at low risk for adverse medication effects

* Coverage is dependent upon the plan. Terms of the policy control.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write Humana, or your Humana insurance agent or broker. In the event of any disagreement between this communication and the plan document, the plan document will control.

Coverage is for certain dosage amounts of over-the-counter (OTC) products so check Humana's \$0 Preventive Drug List for specific information, which can be located at [Humana.com/DrugList](https://www.humana.com/DrugList). To understand more about your plan's prescription drug benefit, go to [Humana.com](https://www.humana.com) and sign in to MyHumana or go to the MyHumana Mobile app. You can also call a Customer Care specialist using the phone number on the back of your Humana member ID card.

\$0 Preventive Medication Coverage

Effective January 1, 2023

Humana is committed to meeting your unique healthcare needs. Listed below are preventive medicines available to you at no cost.* The medicines listed below were selected based upon the guidance issued by the United States Preventive Services Task Force (USPSTF) and the Patient Protection and Affordable Care Act (ACA) requirements.

This list may not apply to all healthcare plans and may change over time subject to new preventive care recommendations or federal guidance. To understand your plan's prescription drug benefit, sign in to **Humana.com**. You can also call a Humana Customer Service representative at the phone number on the back of your Humana member ID card. Some restrictions may apply.

The second column of the chart lists drug names in alphabetical order. Brand medicines are listed in UPPER CASE and generic medicines are listed in lower case.

*You must have a prescription from your doctor for us to process a claim for preventive medicines or products under your pharmacy plan. This includes over-the-counter items. Other contraceptive drugs may be available to you at no cost if medically necessary. To ask for a medical necessity review for a contraceptive drug, your health care provider can contact HCPR (Humana Clinical Pharmacy Review) at **800-555-2546 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. For a member in Puerto Rico, your healthcare provider can contact HCPR in Puerto Rico at **866-488-5991** between 8am – 8pm, Monday – Friday.

Category	Drug Name	Utilization Management Requirements
Aspirin	adult aspirin regimen 81 mg tablet,delayed release - MM	
	adult low dose aspirin 81 mg tablet,delayed release - MM	
	aspirin 81 mg chewable tablet - MM	
	aspirin childrens 81 mg chewable tablet - MM	
	aspirin ec 81 mg tablet - MM	
	BAYER CHEWABLE LOW DOSE ASPIRIN 81 MG TABLET - MM	
	bayer low dose aspirin 81 mg tablet,delayed release - MM	
	children's aspirin 81 mg chewable tablet - MM	
	ecotrin low strength 81 mg tablet,enteric coated - MM	
	st joseph aspirin 81 mg chewable tablet - MM	
	st. joseph aspirin 81 mg tablet,delayed release - MM	
	VAZALORE 81 MG CAPSULE - MM	
	Bowel Prep	CLENPIQ 10 MG-3.5 GRAM-12 GRAM/160 ML ORAL SOLUTION
CLENPIQ 10 MG-3.5 GRAM-12 GRAM/175 ML ORAL SOLUTION		
constulose 10 gram/15 ml oral solution - MM		
gavilyte-c 240 gram-22.72 gram-6.72 gram-5.84 gram oral solution		
gavilyte-g 236 gram-22.74 gram-6.74 gram-5.86 gram oral solution		
gavilyte-n solution		
lactulose 10 gm/15 ml solution - MM		
lactulose 20 gm/30 ml solution - MM		

Category	Drug Name	Utilization Management Requirements
	peg 3350-electrolyte solution	
	peg-3350 and electrolytes soln	
	peg-prep kit	
	trilyte with flavor packets	
Breast Cancer RR	anastrozole 1 mg tablet - MM	QL May Apply
	raloxifene hcl 60 mg tablet - MM	QL May Apply
	tamoxifen 10 mg tablet - MM	
	tamoxifen 20 mg tablet - MM	
Contraceptives	afirmelle 0.1 mg-20 mcg tablet - MM	
	after pill 1.5 mg tablet	
	altavera (28) 0.15 mg-0.03 mg tablet - MM	
	alyacen 1/35 (28) 1 mg-35 mcg tablet - MM	
	alyacen 7/7/7 (28) 0.5 mg/0.75 mg/1 mg-35 mcg tablet - MM	
	amethyst (28) 90 mcg-20 mcg tablet - MM	
	apri 0.15 mg-0.03 mg tablet - MM	
	aranelle (28) 0.5 mg/1 mg/0.5 mg-35 mcg tablet - MM	
	ashlyna 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack - MM	QL May Apply
	aubra 0.1 mg-20 mcg tablet - MM	
	aubra eq 0.1 mg-20 mcg tablet - MM	
	aurovela 1.5/30 (21) 1.5 mg-30 mcg tablet - MM	
	aurovela 1/20 (21) 1 mg-20 mcg tablet - MM	
	aurovela 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet - MM	
	aurovela fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet - MM	
	aurovela fe 1-20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	aviane 0.1 mg-20 mcg tablet - MM	
	ayuna 0.15 mg-0.03 mg tablet - MM	
	azurette (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet - MM	
	balziva (28) 0.4 mg-35 mcg tablet - MM	
	blisovi 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet - MM	
	blisovi fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet - MM	
	blisovi fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	briellyn 0.4 mg-35 mcg tablet - MM	
	camila 0.35 mg tablet - MM	
	caziant (28) 0.1 mg/0.125 mg/0.15 mg-25 mcg tablet - MM	
	chateal (28) 0.15 mg-0.03 mg tablet - MM	
	chateal eq (28) 0.15 mg-0.03 mg tablet - MM	
	cryselle (28) 0.3 mg-30 mcg tablet - MM	
	cyclafem 1-35-28 tablet - MM	
	cyclafem 7-7-7-28 tablet - MM	
	cyred 0.15 mg-0.03 mg tablet - MM	
	cyred eq 0.15 mg-0.03 mg tablet - MM	
	dasetta 1/35 (28) 1 mg-35 mcg tablet - MM	

Category	Drug Name	Utilization Management Requirements
	dasetta 7/7/7 (28) 0.5 mg(7)/0.75 mg(7)/1 mg(7)-35 mcg tablet - MM	
	deblitane 0.35 mg tablet - MM	
	desogestrel-ee 0.15-0.03 mg tb - MM	
	desogestr-eth estrad eth estra - MM	
	dolishale 90 mcg-20 mcg (28) tablet - MM	
	drospirenone-ee 3-0.02 mg tab - MM	
	drospirenone-ee 3-0.03 mg tab - MM	
	econtra ez 1.5 mg tablet	
	econtra one-step 1.5 mg tablet	
	elonest 0.3 mg-30 mcg tablet - MM	
	ELLA 30 MG TABLET	QL May Apply
	eluryng 0.12 mg-0.015 mg/24 hr vaginal ring - MM	QL May Apply
	emoquette 28 day tablet - MM	
	enpresse 50-30 (6)/75-40(5)/125-30(10) tablet - MM	
	enskyce 0.15 mg-0.03 mg tablet - MM	
	errin 0.35 mg tablet - MM	
	estarylla 0.25 mg-35 mcg tablet - MM	
	ethynodiol-eth estra 1mg-35mcg - MM	
	ethynodiol-eth estra 1mg-50mcg - MM	
	etonogestrel-ee vaginal ring - MM	QL May Apply
	falmina (28) 0.1 mg-20 mcg tablet - MM	
	FC2 FEMALE CONDOM	
	FEMCAP 22 MM VAGINAL DEVICE	
	FEMCAP 26 MM VAGINAL DEVICE	
	FEMCAP 30 MM VAGINAL DEVICE	
	femynor 28 tablet - MM	
	finzala 1 mg-20 mcg (24)/75 mg (4) chewable tablet - MM	
	hailey 1.5 mg-30 mcg tablet - MM	
	hailey 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet - MM	
	hailey fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet - MM	
	hailey fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	heather 0.35 mg tablet - MM	
	her style 1.5 mg tablet	
	iclevia 0.15 mg-30 mcg (91) tablets,3 month dose pack - MM	QL May Apply
	incassia 0.35 mg tablet - MM	
	isibloom 0.15 mg-0.03 mg tablet - MM	
	jaimiess 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack - MM	QL May Apply
	jencycla 0.35 mg tablet - MM	
	jolessa 0.15 mg-30 mcg (91) tablets,3 month dose pack - MM	QL May Apply
	juleber 0.15 mg-0.03 mg tablet - MM	
	junel 1.5/30 (21) 1.5 mg-30 mcg tablet - MM	
	junel 1/20 (21) 1 mg-20 mcg tablet - MM	

Category	Drug Name	Utilization Management Requirements
	junel fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet - MM	
	junel fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	junel fe 24 1 mg-20 mcg (24)/75 mg (4) tablet - MM	
	kalliga 0.15 mg-0.03 mg tablet - MM	
	kariva (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet - MM	
	kelnor 1/35 (28) 1 mg-35 mcg tablet - MM	
	kelnor 1-50 (28) 1 mg-50 mcg tablet - MM	
	kurvelo (28) 0.15 mg-0.03 mg tablet - MM	
	KYLEENA 17.5 MCG/24 HRS (5YRS) 19.5MG INTRAUTERINE DEVICE - MM	
	larin 1.5/30 (21) 1.5 mg-30 mcg tablet - MM	
	larin 1/20 (21) 1 mg-20 mcg tablet - MM	
	larin 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet - MM	
	larin fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet - MM	
	larin fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	larissia-28 tablet - MM	
	lessina 0.1 mg-20 mcg tablet - MM	
	levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet - MM	
	levono-e estrad 0.15-0.03-0.01 - MM	QL May Apply
	levonor-e estrad 0.1-0.02-0.01 - MM	QL May Apply
	levonor-eth estrad 0.09-0.02 mg - MM	
	levonor-eth estrad 0.1-0.02 mg - MM	
	levonor-eth estrad 0.15-0.03 - MM	QL May Apply
	levonor-eth estrad triphasic - MM	
	levonorgestrel 1.5 mg tablet	
	levora-28 0.15 mg-0.03 mg tablet - MM	
	LILETTA 20.4 MCG/24 HRS (8 YRS) 52 MG INTRAUTERINE DEVICE - MM	
	lillow-28 tablet - MM	
	lojaimiess 0.1 mg-20 mcg (84)/10 mcg (7) tablets,3 month dose pack - MM	QL May Apply
	loryna (28) 3 mg-0.02 mg tablet - MM	
	low-ogestrel (28) 0.3 mg-30 mcg tablet - MM	
	lo-zumandimine (28) 3 mg-0.02 mg tablet - MM	
	lutura (28) 0.1 mg-20 mcg tablet - MM	
	lyleq 0.35 mg tablet - MM	
	lyza 0.35 mg tablet - MM	
	marlissa (28) 0.15 mg-0.03 mg tablet - MM	
	medroxyprogesterone 150 mg/ml - MM	QL May Apply
	microgestin 1.5/30 (21) 1.5 mg-30 mcg tablet - MM	
	microgestin 1/20 (21) 1 mg-20 mcg tablet - MM	
	microgestin 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet - MM	
	microgestin fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet - MM	

Category	Drug Name	Utilization Management Requirements
	microgestin fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	mili 0.25 mg-35 mcg tablet - MM	
	MIRENA 21 MCG/24 HOURS (8 YRS) 52 MG INTRAUTERINE DEVICE - MM	
	mono-linyah 0.25 mg-35 mcg tablet - MM	
	my choice 1.5 mg tablet	
	my way 1.5 mg tablet	
	necon 0.5/35 (28) 0.5 mg-35 mcg tablet - MM	
	new day 1.5 mg tablet	
	NEXPLANON 68 MG SUBDERMAL IMPLANT	
	nikki (28) 3 mg-0.02 mg tablet - MM	
	nora-be 0.35 mg tablet - MM	
	noret-estr-fe 0.4-0.035(21)-75 - MM	
	noreth-ee-fe 1 mg/20-30-35 mcg - MM	
	noreth-ee-fe 1.5-0.03mg(21)-75 - MM	
	noreth-ee-fe 1-0.02(21)-75 tab - MM	
	norethind-eth estrad 1-0.02 mg - MM	
	norethindrone 0.35 mg tablet - MM	
	norethin-ee 1.5-0.03 mg(21) tb - MM	
	norg-ee 0.18-0.215-0.25/0.025 - MM	
	norg-ee 0.18-0.215-0.25/0.035 - MM	
	norgestimate-ee 0.25-0.035 mg - MM	
	norg-ethin estra 0.25-0.035 mg - MM	
	norlyda 0.35 mg tablet - MM	
	nortrel 0.5/35 (28) 0.5 mg-35 mcg tablet - MM	
	nortrel 1/35 (21) 1 mg-35 mcg tablet - MM	
	nortrel 1/35 (28) 1 mg-35 mcg tablet - MM	
	nortrel 7/7/7 (28) 0.5 mg/0.75 mg/1 mg-35 mcg tablet - MM	
	nylia 1/35 (28) 1 mg-35 mcg tablet - MM	
	nylia 7/7/7 (28) 0.5/0.75/1 mg-35 mcg tablet - MM	
	nymyo 0.25 mg-35 mcg tablet - MM	
	ocella 3 mg-0.03 mg tablet - MM	
	OMNIFLEX DIAPHRAGM 65 MM VAGINAL	
	opcicon one-step 1.5 mg tablet	
	option-2 1.5 mg tablet	
	orsythia-28 tablet - MM	
	PARAGARD T 380A 380 SQUARE MM INTRAUTERINE DEVICE - MM	
	philith 0.4 mg-35 mcg tablet - MM	
	pimtrea (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet - MM	
	pirmella 0.5/0.75/1 mg-35 mcg tablet - MM	
	pirmella 1 mg-35 mcg tablet - MM	
	portia 28 0.15 mg-0.03 mg tablet - MM	
	previfem tablet - MM	

Category	Drug Name	Utilization Management Requirements
	reclipsen (28) 0.15 mg-0.03 mg tablet - MM	
	setlakin 0.15 mg-30 mcg (91) tablets,3 month dose pack - MM	QL May Apply
	sharobel 0.35 mg tablet - MM	
	simliya (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet - MM	
	simpesse 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack - MM	QL May Apply
	SKYLA 14 MCG/24 HRS (3 YRS) 13.5 MG INTRAUTERINE DEVICE - MM	
	sprintec (28) 0.25 mg-35 mcg tablet - MM	
	sronyx 0.1 mg-20 mcg tablet - MM	
	syeda 3 mg-0.03 mg tablet - MM	
	tarina 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet - MM	
	tarina fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	tarina fe 1-20 eq (28) 1 mg-20 mcg (21)/75 mg (7) tablet - MM	
	taysofy 1 mg-20 mcg (24)/75 mg (4) capsule - MM	
	TODAY CONTRACEPTIVE SPONGE 1,000 MG VAGINAL CONTRACEPTIVE SPONGE	
	tri femynor 28 tablet - MM	
	tri-estarylla (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet - MM	
	tri-legest fe 1-20 (5)/1-30(7)/1mg-35mcg(9) tablet - MM	
	tri-linyah (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet - MM	
	tri-lo-estarylla 0.18 mg/0.215 mg/0.25 mg-25 mcg tablet - MM	
	tri-lo-marzia 0.18 mg/0.215 mg/0.25 mg-25 mcg tablet - MM	
	tri-lo-mili 0.18/0.215/0.25 mg-25 mcg tablet - MM	
	tri-lo-sprintec 0.18 mg/0.215 mg/0.25 mg-25 mcg tablet - MM	
	tri-mili (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet - MM	
	tri-nymyo 0.18/0.215/0.25 mg-35 mcg(28) tablet - MM	
	tri-previfem tablet - MM	
	tri-sprintec (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet - MM	
	trivora (28) 50-30 (6)/75-40(5)/125-30(10) tablet - MM	
	tri-vylibra (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet - MM	
	tri-vylibra lo 0.18/0.215/0.25 mg-25 mcg tablet - MM	
	tulana 0.35 mg tablet - MM	
	TYBLUME 0.1 MG-20 MCG CHEWABLE TABLET - MM	
	vcf contraceptive 4 % vaginal gel	
	velivet triphasic regimen (28) 0.1 mg/0.125 mg/0.15 mg-25 mcg tablet - MM	
	vienna 0.1 mg-20 mcg tablet - MM	

Category	Drug Name	Utilization Management Requirements
	viorele (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet - MM	
	volnea (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet - MM	
	vyfemla (28) 0.4 mg-35 mcg tablet - MM	
	vylibra 0.25 mg-35 mcg tablet - MM	
	wera (28) 0.5 mg-35 mcg tablet - MM	
	WIDE-SEAL DIAPHRAGM 60 MM VAGINAL	
	WIDE-SEAL DIAPHRAGM 65 MM VAGINAL	
	WIDE-SEAL DIAPHRAGM 70 MM VAGINAL	
	WIDE-SEAL DIAPHRAGM 75 MM VAGINAL	
	WIDE-SEAL DIAPHRAGM 80 MM VAGINAL	
	WIDE-SEAL DIAPHRAGM 85 MM VAGINAL	
	WIDE-SEAL DIAPHRAGM 90 MM VAGINAL	
	WIDE-SEAL DIAPHRAGM 95 MM VAGINAL	
	xulane 150 mcg-35 mcg/24 hr transdermal patch - MM	QL May Apply
	zafemy 150 mcg-35 mcg/24 hr transdermal patch - MM	QL May Apply
	zarah 3 mg-0.03 mg tablet - MM	
	zovia 1-35 (28) 1 mg-35 mcg tablet - MM	
	zovia 1-35e tablet - MM	
	zumandimine (28) 3 mg-0.03 mg tablet - MM	
Flu Pneu Vaccines	AFLURIA QUAD 2022-2023(6MO UP) 60 MCG (15 MCG X 4)/0.5 ML IM SUSP	
	AFLURIA QUAD 2022-23(3YR UP)(PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	
	COMIRNATY TRIS VACCINE(PF) 30 MCG/0.3 ML INTRAMUSCULAR SUSPENSION	
	FLUAD QUAD 2022-2023(65YR UP)(PF) 60 MCG (15 MCG X 4)/0.5ML IM SYRINGE	
	FLUARIX QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	
	FLUBLOK QUAD 2022-2023 (PF) 180 MCG (45 MCG X 4)/0.5 ML IM SYRINGE	
	FLUCELVAX QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	
	FLUCELVAX QUAD 2022-2023 60 MCG (15 MCG X 4)/0.5 ML IM SUSPENSION	
	FLULAVAL QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	
	FLUMIST QUAD 2022-2023 10EXP6.5-7.5 FF UNIT/0.2 ML NASAL SPRAY SYRINGE	
	FLUZONE HIGH-DOSE QUAD 2022-2023 (PF) 240 MCG/0.7 ML IM SYRINGE	
	FLUZONE QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SUSPENSION	
	FLUZONE QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	

Category	Drug Name	Utilization Management Requirements
	FLUZONE QUAD 2022-2023 60 MCG (15 MCG X 4)/0.5 ML INTRAMUSCULAR SUSP.	
	JANSSEN COVID-19 VACCINE (PF) 0.5 ML INTRAMUSCULAR SUSPENSION (EUA)	
	MODERNA COVID (12Y UP)VAC(EUA)	
	MODERNA COVID(6M-5Y) VACC(EUA)	
	MODERNA COVID-19 BIVALENT BOOST(6MO-5Y)(PF) 10 MCG/0.2 ML IM SUSP(EUA)	
	MODERNA COVID-19 BIVALENT BOOST(6YR UP)(PF) 50 MCG/0.5 ML IM SUSP(EUA)	
	MODERNA COVID-19 BOOSTER (EUA)	
	NOVAVAX COVID-19 VACCINE,ADJUVANTED (PF) 5 MCG/0.5 ML IM SUSPEN (EUA)	
	PFIZER COVID (12Y UP) VAC-GRAY	
	PFIZER COVID (5-11Y) VAC-ORANG	
	PFIZER COVID (6M-4Y)VAC-MAROON	
	PFIZER COVID-19 BIVALENT BOOST(12Y UP)(PF) 30 MCG/0.3 ML IM SUSP (EUA)	
	PFIZER COVID-19 BIVALENT BOOST(5-11YR)(PF) 10 MCG/0.2 ML IM SUSP(EUA)	
	PFIZER COVID-19 BIVALENT VACCINE(6MO-4Y)(PF) 3 MCG/0.2 ML IM SUSP(EUA)	
	PFIZER COVID-19 VACCINE-PURPLE	
	PNEUMOVAX-23 25 MCG/0.5 ML INJECTION SOLUTION	
	PNEUMOVAX-23 25 MCG/0.5 ML INJECTION SYRINGE	
	PREVNAR 13 (PF) 0.5 ML INTRAMUSCULAR SYRINGE	
	PREVNAR 20 (PF) 0.5 ML INTRAMUSCULAR SYRINGE	
	SPIKEVAX (PF) 100 MCG/0.5 ML INTRAMUSCULAR SUSPENSION	
	VAXNEUVANCE (PF) 0.5 ML INTRAMUSCULAR SYRINGE	
Fluoride	fluoride 0.25 mg tablet chew - MM	
	fluoride 0.5 mg tablet chew - MM	
	fluoride 1 mg tablet chewable - MM	
	ludent fluoride 0.25 mg fluoride (0.55 mg sod.fluorid) chewable tablet - MM	
	ludent fluoride 0.5 mg fluoride (1.1 mg sod.fluoride) chewable tablet - MM	
	ludent fluoride 1 mg fluoride (2.2 mg sodium fluoride) chewable tablet - MM	
	sodium fluoride 0.25 (0.55) mg - MM	
	sodium fluoride 0.5 mg(1.1 mg) - MM	
	sodium fluoride 0.5 mg/ml drop - MM	
	sodium fluoride 1 mg (2.2 mg) - MM	
HIV PrEP	emtricitabine-tenofv 200-300mg - MM	QL May Apply

Category	Drug Name	Utilization Management Requirements
Prenatal Folic Acid	BRAINSTRONG PRENATAL 33 MG IRON-800 MCG-350 MG ORAL PACK - MM	
	CLASSIC PRENATAL 28 MG IRON-800 MCG TABLET - MM	
	EXPECTA PRENATAL 28 MG IRON-800 MCG-200 MG ORAL PACK - MM	
	fa-8 0.8 mg capsule - MM	
	folic acid 0.4 mg tablet - MM	
	folic acid 0.8 mg tablet - MM	
	folic acid 400 mcg tablet - MM	
	folic acid 800 mcg capsule - MM	
	folic acid 800 mcg tablet - MM	
	kpn tablet - MM	
	ONE A DAY WOMEN'S PRENATAL DHA 28 MG IRON-800 MCG ORAL PACK - MM	
	one daily prenatal 28 mg-800 mcg-440 mg oral pack - MM	
	ONE-A-DAY PRENATAL 400 MCG-25 MG CHEWABLE TABLET - MM	
	ONE-A-DAY PRENATAL-1 27 MG IRON-800 MCG-235 MG CAPSULE - MM	
	PERRY PRENATAL CAPSULE - MM	
	prenatal + dha 28 mg iron-800 mcg-200 mg oral pack - MM	
	prenatal 28 mg iron-800 mcg tablet - MM	
	prenatal 28 mg-800 mcg tablet - MM	
	prenatal complete 14 mg iron-400 mcg tablet - MM	
	prenatal formula 28 mg iron-800 mcg tablet - MM	
	PRENATAL FORMULA-DHA 28 MG-800 MCG-200 MG CAPSULE - MM	
	prenatal multi 27 mg-800 mcg tablet - MM	
	prenatal multi-dha (algal oil) 27 mg iron-800 mcg-250 mg capsule - MM	
	prenatal multi-dha (with vitamin k) 27 mg iron-800 mcg-260 mg capsule - MM	
	prenatal multivitamins 28 mg iron-800 mcg tablet - MM	
	prenatal one daily 27 mg iron-800 mcg tablet - MM	
	prenatal tablet - MM	
	prenatal tablet 28 mg iron-800 mcg - MM	
	prenatal vitamin 27 mg iron-0.8 mg tablet - MM	
	prenatal vitamin 27 mg iron-800 mcg tablet - MM	
	prenatal vitamins with minerals 28 mg iron-800 mcg tablet - MM	
prenatal with dha and folic acid 400 mcg-32.5 mg chewable tablet - MM		
SIMILAC PRENATAL 27 MG IRON-800 MCG-200 MG ORAL PACK - MM		
STUART ONE 27 MG IRON-800 MCG-200 MG CAPSULE - MM		

Category	Drug Name	Utilization Management Requirements
Prev Vaccines	ULTRA PRENATAL PLUS DHA 27 MG-800 MCG-250 MG-200 MG CAPSULE - MM	
	ACTHIB (PF) 10 MCG/0.5 ML INTRAMUSCULAR SOLUTION	
	ADACEL (TDAP ADOLESN/ADULT)(PF)2 LF-(2.5-5-3-5)-5 LF/0.5 ML IM SYRINGE	
	ADACEL (TDAP ADOLESN/ADULT)(PF)2LF-(2.5-5-3-5MCG)-5 LF/0.5 ML IM SUSP	
	BEXSERO 50 MCG-50 MCG-50 MCG-25 MCG/0.5 ML INTRAMUSCULAR SYRINGE	
	BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SUSPENSION	
	BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SYRINGE	
	COMIRNATY TRIS VACCINE(PF) 30 MCG/0.3 ML INTRAMUSCULAR SUSPENSION	
	DAPTACEL (DTAP PEDIATRIC) (PF) 15 LF UNIT-10 MCG-5 LF/0.5 ML IM SUSP	
	DENGVAXIA (PF) 10EXP4.5-6 CCID50/0.5 ML SUBCUTANEOUS SUSPENSION	
	DIPHThERIA-TETANUS TOXOIDS-PED	
	ENGERIX-B (PF) 20 MCG/ML INTRAMUSCULAR SUSPENSION	
	ENGERIX-B (PF) 20 MCG/ML INTRAMUSCULAR SYRINGE	
	ENGERIX-B PEDIATRIC (PF) 10 MCG/0.5 ML INTRAMUSCULAR SYRINGE	
	GARDASIL 9 (PF) 0.5 ML INTRAMUSCULAR SUSPENSION	
	GARDASIL 9 (PF) 0.5 ML INTRAMUSCULAR SYRINGE	
	HAVRIX (PF) 1,440 ELISA UNIT/ML INTRAMUSCULAR SYRINGE	
	HAVRIX (PF) 720 ELISA UNIT/0.5 ML INTRAMUSCULAR SYRINGE	
	HEPLISAV-B (PF) 20 MCG/0.5 ML INTRAMUSCULAR SYRINGE	
	HIBERIX (PF) 10 MCG/0.5 ML INTRAMUSCULAR SOLUTION	
	INFANRIX (DTAP)(PF) 25 LF UNIT-58MCG-10 LF/0.5ML INTRAMUSCULAR SYRINGE	
	INFANRIX DTAP VIAL	
	IPOL 40 UNIT-8 UNIT-32 UNIT/0.5 ML SUSPENSION FOR INJECTION	
	JANSSEN COVID-19 VACCINE (PF) 0.5 ML INTRAMUSCULAR SUSPENSION (EUA)	
	KINRIX (PF) 25 LF-58 MCG-10 LF/0.5 ML INTRAMUSCULAR SYRINGE	
	KINRIX VIAL	
	MENACTRA (PF) 4 MCG/0.5 ML INTRAMUSCULAR SOLUTION	
	MENQUADFI (PF) 10 MCG/0.5 ML INTRAMUSCULAR SOLUTION	

Category	Drug Name	Utilization Management Requirements
	MENVEO A-C-Y-W-135-DIP (PF) 10 MCG-5 MCG/0.5 ML IM KIT (2 VIALS)	
	MENVEO A-C-Y-W-135-DIP (PF) 10 MCG-5 MCG/0.5 ML IM SOLUTION (1 VIAL)	
	MENVEO MENA COMPONENT (PF) 10 MCG/0.5 ML (FINAL) IM SOLUTION	
	MENVEO MENCYW-135 COMPONENT (PF) 5 MCG X 3/0.5 ML (FINAL) IM SOLUTION	
	M-M-R II (PF) 1,000-12,500 TCID50/0.5 ML SUBCUTANEOUS SOLUTION	
	MODERNA COVID (12Y UP)VAC(EUA)	
	MODERNA COVID(6M-5Y) VACC(EUA)	
	MODERNA COVID-19 BIVALENT BOOST(6MO-5Y)(PF) 10 MCG/0.2 ML IM SUSP(EUA)	
	MODERNA COVID-19 BIVALENT BOOST(6YR UP)(PF) 50 MCG/0.5 ML IM SUSP(EUA)	
	MODERNA COVID-19 BOOSTER (EUA)	
	NOVAVAX COVID-19 VACCINE,ADJUVANTED (PF) 5 MCG/0.5 ML IM SUSPEN (EUA)	
	PEDIARIX (PF) 10 MCG-25 LF-25 MCG-10 LF/0.5 ML INTRAMUSCULAR SYRINGE	
	PEDVAX HIB (PF) 7.5 MCG/0.5 ML INTRAMUSCULAR SOLUTION	
	PENTACEL (PF) 15 LF-48 MCG-62 DU-10 MCG/0.5 ML INTRAMUSCULAR KIT	
	PENTACEL ACTHIB COMPONENT (PF) 10 MCG/0.5 ML INTRAMUSCULAR SOLUTION	
	PENTACEL DTAP-IPV COMPONENT (PF) 15 LF-48 MCG-62 DU/0.5 ML IM SUSP	
	PENTACEL DTAP-IPV COMPONENT VL	
	PENTACEL VIAL KIT	
	PFIZER COVID (12Y UP) VAC-GRAY	
	PFIZER COVID (5-11Y) VAC-ORANG	
	PFIZER COVID (6M-4Y)VAC-MAROON	
	PFIZER COVID-19 BIVALENT BOOST(12Y UP)(PF) 30 MCG/0.3 ML IM SUSP (EUA)	
	PFIZER COVID-19 BIVALENT BOOST(5-11YR)(PF) 10 MCG/0.2 ML IM SUSP(EUA)	
	PFIZER COVID-19 BIVALENT VACCINE(6MO-4Y)(PF) 3 MCG/0.2 ML IM SUSP(EUA)	
	PFIZER COVID-19 VACCINE-PURPLE	
	PREHEVBRIO (PF) 10 MCG/ML INTRAMUSCULAR SUSPENSION	
	PRIORIX (PF) 10EXP3.4-4.2-3.3 CCID50/0.5ML SUBCUTANEOUS SUSPENSION	

Category	Drug Name	Utilization Management Requirements
	PROQUAD (PF) 10EXP3-4.3-3-3.99TCID50/0.5ML SUBCUTANEOUS SUSPENSION	
	QUADRACEL (PF) 15 LF-48 MCG-5 LF UNIT/0.5 ML INTRAMUSCULAR SUSPENSION	
	QUADRACEL (PF) 15 LF-48 MCG-5 LF UNIT/0.5 ML INTRAMUSCULAR SYRINGE	
	RECOMBIVAX HB (PF) 10 MCG/ML INTRAMUSCULAR SUSPENSION	
	RECOMBIVAX HB (PF) 10 MCG/ML INTRAMUSCULAR SYRINGE	
	RECOMBIVAX HB (PF) 40 MCG/ML INTRAMUSCULAR SUSPENSION	
	RECOMBIVAX HB (PF) 5 MCG/0.5 ML INTRAMUSCULAR SUSPENSION	
	RECOMBIVAX HB (PF) 5 MCG/0.5 ML INTRAMUSCULAR SYRINGE	
	ROTARIX 10EXP6 CCID50/1.5 ML ORAL SUSPENSION	
	ROTARIX 10EXP6 CCID50/ML SUSPENSION	
	ROTATEQ VACCINE 2 ML ORAL SOLUTION	
	SHINGRIX (PF) 50 MCG/0.5 ML INTRAMUSCULAR SUSPENSION, KIT	
	SPIKEVAX (PF) 100 MCG/0.5 ML INTRAMUSCULAR SUSPENSION	
	TDVAX 2 LF UNIT-2 LF UNIT/0.5 ML INTRAMUSCULAR SUSPENSION	
	TENIVAC (PF) 5 LF UNIT-2 LF UNIT/0.5 ML INTRAMUSCULAR SUSPENSION	
	TENIVAC (PF) 5 LF UNIT-2 LF UNIT/0.5 ML INTRAMUSCULAR SYRINGE	
	TRUMENBA 120 MCG/0.5 ML INTRAMUSCULAR SYRINGE	
	TWINRIX (PF) 720 ELISA UNIT-20 MCG/ML INTRAMUSCULAR SYRINGE	
	VAQTA (PF) 25 UNIT/0.5 ML INTRAMUSCULAR SUSPENSION	
	VAQTA (PF) 25 UNIT/0.5 ML INTRAMUSCULAR SYRINGE	
	VAQTA (PF) 50 UNIT/ML INTRAMUSCULAR SUSPENSION	
	VAQTA (PF) 50 UNIT/ML INTRAMUSCULAR SYRINGE	
	VARIVAX (PF) 1,350 UNIT/0.5 ML SUBCUTANEOUS SUSPENSION	
	VAXELIS (PF) 15 UNIT-5 UNIT-10 MCG/0.5 ML INTRAMUSCULAR SUSPENSION	
	VAXELIS (PF) 15 UNIT-5 UNIT-10 MCG/0.5 ML INTRAMUSCULAR SYRINGE	
Smoking Cessation	apo-varenicline 0.5 mg tablet	QL May Apply
	apo-varenicline 1 mg tablet	QL May Apply
	bupropion hcl sr 150 mg tablet	QL May Apply
	CHANTIX 0.5 MG TABLET	QL May Apply

Category	Drug Name	Utilization Management Requirements
	CHANTIX 1 MG TABLET	QL May Apply
	CHANTIX CONTINUING MONTH BOX 1 MG TABLET	QL May Apply
	CHANTIX STARTING MONTH BOX 0.5 MG (11)-1 MG (42) TABLETS IN DOSE PACK	QL May Apply
	NICODERM CQ 14 MG/24 HR DAILY TRANSDERMAL PATCH	
	NICODERM CQ 21 MG/24 HR DAILY TRANSDERMAL PATCH	
	NICODERM CQ 7 MG/24 HR DAILY TRANSDERMAL PATCH	
	NICORETTE 2 MG BUCCAL LOZENGE	
	NICORETTE 2 MG BUCCAL MINI LOZENGE	
	NICORETTE 2 MG GUM	
	NICORETTE 4 MG BUCCAL LOZENGE	
	NICORETTE 4 MG BUCCAL MINI LOZENGE	
	NICORETTE 4 MG GUM	
	nicotine 14 mg/24hr patch	
	nicotine 2 mg chewing gum	
	nicotine 2 mg lozenge	
	nicotine 2 mg mini lozenge	
	nicotine 21 mg/24hr patch	
	nicotine 4 mg chewing gum	
	nicotine 4 mg lozenge	
	nicotine 4 mg mini lozenge	
	nicotine 7 mg/24hr patch	
	nicotine transdermal system	
	NICOTROL 10 MG INHALATION CARTRIDGE	
	NICOTROL NS 10 MG/ML NASAL SPRAY	
	quit 2 mg buccal lozenge	
	quit 2 mg gum	
	quit 4 mg buccal lozenge	
	quit 4 mg gum	
	stop smoking aid 2 mg buccal lozenge	
	stop smoking aid 4 mg buccal lozenge	
	varenicline 0.5 mg tablet	QL May Apply
	varenicline 1 mg tablet	QL May Apply
	varenicline starting month box	QL May Apply
Statins	atorvastatin 10 mg tablet - MM	
	atorvastatin 20 mg tablet - MM	
	atorvastatin 40 mg tablet - MM	
	atorvastatin 80 mg tablet - MM	
	lovastatin 10 mg tablet - MM	
	lovastatin 20 mg tablet - MM	
	lovastatin 40 mg tablet - MM	
	simvastatin 10 mg tablet - MM	
	simvastatin 20 mg tablet - MM	
	simvastatin 40 mg tablet - MM	
	simvastatin 5 mg tablet - MM	

Category

Drug Name

simvastatin 80 mg tablet - MM

Humana Plans are offered by the Family of Insurance and Health Plan Companies including Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plans of Michigan, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas,

Inc. – A Health Maintenance Organization or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Emphesys Insurance Company, or Humana Insurance of Puerto Rico, Inc. License # 00187-0009 or administered by Humana Insurance Company or Humana Health Plan, Inc.

For Arizona Residents: Offered by Humana Health Plan, Inc. or insured by Emphesys Insurance Company or insured or administered by Humana Insurance Company or Humana Health Plan, Inc.

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions.

Contraceptive coverage is subject to your employer's coverage selections.



2023 Rx3 Traditional Formulary Changes

Effective January 1, 2023

To view your full Drug List, [click here](#). Para visualizarlo en español, [haga clic aquí](#).

Certain medicines under the Humana Commercial Drug List will have changes to limitation or utilization management requirements for the 2023 plan year. These changes could mean higher or lower costs or changed requirements for Humana members who use these medicines. Humana encourages the use of generic and cost-effective brand medicines whenever possible. Below is a list of some commonly used medicines that have Humana Commercial Drug List utilization management edits in 2023 (e.g., non-formulary [NF] changes, tier/level changes [TC], prior authorization [PA], and step therapy [ST] requirements). Humana members are asked to talk to their doctor or health care professional about possible alternative medicines.

How to read your formulary changes

These requirements and limits may include:

Non-formulary (NF): Certain medicines that were previously covered under your plan benefits will be removed from your Drug List in 2023. If you fill or refill any medicine that is not covered under your prescription drug plan, you may have to pay the full cost of your medicine.

Level/tier change (TC): Covered medicines are grouped in different levels called “tiers.” If you fill or refill a prescription for a medicine or supply that’s moving to a different level, you may pay more or less.

Prior authorization (PA): Some medicines may need to be approved by Humana before it will be covered; this is called a prior authorization. Your doctor will need to contact Humana to get approval for these medicines to be covered by your prescription drug plan.

Step therapy (ST): Some medicines have a step therapy requirement, which means that you need to try at least one lower cost option before the medicine is covered.

Tier changes (TC) Positive

Impacted Drug	Tier Impact	Alternative Drug
BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	Tier 3 to Tier 2	Lowered tier
CORLANOR	Tier 3 to Tier 2	Lowered tier
FARXIGA	Tier 3 to Tier 2	Lowered tier
KRISTALOSE	Tier 3 to Tier 1	Lowered tier
KYLEENA	Tier 3 to Tier 2	Lowered tier
MIRENA	Tier 3 to Tier 2	Lowered tier
SKYLA	Tier 3 to Tier 2	Lowered tier
XIGDUO XR	Tier 3 to Tier 2	Lowered tier

Tier changes (TC) Negative

Impacted Drug	Tier Impact	Alternative Drug
SYMBICORT	Tier 2 to Tier 3	budesonide-formoterol HFA aerosol inhaler Breo Ellipta powder for inhalation Advair HFA aerosol inhaler Wixela Inhub powder for inhalation fluticasone propionate-salmeterol inhalation powder blister
INVOKANA	Tier 2 to Tier 3	Jardiance tablet Farxiga tablet
AZELAIC ACID	Tier 1 to Tier 2	Consult your physician
COLCHICINE	Tier 1 to Tier 2	Consult your physician
FINACEA	Tier 2 to Tier 3	azelaic acid topical gel metronidazole topical cream metronidazole 0.75 % topical gel
INVOKAMET XR	Tier 2 to Tier 3	Synjardy tablet Synjardy XR tablet, extended release Xigduo XR tablet, extended release Farxiga tablet
INVOKAMET	Tier 2 to Tier 3	Synjardy tablet Synjardy XR tablet, extended release Xigduo XR tablet, extended release Farxiga tablet
ZUBSOLV	Tier 2 to Tier 3	buprenorphine-naloxone sublingual film buprenorphine-naloxone sublingual tablet
CAMRESE	Tier 1 to Tier 3	Consult your physician
UNITHROID	Tier 2 to Tier 3	levothyroxine tablet Synthroid tablet Levoxyl tablet

Drugs no longer requiring prior authorization (PA)

Impacted Drug	Alternative Drug
FARXIGA	PA removal
VASCEPA	PA removal
BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	PA removal
BYSTOLIC	PA removal
COLESEVELAM HYDROCHLORIDE	PA removal
BUPRENORPHINE HCL/NALOXONE HCL	PA removal

FLUTICASONE FUROATE/VILANTEROL ELLIPTA	PA removal
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	PA removal
BROVANA	PA removal

Drugs requiring prior authorization (PA)

Impacted Drug	Alternative Drug
ICOSAPENT ETHYL	simvastatin tablet atorvastatin tablet
INVOKANA	Jardiance tablet Farxiga tablet
URSODIOL	ursodiol tablet
BYDUREON BCISE	Victoza 2-Pak subcutaneous pen injector Victoza 3-Pak subcutaneous pen injector Trulicity subcutaneous pen injector Ozempic subcutaneous pen injector Rybelsus tablet
FINACEA	azelaic acid topical gel metronidazole topical cream metronidazole 0.75 % topical gel
INVOKAMET XR	Synjardy tablet Synjardy XR tablet, extended release Xigduo XR tablet, extended release Farxiga tablet
STEGLATRO	Jardiance tablet Farxiga tablet
INVOKAMET	Synjardy tablet Synjardy XR tablet, extended release Xigduo XR tablet, extended release Farxiga tablet
ZUBSOLV	buprenorphine-naloxone sublingual film buprenorphine-naloxone sublingual tablet
SEGLUROMET	Synjardy tablet Synjardy XR tablet, extended release Xigduo XR tablet, extended release Farxiga tablet

Drugs no longer requiring step therapy (ST)

Impacted Drug	Alternative Drug
AZELASTINE HYDROCHLORIDE/FLUTICASONE PROPIONATE	ST removal
AZELAIC ACID	ST removal
XIGDUO XR	ST removal
COLCHICINE	ST removal
BYDUREON BCISE	ST removal
STEGLATRO	ST removal
FLUOCINONIDE	ST removal
SEGLUROMET	ST removal
BYETTA	ST removal

Drugs requiring step therapy (ST)

Impacted Drug	Alternative Drug
SYMBICORT	budesonide-formoterol HFA aerosol inhaler Breo Ellipta powder for inhalation Advair HFA aerosol inhaler Wixela Inhub powder for inhalation fluticasone propionate-salmeterol inhalation powder blister
UNITHROID	levothyroxine tablet Synthroid tablet Levoxyl tablet
INSULIN GLARGINE SOLOSTAR	Lantus Solostar U-100 Insulin subcutaneous pen Lantus U-100 Insulin subcutaneous solution Toujeo SoloStar U-300 Insulin subcutaneous pen Toujeo Max U-300 SoloStar subcutaneous insulin pen Tresiba U-100 Insulin subcutaneous solution
TALICIA	amoxicillin capsule clarithromycin tablet omeprazole capsule,delayed release pantoprazole tablet,delayed release Pylera capsule
DEPAKOTE SPRINKLES	divalproex tablet,delayed release divalproex capsule,delayed release sprinkle lamotrigine tablet levetiracetam tablet

	topiramate tablet
RISPERIDONE ODT	risperidone tablet quetiapine tablet olanzapine tablet ziprasidone capsule aripiprazole tablet
DEPAKOTE	divalproex tablet, delayed release lamotrigine tablet levetiracetam tablet topiramate tablet oxcarbazepine tablet
DEPAKOTE ER	divalproex tablet, delayed release divalproex ER tablet, extended release 24 hr lamotrigine tablet levetiracetam tablet topiramate tablet
INSULIN GLARGINE	Lantus Solostar U-100 Insulin subcutaneous pen Lantus U-100 Insulin subcutaneous solution Toujeo SoloStar U-300 Insulin subcutaneous pen Toujeo Max U-300 SoloStar subcutaneous insulin pen Tresiba U-100 Insulin subcutaneous solution

For more information

If you have any questions, please talk to your doctor. You may also call the number on the back of your Humana member ID card. For 24-hour service you can sign in to MyHumana, your personal, secure online account on **Humana.com**. For additional details about what's covered under your plan, you can also view your Certificate of Coverage, Summary Plan Description or Policy of Insurance on **Humana.com**.

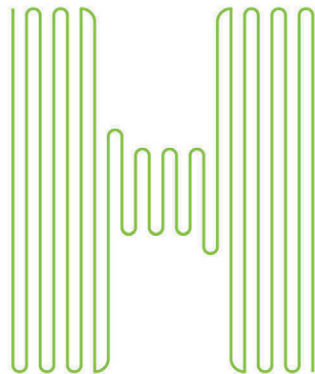
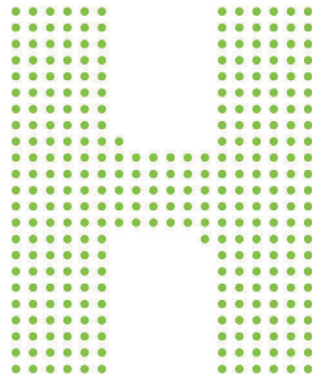
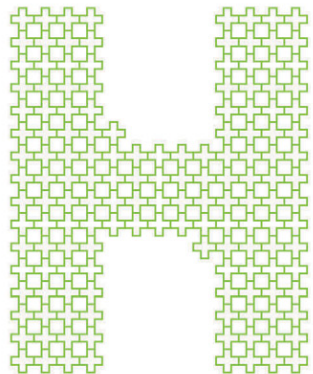
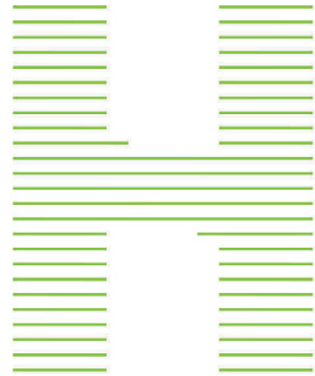
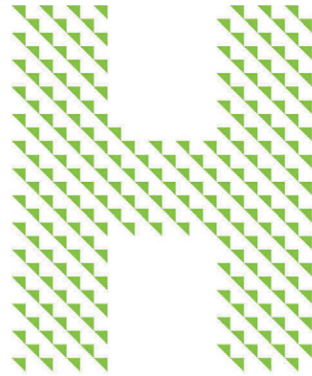
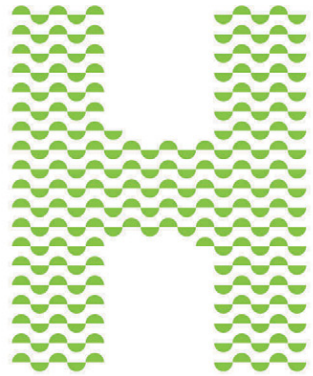
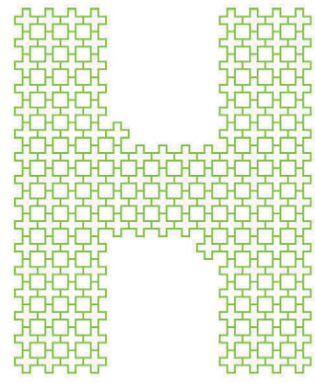
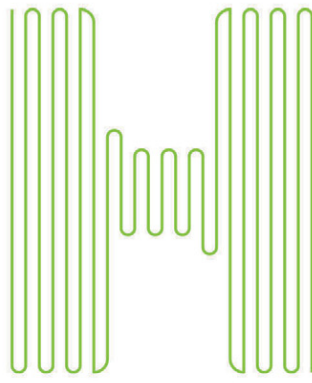
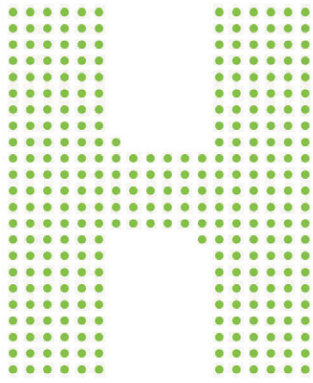
Humana Plans are offered by the Family of Insurance and Health Plan Companies including Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plans of Michigan, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc. – A Health Maintenance Organization or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Emphesys Insurance Company, or Humana Insurance of Puerto Rico, Inc. License # 00187-0009 or administered by Humana Insurance Company or Humana Health Plan, Inc.

For Arizona Residents: Offered by Humana Health Plan, Inc. or insured by Emphesys Insurance Company or insured or administered by Humana Insurance Company or Humana Health Plan, Inc.

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions.





2023 Rx3 Traditional Drug List

This is a list of covered medicines.
This document contains information about the medicines we cover in this plan.

Buscando o español? [Haga clic aqui.](#)



Welcome to Humana

What is the Drug List?

The Humana Drug List (also known as a formulary) is a list of covered medicines selected by Humana. This is a comprehensive list, but is subject to change throughout the year. The medicines in the Drug List are covered by Humana as long as the medicine is medically necessary and other plan rules are followed.

When is the Drug List effective?

The Drug List is effective on January 1st, except for commercial fully-insured policies issued in Illinois, Louisiana, Puerto Rico, and Texas where Drug List changes are effective on a plan's renewal date. These States will continue to use the 2022 version of this Drug List until the plan's renewal date in 2023. You can find that Drug List at [Humana.com/DrugList](https://www.humana.com/DrugList).

How do I use the Drug List?

Medicines are listed in the Drug List alphabetically.

Prescription medicines are grouped into one of three levels – Level 1, Level 2, or Level 3; specialty medicines are also included. Generic medicines have the same active ingredients as brand medicines and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generics to be safe and work the same as brand medicines. Generic medicines often cost much less.

- **Level 1** – Includes all generic medicines.
- **Level 2** – Includes lower-cost brand medicines.
- **Level 3** – Includes higher-cost brand medicines.
- ***Specialty Medicines:** High-cost/high-technology medicines that can often only be obtained at specialty pharmacies. Please visit **Humana.com** and log into MyHumana to view specific prescription drug benefits, including copayments or cost-share, limitations and exclusions; OR refer to your Certificate of Coverage/Insurance or Summary Plan Description/Policy of Insurance.

What if my medicine is not on the Drug List?

You can use the drug search tool by signing into MyHumana at **Humana.com** to view alternatives for your medicine. You can access the drug search tool by clicking "Pharmacy". Medical coverage may apply for some medicines.

If your medicine is not on the Drug List, your healthcare provider can request Humana to approve a coverage exception. To submit an exception request, your healthcare provider can:

- Obtain forms at **Humana.com/PA**
- Submit the request electronically by visiting Covermymeds.com/epa/Humana
- Submit the request by fax to 877-486-2621
- Call Humana Clinical Pharmacy Review (HCPR) at **800-555-CLIN (800-555-2546) (TTY: 711)** between 8 a.m – 8 p.m Eastern time, Monday - Friday. For a member in Puerto Rico, your healthcare provider can contact HCPR in Puerto Rico at **866-488-5991** between 8 a.m – 8 p.m, Monday - Friday.

The coverage exception request will be reviewed and our decision communicated within 24-72 hours after the request is received from the healthcare provider.

What if my medicine has additional requirements or limits?

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

- **Prior authorization (PA):** Some medicines need to be approved in advance to be covered under your pharmacy plan. For these medicines to be covered, your health care provider must get approval from Humana. Your plan benefits won't cover this medicine without prior authorization. You may pay the entire cost of the medicine if you buy it without first getting a prior authorization.
- **Quantity limits (QL):** You may have a limit on how much you can get of some medicines at one time. The quantity limit for each medicine is based on safety or health care concerns and whether your health care provider prescribes a supply for 30, 60, or 90 days. These limits help prevent misuse of medicines. If your prescription is over the limit there are two choices:
 - You can get the amount of medicine that's covered by your plan.

Or

 - If your health care provider thinks you need more than the amount allowed, he or she can ask for prior authorization from Humana for the amount of the medicine that goes over the limit.
- **Step therapy (ST):** Sometimes there's more than one medicine that works to treat a health condition. Some medicines may cost less but still work for you. Before a prescription is filled for a medicine that costs more, you may be asked to try at least one other medicine first.

If your medicine has an additional requirement, your healthcare provider can request Humana to approve a medicine that requires prior authorization, quantity limit, or step therapy. To submit a request, your healthcare provider can:

- Obtain forms at **Humana.com/PA**
- Submit the request electronically by visiting Covermymeds.com/epa/Humana
- Submit the request by fax to 877-486-2621
- Call Humana Clinical Pharmacy Review (HCPR) at **800-555-CLIN (800-555-2546) (TTY: 711)** between 8 a.m – 8 p.m Eastern time, Monday - Friday. For a member in Puerto Rico, your healthcare provider can contact HCPR in Puerto Rico at **866-488-5991** between 8 a.m – 8 p.m, Monday – Friday.

The coverage request will be reviewed and our decision of the coverage determination communicated within 24-72 hours after the request is received from the healthcare provider.

You can find out if your medicine has any additional requirements or limits by looking in the Drug List that begins on page 6.

Can the Drug List change?

Yes. Humana reviews and updates the Drug List as needed. New medicines may be added and medicines that are deemed unsafe by the Food and Drug Administration (FDA) or a medicine's manufacturer are immediately removed.

We will communicate changes to the Drug List to members, by mail, based on the Drug List notification requirements established by each state. Members can view the most up-to-date Drug List on **Humana.com**.

How much will I pay for covered medicines?

The amount you pay often depends on which level your medicine is covered on this Drug List and whether you fill your prescription at an in-network pharmacy. Please refer to your Certificate of Coverage/ Summary Plan Description/Policy of Insurance or call the number on the back of your Humana ID card to reach Customer Care to find out more about your pharmacy coverage. [Click here](#) to find a list of women's preventive medicines that are covered at no additional cost to you. You must have a prescription from your health care provider and fill at a pharmacy in your plan's pharmacy network. Some contraceptive medicines covered on the Drug List may be available to you at no additional cost if medically necessary. Other contraceptive medicines not on the Drug List may be available to you at no additional cost if medically necessary. To ask for a medical necessity review to receive your contraceptive medicine at no additional cost, your health care provider can contact Humana Clinical Pharmacy Review (HCPR) at **800-555-2546 (TTY: 711)** between 8 a.m. – 8 p.m. Eastern time, Monday – Friday. For a member in Puerto Rico, your health care provider can contact HCPR in Puerto Rico at **866-488-5991** between 8 a.m. - 8 p.m. local time, Monday-Friday.

How do I find a Network Pharmacy

To locate in-network pharmacies, go to [Humana.com/Findapharmacy](https://www.humana.com/Findapharmacy), call the number on the back of your Humana ID card, or visit [Humana.com](https://www.humana.com) and log into MyHumana.

CenterWell®

You may be able to fill your medicines through CenterWell® - 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 CenterWell® has received your prescription and all the necessary information. Refills should arrive within 5-7 days. To learn more, visit [CenterWellPharmacy.com](https://www.CenterWellPharmacy.com). You can also call CenterWell® at **844-222-2153 (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. To locate other in-network pharmacies, go to [Humana.com/Findapharmacy](https://www.humana.com/Findapharmacy).

For specific coverage and cost information for existing members:

- You may call the number on the back of your Humana ID card, or visit [Humana.com](https://www.humana.com) and log into MyHumana.
- Access the drug search tool by clicking "Pharmacy".
- Search for your medicine by name.
- Please note: MyHumana only shows benefits as of the date of log in. Depending on your plan, you should wait until after your plan's 2023 renewal date to see your new benefit information.

For More Information

Not all the medicines listed on this Drug List are covered by all prescription drug benefit plans. For more detailed information about your Humana prescription drug coverage, please review your Certificate of Insurance/Summary Plan Description/Policy of Insurance and other plan materials.

If you're thinking about enrolling in a Humana plan, please call the Customer Care number listed in your enrollment materials.

2023 Rx3 Traditional Drug List

The Drug List that begins on the next page provides coverage information about some of the medicines covered by Humana.

How to read your Drug List

The first column of the chart lists medicine names in alphabetical order. Brand medicines are listed in UPPER CASE and generic medicines are listed in lower case. Next to the medicine name you may see the following indicators to tell you about additional coverage information for that medicine:

MM – Maintenance medicines are taken long-term such as medicines you take for high cholesterol, mental health, or high blood pressure. Coverage may be different by plan and you may be required to fill your prescriptions using your plan's mail-delivery pharmacy.

SP – Specialty medicines are typically high-cost/high-technology medicines that can often only be obtained at specialty pharmacies. Specialty medicine coverage may be different by plan.

LD – This medicine is limited distribution and may not be available at all in-network pharmacies, please call the number on the back of your ID card for additional information. This list may not be all inclusive and is subject to change.

DL – This medicine has a dispensing limit and may be limited to a 30 day supply or less as additional restrictions may be applied by state/federal law(s) or your pharmacy. Please speak to your doctor or pharmacist about your treatment options.

The second column lists the drug level. See page 2 for more details on the drug levels in your plan.

The third column shows the utilization management requirements for the medicine. Utilization management means that Humana may have requirements for covering that medicine. These can include prior authorization, quantity limits, or step therapy. See page 2 for more details on these requirements for your plan.

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
1ST TIER UNIFINE PENTIPS 29 GAUGE X 1/2" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS PLUS 31 GAUGE X 1/4" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS PLUS 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
1ST TIER UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE ^{MM}	2	
1ST TIER UNILET COMFORTOUCH LANCET 28 GAUGE ^{MM}	2	
1ST TIER UNILET COMFORTOUCH LANCET 30 GAUGE ^{MM}	2	
2-IN-1 LANCET DEVICE 30 GAUGE ^{MM}	3	
2TEK CONTROL (HIGH-NORMAL) SOLUTION ^{MM}	3	
2TEK GLUCOSE/BLOOD PRESSURE KIT ^{MM}	3	ST
abacavir 20 mg/ml oral solution ^{MM}	1	QL(960 per 30 days)
abacavir 300 mg tablet ^{MM}	1	QL(60 per 30 days)
abacavir 300 mg-lamivudine 150 mg-zidovudine 300 mg tablet ^{MM}	1	QL(60 per 30 days)
abacavir 600 mg-lamivudine 300 mg tablet ^{MM}	1	QL(30 per 30 days)
ABILIFY 10 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
ABILIFY 15 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
ABILIFY 2 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
ABILIFY 20 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
ABILIFY 30 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
ABILIFY 5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
ABILIFY MAINTENA 300 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE ^{DL,MM,SP}	*	QL(1 per 28 days)
ABILIFY MAINTENA 300 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	QL(1 per 28 days)
ABILIFY MAINTENA 400 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE ^{DL,MM,SP}	*	QL(1 per 28 days)
ABILIFY MAINTENA 400 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	QL(1 per 28 days)
ABILIFY MYCITE 10 MG TABLET WITH SENSOR AND PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE 15 MG TABLET WITH SENSOR AND PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE 2 MG TABLET WITH SENSOR AND PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE 20 MG TABLET WITH SENSOR AND PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE 30 MG TABLET WITH SENSOR AND PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE 5 MG TABLET WITH SENSOR AND PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 10 MG TABLET WITH SENSOR AND STRIP ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 15 MG TABLET WITH SENSOR AND STRIP ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 2 MG TABLET WITH SENSOR AND STRIP ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 20 MG TABLET WITH SENSOR AND STRIP ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 30 MG TABLET WITH SENSOR AND STRIP ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 5 MG TABLET WITH SENSOR AND STRIP ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 10 MG ORAL TABLET WITH SENSOR, STRIP, POD ^{DL,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 15 MG ORAL TABLET WITH SENSOR, STRIP, POD ^{DL,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 2 MG ORAL TABLET WITH SENSOR, STRIP, POD ^{DL,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 20 MG ORAL TABLET WITH SENSOR, STRIP, POD ^{DL,SP}	*	PA,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ABILIFY MYCITE STARTER KIT 30 MG ORAL TABLET WITH SENSOR, STRIP, POD ^{DL,SP}	*	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 5 MG ORAL TABLET WITH SENSOR, STRIP, POD ^{DL,SP}	*	PA,QL(30 per 30 days)
abiraterone 250 mg tablet ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
abiraterone 500 mg tablet ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ABOUTTIME PEN NEEDLE 30 GAUGE X 5/16 ^{MM}	2	
ABOUTTIME PEN NEEDLE 31 GAUGE X 3/16 ^{MM}	2	
ABOUTTIME PEN NEEDLE 31 GAUGE X 5/16 ^{MM}	2	
ABOUTTIME PEN NEEDLE 32 GAUGE X 5/32 ^{MM}	2	
ABSORICA 10 MG CAPSULE	3	ST,QL(60 per 30 days)
ABSORICA 20 MG CAPSULE	3	ST,QL(60 per 30 days)
ABSORICA 25 MG CAPSULE ^{DL,SP}	*	ST,QL(60 per 30 days)
ABSORICA 30 MG CAPSULE	3	ST,QL(60 per 30 days)
ABSORICA 35 MG CAPSULE ^{DL,SP}	*	ST,QL(60 per 30 days)
ABSORICA 40 MG CAPSULE	3	ST,QL(120 per 30 days)
ABSORICA LD 16 MG CAPSULE ^{DL,SP}	*	ST,QL(60 per 30 days)
ABSORICA LD 24 MG CAPSULE ^{DL,SP}	*	ST,QL(60 per 30 days)
ABSORICA LD 32 MG CAPSULE ^{DL,SP}	*	ST,QL(120 per 30 days)
ABSORICA LD 8 MG CAPSULE ^{DL,SP}	*	ST,QL(60 per 30 days)
acamprosate 333 mg tablet, delayed release ^{MM}	1	QL(180 per 30 days)
ACANYA 1.2 %-2.5 % TOPICAL GEL WITH PUMP	3	ST
acarbose 100 mg tablet ^{MM}	1	
acarbose 25 mg tablet ^{MM}	1	
acarbose 50 mg tablet ^{MM}	1	
ACCOLATE 10 MG TABLET ^{MM}	3	QL(60 per 30 days)
ACCOLATE 20 MG TABLET ^{MM}	3	QL(60 per 30 days)
ACCRUFER 30 MG CAPSULE	3	PA,QL(60 per 30 days)
ACCU-CHEK AVIVA CONTROL SOLN SOLUTION ^{MM}	3	
ACCU-CHEK AVIVA PLUS METER ^{MM}	2	
ACCU-CHEK AVIVA PLUS TEST STRIPS ^{MM}	2	QL(150 per 30 days)
ACCU-CHEK FASTCLIX LANCET DRUM ^{MM}	2	
ACCU-CHEK FASTCLIX LANCING DEVICE KIT ^{MM}	2	
ACCU-CHEK GUIDE GLUCOSE METER ^{MM}	2	
ACCU-CHEK GUIDE L1-L2 CONTROL SOLUTION ^{MM}	3	
ACCU-CHEK GUIDE ME GLUCOSE METER ^{MM}	2	
ACCU-CHEK GUIDE TEST STRIPS ^{MM}	2	QL(150 per 30 days)
ACCU-CHEK MULTICLIX LANCET KIT ^{MM}	2	
ACCU-CHEK SAFE-T-PRO 23 GAUGE ^{MM}	2	
ACCU-CHEK SAFE-T-PRO PLUS 23 GAUGE ^{MM}	2	
ACCU-CHEK SMARTVIEW CONTROL SOLUTION ^{MM}	3	
ACCU-CHEK SMARTVIEW TEST STRIPS ^{MM}	2	QL(150 per 30 days)
ACCU-CHEK SOFTCLIX LANCETS ^{MM}	2	
ACCU-CHEK SOFTCLIX LANCING DEVICE+LANCETS KIT ^{MM}	2	
ACCUPRIL 10 MG TABLET ^{MM}	3	
ACCUPRIL 20 MG TABLET ^{MM}	3	
ACCUPRIL 40 MG TABLET ^{MM}	3	
ACCUPRIL 5 MG TABLET ^{MM}	3	
ACCURETIC 10 MG-12.5 MG TABLET ^{MM}	3	
ACCURETIC 20 MG-12.5 MG TABLET ^{MM}	3	
ACCURETIC 20 MG-25 MG TABLET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
accutane 10 mg capsule	1	QL(60 per 30 days)
accutane 20 mg capsule	1	QL(60 per 30 days)
accutane 30 mg capsule	1	QL(60 per 30 days)
accutane 40 mg capsule	1	QL(120 per 30 days)
ACCUTREND GLUCOSE CONTROL SOLUTION ^{MM}	3	
ACCUTREND GLUCOSE TEST STRIPS ^{MM}	2	QL(150 per 30 days)
ACE AEROSOL CLOUD ENHANCER SPACER	2	
acebutolol 200 mg capsule ^{MM}	1	
acebutolol 400 mg capsule ^{MM}	1	
acetaminophen 120 mg-codeine 12 mg/5 ml (5 ml) oral solution ^{DL}	1	QL(2700 per 30 days)
acetaminophen 120 mg-codeine 12 mg/5 ml oral solution ^{DL}	1	QL(2700 per 30 days)
acetaminophen 300 mg-codeine 15 mg tablet ^{DL}	1	QL(390 per 30 days)
acetaminophen 300 mg-codeine 30 mg tablet ^{DL}	1	QL(360 per 30 days)
acetaminophen 300 mg-codeine 30 mg/12.5 ml (12.5 ml) oral solution ^{DL}	1	QL(2700 per 30 days)
acetaminophen 300 mg-codeine 60 mg tablet ^{DL}	1	QL(180 per 30 days)
acetaminophen 320.5 mg-caffeine 30 mg-dihydrocodeine 16 mg capsule ^{DL}	1	QL(300 per 30 days)
acetazolamide 125 mg tablet ^{MM}	1	QL(120 per 30 days)
acetazolamide 250 mg tablet ^{MM}	1	QL(120 per 30 days)
acetazolamide er 500 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
acetic acid 2 % ear solution	1	
acetylcysteine 100 mg/ml (10 %) solution	1	
acetylcysteine 200 mg/ml (20 %) solution	1	
ACIPHEX 20 MG TABLET,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
ACIPHEX SPRINKLE 10 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
ACIPHEX SPRINKLE 5 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
acitretin 10 mg capsule ^{DL}	1	PA
acitretin 17.5 mg capsule ^{DL}	1	PA
acitretin 25 mg capsule ^{DL}	1	PA
ACTEMRA 162 MG/0.9 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(3.6 per 28 days)
ACTEMRA ACTPEN 162 MG/0.9 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(3.6 per 28 days)
ACTHAR 80 UNIT/ML INJECTION GEL ^{DL,LD,SP}	*	PA,QL(30 per 30 days)
ACTI-LANCE LANCETS 17 GAUGE ^{MM}	2	
ACTI-LANCE LANCETS 23 GAUGE ^{MM}	2	
ACTI-LANCE LANCETS 28 GAUGE ^{MM}	2	
ACTICLATE 150 MG TABLET	3	ST,QL(30 per 30 days)
ACTICLATE 75 MG TABLET	3	ST,QL(60 per 30 days)
ACTIMMUNE 100 MCG (2 MILLION UNIT)/0.5 ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	PA,QL(12 per 30 days)
ACTIQ 1,200 MCG LOZENGE ON A HANDLE ^{DL}	3	PA,QL(120 per 30 days)
ACTIQ 1,600 MCG LOZENGE ON A HANDLE ^{DL}	3	PA,QL(120 per 30 days)
ACTIQ 200 MCG LOZENGE ON A HANDLE ^{DL}	3	PA,QL(120 per 30 days)
ACTIQ 400 MCG LOZENGE ON A HANDLE ^{DL}	3	PA,QL(120 per 30 days)
ACTIQ 600 MCG LOZENGE ON A HANDLE ^{DL}	3	PA,QL(120 per 30 days)
ACTIQ 800 MCG LOZENGE ON A HANDLE ^{DL}	3	PA,QL(120 per 30 days)
ACTIVE FE 75 MG IRON-1,250 MCG TABLET	3	
ACTIVELLA 1 MG-0.5 MG TABLET ^{MM}	3	
ACTONEL 150 MG TABLET ^{MM}	3	QL(1 per 30 days)
ACTONEL 35 MG TABLET ^{MM}	3	QL(4 per 28 days)
ACTOPLUS MET 15 MG-500 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ACTOPLUS MET 15 MG-850 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ACTOS 15 MG TABLET ^{MM}	3	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ACTOS 30 MG TABLET ^{MM}	3	QL(30 per 30 days)
ACTOS 45 MG TABLET ^{MM}	3	QL(30 per 30 days)
ACULAR 0.5 % EYE DROPS	3	ST,QL(10 per 30 days)
ACULAR LS 0.4 % EYE DROPS	3	ST,QL(10 per 30 days)
ACUVAIL (PF) 0.45 % EYE DROPS IN A DROPPERETTE	3	ST
acyclovir 200 mg capsule ^{MM}	1	
acyclovir 200 mg/5 ml oral suspension ^{MM}	1	
acyclovir 400 mg tablet ^{MM}	1	
acyclovir 5 % topical cream	1	PA
acyclovir 5 % topical ointment	1	PA
acyclovir 800 mg tablet ^{MM}	1	
ACZONE 5 % TOPICAL GEL	3	ST
ACZONE 7.5 % TOPICAL GEL WITH PUMP	3	ST
ADACEL (TDAP ADOLESN/ADULT)(PF)2 LF-(2.5-5-3-5)-5 LF/0.5 ML IM SYRINGE	3	
ADACEL (TDAP ADOLESN/ADULT)(PF)2LF-(2.5-5-3-5MCG)-5 LF/0.5 ML IM SUSP	3	
adapalene 0.1 % lotion	1	ST
adapalene 0.1 % topical cream	1	
adapalene 0.1 % topical gel	1	
adapalene 0.1 % topical solution ^{DL,SP}	*	ST
adapalene 0.1 % topical swab	1	ST,QL(30 per 30 days)
adapalene 0.1 %-benzoyl peroxide 2.5 % topical gel with pump	1	
adapalene 0.3 % topical gel	1	ST
adapalene 0.3 % topical gel with pump	1	ST
adapalene 0.3 %-benzoyl peroxide 2.5 % topical gel with pump	1	ST
ADBRY 150 MG/ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
ADCIRCA 20 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
ADDERALL 10 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ADDERALL 12.5 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ADDERALL 15 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ADDERALL 20 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ADDERALL 30 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ADDERALL 5 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ADDERALL 7.5 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ADDERALL XR 10 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
ADDERALL XR 15 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
ADDERALL XR 20 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
ADDERALL XR 25 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
ADDERALL XR 30 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
ADDERALL XR 5 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
adefovir 10 mg tablet ^{DL,SP}	*	
ADEMPAS 0.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ADEMPAS 1 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ADEMPAS 1.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ADEMPAS 2 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ADEMPAS 2.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ADHANSIA XR 25 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
ADHANSIA XR 35 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
ADHANSIA XR 45 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
ADHANSIA XR 55 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
ADHANSIA XR 70 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ADHANSIA XR 85 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
ADJUSTABLE LANCING DEVICE	3	
ADLARITY 10 MG/24 HOUR WEEKLY TRANSDERMAL PATCH ^{MM}	3	ST,QL(4 per 28 days)
ADLARITY 5 MG/24 HOUR WEEKLY TRANSDERMAL PATCH ^{MM}	3	ST,QL(4 per 28 days)
ADLYXIN 10 MCG/0.2 ML-20 MCG/0.2 ML SUBCUTANEOUS PEN INJECTOR	3	PA,QL(6 per 28 days)
ADLYXIN 20 MCG/0.2 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	3	PA,QL(6 per 28 days)
ADMELOG SOLOSTAR U-100 INSULIN LISPRO 100 UNIT/ML SUBCUTANEOUS PEN ^{MM}	3	ST
ADMELOG U-100 INSULIN LISPRO 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION ^{MM}	3	ST,QL(60 per 30 days)
ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION ^{MM}	3	ST,QL(60 per 30 days)
ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION ^{MM}	3	ST,QL(60 per 30 days)
ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER ^{MM}	2	QL(12 per 30 days)
ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER ^{MM}	2	QL(12 per 30 days)
ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER ^{MM}	2	QL(12 per 30 days)
ADVANCED GLUCOSE METER ^{MM}	3	ST
ADVANCED GLUCOSE METER TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ADVANCED LANCING DEVICE KIT ^{MM}	2	
ADVANCED TRAVEL LANCETS 28 GAUGE ^{MM}	2	
ADVANCED TRAVEL LANCETS 30 GAUGE ^{MM}	2	
ADVOCATE BLOOD GLUCOSE MONITOR ^{MM}	3	ST
ADVOCATE CONTROL SOLUTION HIGH ^{MM}	3	
ADVOCATE DUO DEVICE	3	ST
ADVOCATE LANCET 26 GAUGE ^{MM}	2	
ADVOCATE LANCET 30 GAUGE ^{MM}	2	
ADVOCATE LANCING DEVICE	2	
ADVOCATE LOW CONTROL SOLUTION ^{MM}	3	
ADVOCATE PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	3	
ADVOCATE PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	3	
ADVOCATE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	3	
ADVOCATE PEN NEEDLE 33 GAUGE X 5/32" ^{MM}	2	
ADVOCATE RAPID-SAFE LANCING DEVICE	3	
ADVOCATE REDI-CODE DUO METER	3	ST
ADVOCATE REDI-CODE GLUCOSE MONITOR ^{MM}	3	ST
ADVOCATE REDI-CODE GLUCOSE MONITOR KIT ^{MM}	3	ST
ADVOCATE REDI-CODE PLUS ^{MM}	3	ST
ADVOCATE REDI-CODE PLUS CTRL LOW SOLUTION ^{MM}	3	
ADVOCATE REDI-CODE PLUS STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ADVOCATE REDI-CODE STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ADVOCATE REDI-CODE+ CTRL HIGH SOLUTION ^{MM}	3	
ADVOCATE SYRINGES 0.3 ML 29 GAUGE X 1/2" ^{MM}	3	
ADVOCATE SYRINGES 0.3 ML 30 GAUGE X 5/16" ^{MM}	3	
ADVOCATE SYRINGES 0.3 ML 31 GAUGE X 5/16" ^{MM}	3	
ADVOCATE SYRINGES 0.5 ML 29 GAUGE X 1/2" ^{MM}	3	
ADVOCATE SYRINGES 0.5 ML 30 GAUGE X 5/16" ^{MM}	3	
ADVOCATE SYRINGES 0.5 ML 31 GAUGE X 5/16" ^{MM}	3	
ADVOCATE SYRINGES 1 ML 29 GAUGE X 1/2" ^{MM}	3	
ADVOCATE SYRINGES 1 ML 30 GAUGE X 5/16" ^{MM}	3	
ADVOCATE SYRINGES 1 ML 31 GAUGE X 5/16" ^{MM}	3	
ADVOCATE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ADZENYS ER 1.25 MG/ML SUSPENSION, EXTENDED RELEASE 24HR ^{MM}	3	ST,QL(450 per 30 days)
ADZENYS XR-ODT 12.5 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
ADZENYS XR-ODT 15.7 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
ADZENYS XR-ODT 18.8 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
ADZENYS XR-ODT 3.1 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
ADZENYS XR-ODT 6.3 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
ADZENYS XR-ODT 9.4 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
AEMCOLO 194 MG TABLET,DELAYED RELEASE	3	PA,QL(12 per 30 days)
AEROCHAMBER MINI	3	
AEROCHAMBER MV SPACER	2	
AEROCHAMBER PLUS FLOW-VU	3	
AEROCHAMBER PLUS FLOW-VU,LARGE MASK	2	
AEROCHAMBER PLUS FLOW-VU,MEDIUM MASK	2	
AEROCHAMBER PLUS FLOW-VU,SMALL MASK	2	
AEROCHAMBER PLUS Z STAT LARGE MASK	2	
AEROCHAMBER PLUS Z STAT MEDIUM MASK	2	
AEROCHAMBER PLUS Z STAT SMALL MASK	2	
AEROCHAMBER PLUS Z STAT SPACER	2	
AEROCHAMBER Z-STAT PLUS-FLOW SIGNAL	2	
AEROGEAR ACTION ASTHMA KIT	3	
AEROTRACH PLUS SPACER	2	
AEROVENT PLUS SPACER	2	
AFINITOR 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AFINITOR 2.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AFINITOR 5 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AFINITOR 7.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AFINITOR DISPERZ 2 MG TABLET FOR ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AFINITOR DISPERZ 3 MG TABLET FOR ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AFINITOR DISPERZ 5 MG TABLET FOR ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
afirmelle 0.1 mg-20 mcg tablet ^{MM}	1	
AFLURIA QUAD 2022-2023(6MO UP) 60 MCG (15 MCG X 4)/0.5 ML IM SUSP	3	
AFLURIA QUAD 2022-23(3YR UP)(PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	3	
AFREZZA (REGULAR INSULIN) 8 UNIT (90)/12 UNIT (90) CARTRIDGE,INHALER ^{MM}	3	PA,QL(180 per 30 days)
AFREZZA 12 UNIT CARTRIDGE WITH INHALER ^{MM}	3	PA,QL(90 per 30 days)
AFREZZA 4 UNIT (60)/8 UNIT (60)/12 UNIT (60) CARTRIDGE WITH INHALER ^{MM}	3	PA,QL(180 per 30 days)
AFREZZA 4 UNIT (90)/8 UNIT (90) CARTRIDGE WITH INHALER ^{MM}	3	PA,QL(180 per 30 days)
AFREZZA 4 UNIT CARTRIDGE WITH INHALER ^{MM}	3	PA,QL(90 per 30 days)
AFREZZA 8 UNIT CARTRIDGE WITH INHALER ^{MM}	3	PA,QL(90 per 30 days)
AGAMATRIX AMP GLUCOSE MONITORING SYSTEM ^{MM}	3	ST
AGAMATRIX AMP TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
AGAMATRIX CONTROL HIGH SOLUTION ^{MM}	3	
AGAMATRIX CONTROL NORM-HI SOLUTION ^{MM}	3	
AGAMATRIX PRESTO TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
AGRYLIN 0.5 MG CAPSULE ^{MM}	3	
AIMOVIQ AUTOINJECTOR 140 MG/ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	2	PA,QL(1 per 30 days)
AIMOVIQ AUTOINJECTOR 70 MG/ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	2	PA,QL(2 per 30 days)
AIRDUO DIGIHALER 113 MCG-14 MCG/ACTUATION BREATH ACT,POWDER SENSOR ^{MM}	3	ST,QL(1 per 30 days)
AIRDUO DIGIHALER 232 MCG-14 MCG/ACTUATION BREATH ACT,POWDER SENSOR ^{MM}	3	ST,QL(1 per 30 days)
AIRDUO DIGIHALER 55 MCG-14 MCG/ACTUATION BREATH ACT,POWDER SENSOR ^{MM}	3	ST,QL(1 per 30 days)
AIRDUO RESPICLICK 113 MCG-14 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(1 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
AIRDUO RESPICLICK 232 MCG-14 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(1 per 30 days)
AIRDUO RESPICLICK 55 MCG-14 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(1 per 30 days)
AJOVY 225 MG/1.5 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.5 per 30 days)
AJOVY SYRINGE 225 MG/1.5 ML SUBCUTANEOUS ^{MM}	3	PA,QL(1.5 per 30 days)
ak-poly-bac 500 unit-10,000 unit/gram eye ointment	1	
AKLIEF 0.005 % TOPICAL CREAM	3	PA
AKTEN (PF) 3.5 % EYE GEL	3	
AKYNZEO (NETUPITANT) 300 MG-0.5 MG CAPSULE	3	PA,QL(4 per 28 days)
ALA-CORT 1 % TOPICAL CREAM	3	
ALA-SCALP 2 % LOTION	3	
albendazole 200 mg tablet	1	
ALBENZA 200 MG TABLET	3	
albuterol sulfate 0.63 mg/3 ml solution for nebulization ^{MM}	1	
albuterol sulfate 1.25 mg/3 ml solution for nebulization ^{MM}	1	
albuterol sulfate 2 mg tablet ^{MM}	1	
albuterol sulfate 2 mg/5 ml oral syrup ^{MM}	1	
albuterol sulfate 2.5 mg/3 ml (0.083 %) solution for nebulization ^{MM}	1	
albuterol sulfate 4 mg tablet ^{MM}	1	
albuterol sulfate concentrate 2.5 mg/0.5 ml solution for nebulization ^{MM}	1	
albuterol sulfate concentrate 5 mg/ml(0.5 %) solution for nebulization ^{MM}	1	
albuterol sulfate er 4 mg tablet,extended release,12 hr ^{MM}	1	
albuterol sulfate er 8 mg tablet,extended release,12 hr ^{MM}	1	
albuterol sulfate hfa 90 mcg/actuation aerosol inhaler ^{MM}	1	QL(36 per 30 days)
ALCAINE 0.5 % EYE DROPS	1	
alclometasone 0.05 % topical cream	1	
alclometasone 0.05 % topical ointment	1	
ALDACTAZIDE 25 MG-25 MG TABLET ^{MM}	3	
ALDACTAZIDE 50 MG-50 MG TABLET ^{MM}	3	
ALDACTONE 100 MG TABLET ^{MM}	3	
ALDACTONE 25 MG TABLET ^{MM}	3	
ALDACTONE 50 MG TABLET ^{MM}	3	
ALDARA 5 % TOPICAL CREAM PACKET	3	QL(12 per 30 days)
ALECENSA 150 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(240 per 30 days)
alendronate 10 mg tablet ^{MM}	1	QL(30 per 30 days)
alendronate 35 mg tablet ^{MM}	1	QL(4 per 28 days)
alendronate 5 mg tablet ^{MM}	1	QL(30 per 30 days)
alendronate 70 mg tablet ^{MM}	1	QL(4 per 28 days)
alendronate 70 mg/75 ml oral solution ^{MM}	1	QL(300 per 28 days)
alfuzosin er 10 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
ALINIA 100 MG/5 ML ORAL SUSPENSION ^{DL,SP}	*	QL(150 per 30 days)
ALINIA 500 MG TABLET ^{DL,SP}	*	QL(40 per 30 days)
aliskiren 150 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
aliskiren 300 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
ALKERAN 2 MG TABLET ^{DL,SP}	*	QL(80 per 30 days)
ALKINDI SPRINKLE 0.5 MG CAPSULE ^{DL,MM,SP}	*	PA
ALKINDI SPRINKLE 1 MG CAPSULE ^{DL,MM,SP}	*	PA
ALKINDI SPRINKLE 2 MG CAPSULE ^{DL,MM,SP}	*	PA
ALKINDI SPRINKLE 5 MG CAPSULE ^{DL,MM,SP}	*	PA
ALLERGIST TRAY 1/2 ML 27 GAUGE X 3/8" SYRINGE	3	
ALLERGIST TRAY INTRADERMAL BEVEL 1 ML 26 GAUGE X 1/2" SYRINGE	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ALLERGIST TRAY INTRADERMAL BEVEL 1 ML 26 GAUGE X 3/8" SYRINGE	3	
ALLERGIST TRAY INTRADERMAL BEVEL 1 ML 27 GAUGE X 3/8" SYRINGE	3	
ALLERGIST TRAY REGULAR BEVEL 1 ML 27 GAUGE X 3/8" SYRINGE	3	
allopurinol 100 mg tablet ^{MM}	1	
allopurinol 200 mg tablet ^{MM}	3	
allopurinol 300 mg tablet ^{MM}	1	
ALLZITAL 25 MG-325 MG TABLET	3	QL(360 per 30 days)
almotriptan malate 12.5 mg tablet	1	ST,QL(9 per 30 days)
almotriptan malate 6.25 mg tablet	1	ST,QL(9 per 30 days)
ALOCRIL 2 % EYE DROPS	3	ST
alogliptin 12.5 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 12.5 mg-metformin 1,000 mg tablet ^{MM}	3	PA,QL(60 per 30 days)
alogliptin 12.5 mg-metformin 500 mg tablet ^{MM}	3	PA,QL(60 per 30 days)
alogliptin 12.5 mg-pioglitazone 15 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 12.5 mg-pioglitazone 30 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 12.5 mg-pioglitazone 45 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 25 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 25 mg-pioglitazone 15 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 25 mg-pioglitazone 30 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 25 mg-pioglitazone 45 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
alogliptin 6.25 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
ALOMIDE 0.1 % EYE DROPS	3	ST
ALORA 0.025 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
ALORA 0.05 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
ALORA 0.075 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
ALORA 0.1 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
alosetron 0.5 mg tablet ^{DL,SP}	*	PA,QL(60 per 30 days)
alosetron 1 mg tablet ^{DL,SP}	*	PA,QL(60 per 30 days)
ALPHAGAN P 0.1 % EYE DROPS ^{MM}	3	ST,QL(10 per 30 days)
ALPHAGAN P 0.15 % EYE DROPS ^{MM}	3	ST,QL(10 per 30 days)
alprazolam 0.25 mg disintegrating tablet ^{DL}	1	QL(120 per 30 days)
alprazolam 0.25 mg tablet ^{DL}	1	QL(120 per 30 days)
alprazolam 0.5 mg disintegrating tablet ^{DL}	1	QL(120 per 30 days)
alprazolam 0.5 mg tablet ^{DL}	1	QL(120 per 30 days)
alprazolam 1 mg disintegrating tablet ^{DL}	1	QL(120 per 30 days)
alprazolam 1 mg tablet ^{DL}	1	QL(120 per 30 days)
alprazolam 2 mg disintegrating tablet ^{DL}	1	QL(90 per 30 days)
alprazolam 2 mg tablet ^{DL}	1	QL(150 per 30 days)
alprazolam er 0.5 mg tablet,extended release 24 hr ^{DL}	1	QL(60 per 30 days)
alprazolam er 1 mg tablet,extended release 24 hr ^{DL}	1	QL(60 per 30 days)
alprazolam er 2 mg tablet,extended release 24 hr ^{DL}	1	QL(60 per 30 days)
alprazolam er 3 mg tablet,extended release 24 hr ^{DL}	1	QL(60 per 30 days)
alprazolam intensol 1 mg/ml oral concentrate ^{DL}	1	
ALREX 0.2 % EYE DROPS,SUSPENSION	3	ST
ALTABAX 1 % TOPICAL OINTMENT	3	
ALTACE 1.25 MG CAPSULE ^{MM}	3	
ALTACE 10 MG CAPSULE ^{MM}	3	
ALTACE 2.5 MG CAPSULE ^{MM}	3	
ALTACE 5 MG CAPSULE ^{MM}	3	
altavera (28) 0.15 mg-0.03 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ALTERNATE SITE LANCET 26 GAUGE ^{MM}	2	
ALTERNATE SITE LANCING DEVICE	3	
ALTOPREV 20 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
ALTOPREV 40 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
ALTOPREV 60 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
ALTRENO 0.05 % LOTION	3	PA
ALUNBRIG 180 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)-180 MG (23) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(30 per 30 days)
ALUNBRIG 90 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ALVESCO 160 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(18.3 per 28 days)
ALVESCO 80 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(18.3 per 28 days)
alvimopan 12 mg capsule	1	QL(15 per 365 days)
alyacen 1/35 (28) 1 mg-35 mcg tablet ^{MM}	1	
alyacen 7/7/7 (28) 0.5 mg/0.75 mg/1 mg-35 mcg tablet ^{MM}	1	
alyq 20 mg tablet ^{MM}	1	PA,QL(60 per 30 days)
amabelz 0.5 mg-0.1 mg tablet ^{MM}	1	
amabelz 1 mg-0.5 mg tablet ^{MM}	1	
amantadine hcl 100 mg capsule ^{MM}	1	
amantadine hcl 100 mg tablet ^{MM}	1	
amantadine hcl 50 mg/5 ml oral solution ^{MM}	1	
AMARYL 1 MG TABLET ^{MM}	3	
AMARYL 2 MG TABLET ^{MM}	3	
AMARYL 4 MG TABLET ^{MM}	3	
AMBIEN 10 MG TABLET	3	ST,QL(30 per 30 days)
AMBIEN 5 MG TABLET	3	ST,QL(30 per 30 days)
AMBIEN CR 12.5 MG TABLET,EXTENDED RELEASE	3	ST,QL(30 per 30 days)
AMBIEN CR 6.25 MG TABLET,EXTENDED RELEASE	3	ST,QL(30 per 30 days)
ambrisentan 10 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ambrisentan 5 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
amcinonide 0.1 % lotion	1	
amcinonide 0.1 % topical cream	1	
AMERGE 1 MG TABLET	3	ST,QL(9 per 30 days)
AMERGE 2.5 MG TABLET	3	ST,QL(9 per 30 days)
amethia 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
amethyst (28) 90 mcg-20 mcg tablet ^{MM}	1	
AMICAR 1,000 MG TABLET	3	
AMICAR 250 MG/ML (25 %) ORAL SOLUTION ^{DL,SP}	*	
AMICAR 500 MG TABLET	3	
amiloride 5 mg tablet ^{MM}	1	
amiloride 5 mg-hydrochlorothiazide 50 mg tablet ^{MM}	1	
aminocaproic acid 1,000 mg tablet	1	
aminocaproic acid 250 mg/ml (25 %) oral solution ^{DL,SP}	*	
aminocaproic acid 500 mg tablet	1	
AMINOSYN 7 % WITH ELECTROLYTES INTRAVENOUS SOLUTION	3	
AMINOSYN 8.5 % WITH ELECTROLYTES INTRAVENOUS SOLUTION	3	
AMINOSYN II 8.5 % WITH ELECTROLYTES INTRAVENOUS SOLUTION	3	
AMINOSYN M 3.5 % INTRAVENOUS SOLUTION	3	
AMINOSYN-HBC 7% INTRAVENOUS SOLUTION	3	
amiodarone 100 mg tablet ^{MM}	1	
amiodarone 200 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
amiodarone 400 mg tablet ^{MM}	1	
AMITIZA 24 MCG CAPSULE ^{MM}	3	PA,QL(60 per 30 days)
AMITIZA 8 MCG CAPSULE ^{MM}	3	PA,QL(60 per 30 days)
amitriptyline 10 mg tablet ^{MM}	1	
amitriptyline 100 mg tablet ^{MM}	1	
amitriptyline 150 mg tablet ^{MM}	1	
amitriptyline 25 mg tablet ^{MM}	1	
amitriptyline 50 mg tablet ^{MM}	1	
amitriptyline 75 mg tablet ^{MM}	1	
amitriptyline-chlordiazepoxide 12.5 mg-5 mg tablet ^{DL,MM}	1	
amitriptyline-chlordiazepoxide 25 mg-10 mg tablet ^{DL,MM}	1	
AMJEVITA 20 MG/0.4 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(2.4 per 28 days)
AMJEVITA 40 MG/0.8 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(4.8 per 28 days)
AMJEVITA AUTOINJECTOR 40 MG/0.8 ML SUBCUTANEOUS AUTO-INJECTOR ^{DL,MM,SP}	*	PA,QL(4.8 per 28 days)
amlodipine 10 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-atorvastatin 10 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-atorvastatin 20 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-atorvastatin 40 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-atorvastatin 80 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-benazepril 20 mg capsule ^{MM}	1	QL(60 per 30 days)
amlodipine 10 mg-benazepril 40 mg capsule ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-olmesartan 20 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 10 mg-olmesartan 40 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 10 mg-valsartan 160 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-valsartan 160 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 10 mg-valsartan 160 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 10 mg-valsartan 320 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 10 mg-valsartan 320 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 2.5 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 2.5 mg-atorvastatin 10 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 2.5 mg-atorvastatin 20 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 2.5 mg-atorvastatin 40 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 2.5 mg-benazepril 10 mg capsule ^{MM}	1	QL(60 per 30 days)
amlodipine 5 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 5 mg-atorvastatin 10 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 5 mg-atorvastatin 20 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 5 mg-atorvastatin 40 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 5 mg-atorvastatin 80 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 5 mg-benazepril 10 mg capsule ^{MM}	1	QL(60 per 30 days)
amlodipine 5 mg-benazepril 20 mg capsule ^{MM}	1	QL(60 per 30 days)
amlodipine 5 mg-benazepril 40 mg capsule ^{MM}	1	QL(30 per 30 days)
amlodipine 5 mg-olmesartan 20 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 5 mg-olmesartan 40 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 5 mg-valsartan 160 mg tablet ^{MM}	1	QL(30 per 30 days)
amlodipine 5 mg-valsartan 160 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 5 mg-valsartan 160 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
amlodipine 5 mg-valsartan 320 mg tablet ^{MM}	1	QL(30 per 30 days)
ammonium lactate 12 % lotion	1	
ammonium lactate 12 % topical cream	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
amneestem 10 mg capsule	1	QL(60 per 30 days)
amneestem 20 mg capsule	1	QL(60 per 30 days)
amneestem 40 mg capsule	1	QL(120 per 30 days)
amoxapine 100 mg tablet ^{MM}	1	
amoxapine 150 mg tablet ^{MM}	1	
amoxapine 25 mg tablet ^{MM}	1	
amoxapine 50 mg tablet ^{MM}	1	
amoxicillin 125 mg chewable tablet	1	
amoxicillin 125 mg/5 ml oral suspension	1	
amoxicillin 200 mg-potassium clavulanate 28.5 mg chewable tablet	1	
amoxicillin 200 mg-potassium clavulanate 28.5 mg/5 ml oral suspension	1	
amoxicillin 200 mg/5 ml oral suspension	1	
amoxicillin 250 mg capsule	1	
amoxicillin 250 mg chewable tablet	1	
amoxicillin 250 mg-potassium clavulanate 125 mg tablet	1	
amoxicillin 250 mg-potassium clavulanate 62.5 mg/5 ml oral suspension	1	
amoxicillin 250 mg/5 ml oral suspension	1	
amoxicillin 400 mg-potassium clavulanate 57 mg chewable tablet	1	
amoxicillin 400 mg-potassium clavulanate 57 mg/5 ml oral suspension	1	
amoxicillin 400 mg/5 ml oral suspension	1	
amoxicillin 500 mg capsule	1	
amoxicillin 500 mg tablet	1	
amoxicillin 500 mg-clarithromycin 500 mg-lansoprazole 30 mg combo pack	1	
amoxicillin 500 mg-potassium clavulanate 125 mg tablet	1	
amoxicillin 600 mg-potassium clavulanate 42.9 mg/5 ml oral suspension	1	
amoxicillin 875 mg tablet	1	
amoxicillin 875 mg-potassium clavulanate 125 mg tablet	1	
amoxicillin-potassium clavulanate 1,000 mg-62.5 mg tablet,ext.rel 12hr	1	
amphetamine er 1.25 mg/ml oral 24 hr extended-release suspension ^{MM}	3	ST,QL(450 per 30 days)
amphetamine sulfate 10 mg tablet ^{MM}	1	ST,QL(90 per 30 days)
amphetamine sulfate 5 mg tablet ^{MM}	1	ST,QL(90 per 30 days)
ampicillin 250 mg capsule	1	
ampicillin 500 mg capsule	1	
AMPYRA 10 MG TABLET,EXTENDED RELEASE ^{LD,MM}	3	PA,QL(60 per 30 days)
AMRIX 15 MG CAPSULE,EXTENDED RELEASE	3	PA,QL(21 per 30 days)
AMRIX 30 MG CAPSULE,EXTENDED RELEASE	3	PA,QL(21 per 30 days)
AMZEEQ 4 % TOPICAL FOAM	3	PA
ANAFRANIL 25 MG CAPSULE ^{MM}	3	
ANAFRANIL 50 MG CAPSULE ^{MM}	3	
ANAFRANIL 75 MG CAPSULE ^{MM}	3	
anagrelide 0.5 mg capsule ^{MM}	1	
anagrelide 1 mg capsule ^{MM}	1	
ANALPRAM-HC 1 %-1 % RECTAL CREAM	3	
ANALPRAM-HC 2.5 %-1 % LOTION	3	
ANAPROX DS 550 MG TABLET ^{MM}	3	
ANASPAZ 0.125 MG DISINTEGRATING TABLET ^{MM}	3	
anastrozole 1 mg tablet ^{MM}	1	QL(30 per 30 days)
ANCOBON 250 MG CAPSULE	3	
ANCOBON 500 MG CAPSULE	3	
ANDRODERM 2 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	PA,QL(90 per 30 days)
ANDRODERM 4 MG/24 HR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	PA,QL(30 per 30 days)
ANDROGEL 1 % (25 MG/2.5 GRAM) TRANSDERMAL GEL PACKET ^{MM}	3	PA,QL(300 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ANDROGEL 1 % (50 MG/5 GRAM) TRANSDERMAL GEL PACKET ^{MM}	3	PA,QL(300 per 30 days)
ANDROGEL 1.62 % (20.25 MG/1.25 GRAM) TRANSDERMAL GEL PACKET ^{MM}	3	PA,QL(37.5 per 30 days)
ANDROGEL 1.62 % (40.5 MG/2.5 GRAM) TRANSDERMAL GEL PACKET ^{MM}	3	PA,QL(150 per 30 days)
ANDROGEL 20.25 MG/1.25 GRAM PER PUMP ACT. (1.62 %) TRANSDERMAL GEL ^{MM}	3	PA,QL(150 per 30 days)
ANDROID 10 MG CAPSULE ^{DL,MM,SP}	*	
ANGELIQ 0.25 MG-0.5 MG TABLET ^{MM}	3	
ANGELIQ 0.5 MG-1 MG TABLET ^{MM}	3	
ANNOVERA 0.15 MG-0.013 MG/24 HR VAGINAL RING ^{MM}	3	QL(1 per 365 days)
ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
ANTARA 30 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
ANTARA 90 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
ANTIVERT 25 MG CHEWABLE TABLET	3	
ANTIVERT 50 MG TABLET	3	
anusol-hc 2.5 % topical cream with perineal applicator	1	
ANZEMET 50 MG TABLET	3	
APADAZ 4.08 MG-325 MG TABLET ^{DL}	3	PA,QL(168 per 30 days)
APADAZ 6.12 MG-325 MG TABLET ^{DL}	3	PA,QL(168 per 30 days)
APADAZ 8.16 MG-325 MG TABLET ^{DL}	3	PA,QL(168 per 30 days)
apexicon e 0.05 % topical cream	1	ST
APIDRA SOLOSTAR U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN ^{MM}	3	ST
APIDRA U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
APLENZIN 174 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
APLENZIN 348 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
APLENZIN 522 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
APOKYN 10 MG/ML SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	QL(84 per 28 days)
apomorphine 10 mg/ml subcutaneous cartridge ^{DL,MM,SP}	*	QL(84 per 28 days)
apraclonidine 0.5 % eye drops	1	
aprepitant 125 mg (1)-80 mg (2) capsules in a dose pack	1	PA,QL(6 per 28 days)
aprepitant 125 mg capsule	1	PA,QL(2 per 28 days)
aprepitant 40 mg capsule	1	PA,QL(2 per 28 days)
aprepitant 80 mg capsule	1	PA,QL(4 per 28 days)
APRETUDE 600 MG/3 ML (200 MG/ML) IM SUSPENSION, EXTENDED RELEASE ^{DL,MM,SP}	*	QL(21 per 365 days)
apri 0.15 mg-0.03 mg tablet ^{MM}	1	
APRISO 0.375 GRAM CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(120 per 30 days)
APTENSIO XR 10 MG CAPSULE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
APTENSIO XR 15 MG CAPSULE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
APTENSIO XR 20 MG CAPSULE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
APTENSIO XR 30 MG CAPSULE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
APTENSIO XR 40 MG CAPSULE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
APTENSIO XR 50 MG CAPSULE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
APTENSIO XR 60 MG CAPSULE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
APTIOM 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
APTIOM 400 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
APTIOM 600 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
APTIOM 800 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
APTIVUS (WITH VITAMIN E) 100 MG/ML ORAL SOLUTION ^{MM,SP}	*	QL(285 per 28 days)
APTIVUS 250 MG CAPSULE ^{MM,SP}	*	QL(120 per 30 days)
AQUA LANCE LANCING DEVICE	3	
ARAKODA 100 MG TABLET	3	QL(56 per 180 days)
aranelle (28) 0.5 mg/1 mg/0.5 mg-35 mcg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ARANESP 10 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(1.6 per 30 days)
ARANESP 100 MCG/0.5 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(2 per 30 days)
ARANESP 100 MCG/ML (IN POLYSORBATE) INJECTION ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
ARANESP 150 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(1.2 per 30 days)
ARANESP 200 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(1.6 per 30 days)
ARANESP 200 MCG/ML (IN POLYSORBATE) INJECTION ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
ARANESP 25 MCG/0.42 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(1.68 per 30 days)
ARANESP 25 MCG/ML (IN POLYSORBATE) INJECTION ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
ARANESP 300 MCG/0.6 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(2.4 per 30 days)
ARANESP 40 MCG/0.4 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(1.6 per 30 days)
ARANESP 40 MCG/ML (IN POLYSORBATE) INJECTION ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
ARANESP 500 MCG/ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
ARANESP 60 MCG/0.3 ML (IN POLYSORBATE) INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(1.2 per 30 days)
ARANESP 60 MCG/ML (IN POLYSORBATE) INJECTION ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
ARAVA 10 MG TABLET ^{MM}	3	QL(30 per 30 days)
ARAVA 20 MG TABLET ^{MM}	3	QL(30 per 30 days)
ARAZLO 0.045 % LOTION	3	PA
ARCALYST 220 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(1 per 30 days)
arformoterol 15 mcg/2 ml solution for nebulization ^{DL,MM}	1	QL(120 per 30 days)
ARICEPT 10 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ARICEPT 23 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ARICEPT 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ARIKAYCE 590 MG/8.4 ML SUSPENSION FOR INHALATION VIA NEBULIZATION ^{DL,SP}	*	PA,QL(235.2 per 28 days)
ARIMIDEX 1 MG TABLET ^{MM}	3	QL(30 per 30 days)
aripiprazole 1 mg/ml oral solution ^{MM}	1	QL(750 per 30 days)
aripiprazole 10 mg disintegrating tablet ^{MM}	1	PA,QL(60 per 30 days)
aripiprazole 10 mg tablet ^{MM}	1	QL(30 per 30 days)
aripiprazole 15 mg disintegrating tablet ^{MM}	1	PA,QL(60 per 30 days)
aripiprazole 15 mg tablet ^{MM}	1	QL(30 per 30 days)
aripiprazole 2 mg tablet ^{MM}	1	QL(30 per 30 days)
aripiprazole 20 mg tablet ^{MM}	1	QL(30 per 30 days)
aripiprazole 30 mg tablet ^{MM}	1	QL(30 per 30 days)
aripiprazole 5 mg tablet ^{MM}	1	QL(30 per 30 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, EXTEND.REL. IM SYRINGE ^{MM,SP}	*	QL(3.9 per 56 days)
ARISTADA 441 MG/1.6 ML SUSPENSION, EXTEND.REL. IM SYRINGE ^{DL,MM,SP}	*	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, EXTEND.REL. IM SYRINGE ^{DL,MM,SP}	*	QL(2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, EXTEND.REL. IM SYRINGE ^{DL,MM,SP}	*	QL(3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, EXTEND.REL. IM SYRINGE ^{SP}	*	QL(2.4 per 42 days)
ARIXTRA 10 MG/0.8 ML SUBCUTANEOUS SOLUTION SYRINGE ^{DL,SP}	*	QL(24 per 30 days)
ARIXTRA 2.5 MG/0.5 ML SUBCUTANEOUS SOLUTION SYRINGE ^{DL,SP}	*	QL(15 per 30 days)
ARIXTRA 5 MG/0.4 ML SUBCUTANEOUS SOLUTION SYRINGE ^{DL,SP}	*	QL(12 per 30 days)
ARIXTRA 7.5 MG/0.6 ML SUBCUTANEOUS SOLUTION SYRINGE ^{DL,SP}	*	QL(18 per 30 days)
armodafinil 150 mg tablet ^{MM}	1	PA,QL(30 per 30 days)
armodafinil 200 mg tablet ^{MM}	1	PA,QL(30 per 30 days)
armodafinil 250 mg tablet ^{MM}	1	PA,QL(30 per 30 days)
armodafinil 50 mg tablet ^{MM}	1	PA,QL(60 per 30 days)
ARMONAIR DIGIHALER 113 MCG/ACTUATION AEROSOL POWDER BREATH ACT, SENSOR ^{MM}	3	ST,QL(1 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ARMONAIR DIGIHALER 232 MCG/ACTUATION AEROSOL POWDER BREATH ACT, SENSOR ^{MM}	3	ST,QL(1 per 30 days)
ARMONAIR DIGIHALER 55 MCG/ACTUATION AEROSOL POWDER BREATH ACT, SENSOR ^{MM}	3	ST,QL(1 per 30 days)
ARMOUR THYROID 120 MG TABLET ^{MM}	3	
ARMOUR THYROID 15 MG TABLET ^{MM}	3	
ARMOUR THYROID 180 MG TABLET ^{MM}	3	
ARMOUR THYROID 240 MG TABLET ^{MM}	3	
ARMOUR THYROID 30 MG TABLET ^{MM}	3	
ARMOUR THYROID 300 MG TABLET ^{MM}	3	
ARMOUR THYROID 60 MG TABLET ^{MM}	3	
ARMOUR THYROID 90 MG TABLET ^{MM}	3	
ARNUITY ELLIPTA 100 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(30 per 30 days)
ARNUITY ELLIPTA 200 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(30 per 30 days)
ARNUITY ELLIPTA 50 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(30 per 30 days)
AROMASIN 25 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ARTHROTEC 50 MG-200 MCG TABLET,FILM-COATED	3	ST
ARTHROTEC 75 75 MG-200 MCG TABLET,FILM-COATED	3	ST
ASACOL HD 800 MG TABLET,DELAYED RELEASE ^{DL,MM,SP}	*	ST,QL(180 per 30 days)
ascomp with codeine 30 mg-50 mg-325 mg-40 mg capsule ^{DL}	1	QL(360 per 30 days)
asenapine 10 mg sublingual tablet ^{MM,SP}	*	PA,QL(60 per 30 days)
asenapine 2.5 mg sublingual tablet ^{MM,SP}	*	PA,QL(60 per 30 days)
asenapine 5 mg sublingual tablet ^{MM,SP}	*	PA,QL(60 per 30 days)
ashlyna 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
ASMANEX HFA 100 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(13 per 30 days)
ASMANEX HFA 200 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(13 per 30 days)
ASMANEX HFA 50 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(13 per 30 days)
ASMANEX TWISTHALER 110 MCG/ACTUATION(30 DOSES) BREATH ACTIVATED INHALR ^{MM}	3	ST,QL(1 per 28 days)
ASMANEX TWISTHALER 220 MCG/ACTUATION(120 DOSES) BREATH ACTIVATED INHLR ^{MM}	3	ST,QL(1 per 28 days)
ASMANEX TWISTHALER 220 MCG/ACTUATION(14 DOSES) BREATH ACTIVATED INHALR ^{MM}	3	ST,QL(1 per 28 days)
ASMANEX TWISTHALER 220 MCG/ACTUATION(30 DOSES) BREATH ACTIVATED INHALR ^{MM}	3	ST,QL(1 per 28 days)
ASMANEX TWISTHALER 220 MCG/ACTUATION(60 DOSES) BREATH ACTIVATED INHALR ^{MM}	3	ST,QL(1 per 28 days)
aspirin 25 mg-dipyridamole 200 mg capsule,ext.release 12 hr multiphase ^{MM}	1	ST
aspirin 325 mg-omeprazole 40 mg tablet,immediate and delayed release ^{MM}	1	PA,QL(30 per 30 days)
aspirin 81 mg-omeprazole 40 mg tablet,immediate and delayed release ^{MM}	1	PA,QL(30 per 30 days)
ASPRUZYO SPRINKLE 1,000 MG GRANULES,EXTENDED RELEASE IN PACKET ^{MM}	3	QL(60 per 30 days)
ASPRUZYO SPRINKLE 500 MG GRANULES,EXTENDED RELEASE IN PACKET ^{MM}	3	QL(60 per 30 days)
ASSURE 4 CONTROL SOLUTION COMBO PACK ^{MM}	3	
ASSURE 4 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ASSURE DOSE NORMAL CONTROL SOLUTION ^{MM}	3	
ASSURE DOSE NORMAL-HIGH CONTROL SOLUTION ^{MM}	3	
ASSURE HAEMOLANCE PLUS 18 GAUGE ^{MM}	3	
ASSURE HAEMOLANCE PLUS 21 GAUGE ^{MM}	3	
ASSURE HAEMOLANCE PLUS 25 GAUGE ^{MM}	3	
ASSURE HAEMOLANCE PLUS 28 GAUGE ^{MM}	3	
ASSURE ID DUO-SHIELD 30 GAUGE X 3/16" NEEDLE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ASSURE ID DUO-SHIELD 30 GAUGE X 5/16" NEEDLE ^{MM}	2	
ASSURE ID INSULIN SAFETY 0.5 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
ASSURE ID INSULIN SAFETY 0.5 ML 31 GAUGE X 15/64" SYRINGE ^{MM}	2	
ASSURE ID INSULIN SAFETY 1 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
ASSURE ID INSULIN SAFETY 1 ML 31 GAUGE X 15/64" SYRINGE ^{MM}	2	
ASSURE ID PEN NEEDLE 30 GAUGE X 3/16" ^{MM}	2	
ASSURE ID PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
ASSURE ID PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
ASSURE LANCE 25 GAUGE ^{MM}	2	
ASSURE LANCE 28 GAUGE ^{MM}	2	
ASSURE LANCE PLUS 21 GAUGE ^{MM}	2	
ASSURE LANCE PLUS 25 GAUGE ^{MM}	2	
ASSURE LANCE PLUS 30 GAUGE ^{MM}	2	
ASSURE PLATINUM GLUCOSE METER ^{MM}	3	ST
ASSURE PLATINUM TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
ASSURE PRISM CONTROL 1-2 SOLUTION ^{MM}	3	
ASSURE PRISM MULTI METER ^{MM}	3	ST
ASSURE PRISM MULTI STRIP ^{MM}	3	ST,QL(150 per 30 days)
ASTAGRAF XL 0.5 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
ASTAGRAF XL 1 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
ASTAGRAF XL 5 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
ASTHMAPACK CHILDREN'S KIT	3	
ATACAND 16 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ATACAND 32 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ATACAND 4 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ATACAND 8 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ATACAND HCT 16 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ATACAND HCT 32 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ATACAND HCT 32 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
atazanavir 150 mg capsule ^{MM}	1	QL(60 per 30 days)
atazanavir 200 mg capsule ^{MM}	1	QL(60 per 30 days)
atazanavir 300 mg capsule ^{MM}	1	QL(30 per 30 days)
ATELVIA 35 MG TABLET,DELAYED RELEASE ^{MM}	3	QL(4 per 28 days)
atenolol 100 mg tablet ^{MM}	1	
atenolol 100 mg-chlorthalidone 25 mg tablet ^{MM}	1	
atenolol 25 mg tablet ^{MM}	1	
atenolol 50 mg tablet ^{MM}	1	
atenolol 50 mg-chlorthalidone 25 mg tablet ^{MM}	1	
ATIVAN 0.5 MG TABLET ^{DL}	3	QL(90 per 30 days)
ATIVAN 1 MG TABLET ^{DL}	3	QL(90 per 30 days)
ATIVAN 2 MG TABLET ^{DL}	3	QL(150 per 30 days)
atomoxetine 10 mg capsule ^{MM}	1	QL(60 per 30 days)
atomoxetine 100 mg capsule ^{MM}	1	QL(30 per 30 days)
atomoxetine 18 mg capsule ^{MM}	1	QL(60 per 30 days)
atomoxetine 25 mg capsule ^{MM}	1	QL(60 per 30 days)
atomoxetine 40 mg capsule ^{MM}	1	QL(60 per 30 days)
atomoxetine 60 mg capsule ^{MM}	1	QL(30 per 30 days)
atomoxetine 80 mg capsule ^{MM}	1	QL(30 per 30 days)
ATORVALIQ 20 MG/5 ML (4 MG/ML) ORAL SUSPENSION ^{MM}	3	ST,QL(600 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
atorvastatin 10 mg tablet ^{MM}	1	
atorvastatin 20 mg tablet ^{MM}	1	
atorvastatin 40 mg tablet ^{MM}	1	
atorvastatin 80 mg tablet ^{MM}	1	
atovaquone 250 mg-proguanil 100 mg tablet	1	QL(30 per 30 days)
atovaquone 750 mg/5 ml oral suspension ^{DL,SP}	*	QL(600 per 30 days)
atovaquone-proguanil (pediatric) 62.5 mg-25 mg tablet	1	QL(30 per 30 days)
ATRALIN 0.05 % TOPICAL GEL	3	PA
ATRIPLA 600 MG-200 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
atropine 1 % eye drops ^{MM}	1	
ATROVENT HFA 17 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(25.8 per 30 days)
AUBAGIO 14 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
AUBAGIO 7 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
aubra 0.1 mg-20 mcg tablet ^{MM}	1	
aubra eq 0.1 mg-20 mcg tablet ^{MM}	1	
AUGMENTIN 125 MG-31.25 MG/5 ML ORAL SUSPENSION	3	
AUGMENTIN 250 MG-62.5 MG/5 ML ORAL SUSPENSION	3	
AUGMENTIN 500 MG-125 MG TABLET	3	
AUGMENTIN ES-600 600 MG-42.9 MG/5 ML ORAL SUSPENSION	3	
AUGMENTIN XR 1,000 MG-62.5 MG TABLET,EXTENDED RELEASE	3	
aurovela 1.5/30 (21) 1.5 mg-30 mcg tablet ^{MM}	1	
aurovela 1/20 (21) 1 mg-20 mcg tablet ^{MM}	1	
aurovela 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet ^{MM}	1	
aurovela fe 1-20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
aurovela fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet ^{MM}	1	
AURYXIA 210 MG IRON TABLET ^{DL,MM,SP}	*	PA,QL(360 per 30 days)
AUSTEDO 12 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
AUSTEDO 6 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
AUSTEDO 9 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
AUSTEDO XR 12 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
AUSTEDO XR 24 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
AUSTEDO XR 6 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
AUTO-LANCET MINI	3	
AUTOJECT 2 INJECTION DEVICE SUBCUTANEOUS INSULIN PEN ^{MM}	3	
AUTOLET IMPRESSION LANCING DEVICE KIT ^{MM}	3	
AUTOLET LANCING DEVICE	2	
AUTOLET PLUS LANCING DEVICE	3	
AUTOPEN 1 TO 21 UNITS SUBCUTANEOUS ^{MM}	3	
AUTOPEN 2 TO 42 UNITS SUBCUTANEOUS ^{MM}	3	
AUVELITY 45 MG-105 MG TABLET, EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
AUVI-Q 0.1 MG/0.1 ML INJECTION,AUTO-INJECTOR	3	QL(4 per 30 days)
AUVI-Q 0.15 MG/0.15 ML AUTO-INJECTOR (FOR 33 LB TO 66 LB PATIENTS)	3	QL(4 per 30 days)
AUVI-Q 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR	3	QL(4 per 30 days)
AVALIDE 150 MG-12.5 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
AVALIDE 300 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
AVAPRO 150 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
AVAPRO 300 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
AVAPRO 75 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
aviane 0.1 mg-20 mcg tablet ^{MM}	1	
avidoxy 100 mg tablet	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
AVITA 0.025 % TOPICAL CREAM	3	PA
AVITA 0.025 % TOPICAL GEL	3	PA
AVODART 0.5 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
AVONEX 30 MCG/0.5 ML INTRAMUSCULAR PEN KIT ^{DL,MM,SP}	*	PA,QL(1 per 28 days)
AVONEX 30 MCG/0.5 ML INTRAMUSCULAR SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(1 per 28 days)
AYGESTIN 5 MG TABLET ^{MM}	3	
ayuna 0.15 mg-0.03 mg tablet ^{MM}	1	
AYVAKIT 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AYVAKIT 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AYVAKIT 25 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AYVAKIT 300 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AYVAKIT 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
AZASAN 100 MG TABLET ^{MM}	3	
AZASAN 75 MG TABLET ^{MM}	3	
AZASITE 1 % EYE DROPS	3	ST,QL(2.5 per 25 days)
azathioprine 100 mg tablet ^{MM}	1	
azathioprine 50 mg tablet ^{MM}	1	
azathioprine 75 mg tablet ^{MM}	1	
azelaic acid 15 % topical gel	1	
azelastine 0.05 % eye drops	1	
azelastine 137 mcg (0.1 %) nasal spray aerosol ^{MM}	1	QL(30 per 25 days)
azelastine 205.5 mcg (0.15 %) nasal spray ^{MM}	1	QL(30 per 25 days)
azelastine-fluticasone 137 mcg-50 mcg/spray nasal spray	1	QL(23 per 28 days)
AZELEX 20 % TOPICAL CREAM	3	
AZILECT 0.5 MG TABLET ^{MM}	3	ST
AZILECT 1 MG TABLET ^{MM}	3	ST
azithromycin 1 gram oral packet	1	
azithromycin 100 mg/5 ml oral suspension	1	
azithromycin 200 mg/5 ml oral suspension	1	
azithromycin 250 mg tablet	1	
azithromycin 500 mg tablet	1	
azithromycin 600 mg tablet	1	QL(16 per 60 days)
AZOPT 1 % EYE DROPS,SUSPENSION ^{MM}	3	ST,QL(10 per 28 days)
AZOR 10 MG-20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
AZOR 10 MG-40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
AZOR 5 MG-20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
AZOR 5 MG-40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
AZSTARYS 26.1 MG-5.2 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
AZSTARYS 39.2 MG-7.8 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
AZSTARYS 52.3 MG-10.4 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
AZULFIDINE 500 MG TABLET ^{MM}	3	QL(240 per 30 days)
AZULFIDINE EN-TABS 500 MG TABLET,DELAYED RELEASE ^{MM}	3	QL(240 per 30 days)
azurette (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet ^{MM}	1	
bacitracin 500 unit/gram eye ointment	1	
bacitracin-polymyxin b 500 unit-10,000 unit/gram eye ointment	1	
baclofen 10 mg tablet ^{MM}	1	QL(240 per 30 days)
baclofen 20 mg tablet ^{MM}	1	QL(120 per 30 days)
baclofen 25 mg/5 ml (5 mg/ml) oral suspension ^{DL,MM,SP}	*	PA,QL(480 per 30 days)
baclofen 5 mg tablet ^{MM}	1	QL(90 per 30 days)
baclofen 5 mg/5 ml oral solution ^{DL,MM,SP}	*	PA,QL(2400 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
BACTRIM 400 MG-80 MG TABLET	3	
BACTRIM DS 800 MG-160 MG TABLET	3	
BAFIERTAM 95 MG CAPSULE,DELAYED RELEASE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
bal-care dha 27 mg-1 mg-430 mg tablet-capsule,delayered release ^{MM}	1	
BAL-CARE DHA ESSENTIAL 27 MG IRON-1 MG-374 MG TABLET,CAPSULE,DELAY REL ^{MM}	3	
BALCOLTRA 0.1 MG-0.02 MG(21)/36.5 MG(7) TABLET ^{MM}	3	
balsalazide 750 mg capsule	1	QL(270 per 30 days)
BALVERSA 3 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
BALVERSA 4 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
BALVERSA 5 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
balziva (28) 0.4 mg-35 mcg tablet ^{MM}	1	
BANZEL 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(480 per 30 days)
BANZEL 40 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(2760 per 30 days)
BANZEL 400 MG TABLET ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
BAQSIMI 3 MG/ACTUATION NASAL SPRAY	2	
BARACLUDE 0.05 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	QL(630 per 30 days)
BARACLUDE 0.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BARACLUDE 1 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BASAGLAR KWIKPEN U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST
BASAGLAR TEMPO PEN (U-100) INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST
BAXDELA 450 MG TABLET	3	QL(28 per 14 days)
BD ALLERGIST TRAY REG BEVEL 1 ML 26 GAUGE X 1/2" SYRINGE	3	
BD ALLERGIST TRAY REG BEVEL 1 ML 27 X 1/2" SYRINGE	3	
BD ALLERGIST TRAY REG BEVEL 1/2 ML 27 X 1/2"	3	
BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16" ^{MM}	2	
BD ECLIPSE 25 GAUGE X 1 1/2" NEEDLE	2	
BD ECLIPSE LUER-LOK 1 ML 30 GAUGE X 1/2" SYRINGE ^{MM}	2	
BD ECLIPSE LUER-LOK 30 X 1/2" NEEDLE	2	
BD FILTER NEEDLE-5 MICRON 19 X 1 1/2"	3	
BD INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE 1 ML 25 GAUGE X 5/8" ^{MM}	2	
BD INSULIN SYRINGE 1 ML 25 X 1" ^{MM}	2	
BD INSULIN SYRINGE 1 ML 26 X 1/2" ^{MM}	2	
BD INSULIN SYRINGE 1 ML 27 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE MICRO-FINE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE SAFETY-LOK 1 ML 29 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE SLIP TIP 1 ML ^{MM}	2	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64"	2	
BD INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
BD INSULIN SYRINGE ULTRA-FINE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE ULTRA-FINE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
BD INSULIN SYRINGE ULTRA-FINE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
BD INSULIN SYRINGE ULTRA-FINE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
BD INTEGRA SYRINGE 3 ML 25 GAUGE X 1"	3	
BD LO-DOSE MICRO-FINE IV 1/2 ML 28 GAUGE X 1/2" SYRINGE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
BD LO-DOSE ULTRA-FINE 0.5 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
BD MICROTAINER LANCET 21 GAUGE ^{MM}	2	
BD MICROTAINER LANCET 30 GAUGE ^{MM}	2	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
BD SAFETYGLIDE ALLERGIST TRAY 1 ML 27 X 1/2" SYRINGE	3	
BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64" ^{MM}	2	
BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
BD SAFETYGLIDE INSULIN SYRINGE 0.5 ML 31 GAUGE X 15/64" ^{MM}	2	
BD SAFETYGLIDE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
BD SAFETYGLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64" ^{MM}	2	
BD SAFETYGLIDE SYRINGE 1 ML 27 GAUGE X 5/8" ^{MM}	2	
BD ULTRA FINE LANCETS 33 GAUGE ^{MM}	2	
BD ULTRA-FINE II LANCETS 30 GAUGE ^{MM}	2	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
BD VEO INSULIN SYRINGE ULTRA-FINE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" ^{MM}	2	
BD VEO INSULIN SYRINGE ULTRA-FINE 0.3 ML 31 GAUGE X 15/64" ^{MM}	2	
BD VEO INSULIN SYRINGE ULTRA-FINE 1 ML 31 GAUGE X 15/64" ^{MM}	2	
BD VEO INSULIN SYRINGE ULTRA-FINE 1/2 ML 31 GAUGE X 15/64" ^{MM}	2	
BD VERITOR AT-HOME COVID-19 TEST KIT	3	
BECONASE AQ 42 MCG (0.042 %) NASAL SPRAY ^{MM}	3	ST,QL(50 per 30 days)
BELBUCA 150 MCG BUCCAL FILM ^{DL}	2	QL(60 per 30 days)
BELBUCA 300 MCG BUCCAL FILM ^{DL}	2	QL(60 per 30 days)
BELBUCA 450 MCG BUCCAL FILM ^{DL}	2	QL(60 per 30 days)
BELBUCA 600 MCG BUCCAL FILM ^{DL}	2	QL(60 per 30 days)
BELBUCA 75 MCG BUCCAL FILM ^{DL}	2	QL(60 per 30 days)
BELBUCA 750 MCG BUCCAL FILM ^{DL}	2	QL(60 per 30 days)
BELBUCA 900 MCG BUCCAL FILM ^{DL}	2	QL(60 per 30 days)
BELSOMRA 10 MG TABLET	3	ST,QL(30 per 30 days)
BELSOMRA 15 MG TABLET	3	ST,QL(30 per 30 days)
BELSOMRA 20 MG TABLET	3	ST,QL(30 per 30 days)
BELSOMRA 5 MG TABLET	3	ST,QL(30 per 30 days)
benazepril 10 mg tablet ^{MM}	1	
benazepril 10 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
benazepril 20 mg tablet ^{MM}	1	
benazepril 20 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
benazepril 20 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
benazepril 40 mg tablet ^{MM}	1	
benazepril 5 mg tablet ^{MM}	1	
benazepril 5 mg-hydrochlorothiazide 6.25 mg tablet ^{MM}	1	
BENICAR 20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BENICAR 40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BENICAR 5 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
BENICAR HCT 20 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BENICAR HCT 40 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BENICAR HCT 40 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BENLYSTA 200 MG/ML SUBCUTANEOUS AUTO-INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(8 per 28 days)
BENLYSTA 200 MG/ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(8 per 28 days)
BENZAFLIN 1 %-5 % TOPICAL GEL	3	
BENZAFLIN PUMP 1 %-5 % TOPICAL GEL	3	
BENZAMYCIN 3 %-5 % TOPICAL GEL	3	
benzhydrocodone 4.08 mg-acetaminophen 325 mg tablet ^{DL}	1	PA,QL(168 per 30 days)
benzhydrocodone 6.12 mg-acetaminophen 325 mg tablet ^{DL}	1	PA,QL(168 per 30 days)
benzhydrocodone 8.16 mg-acetaminophen 325 mg tablet ^{DL}	1	PA,QL(168 per 30 days)
benznidazole 100 mg tablet	3	QL(240 per 365 days)
benznidazole 12.5 mg tablet	3	QL(720 per 365 days)
benzonatate 100 mg capsule	1	
benzonatate 150 mg capsule	1	
benzonatate 200 mg capsule	1	
benztropine 0.5 mg tablet ^{MM}	1	
benztropine 1 mg tablet ^{MM}	1	
benztropine 2 mg tablet ^{MM}	1	
bepotastine besilate 1.5 % eye drops	1	ST,QL(5 per 25 days)
BEPREVE 1.5 % EYE DROPS	3	ST,QL(5 per 25 days)
beseer 0.05 % lotion	1	ST
BESIVANCE 0.6 % EYE DROPS,SUSPENSION	3	ST
BESREMI 500 MCG/ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
BETADINE OPHTHALMIC PREP 5 % SOLUTION	3	
betaine 1 gram/scoop oral powder ^{DL,MM,SP}	*	
betamethasone dipropionate 0.05 % lotion	1	
betamethasone dipropionate 0.05 % topical cream	1	
betamethasone dipropionate 0.05 % topical ointment	1	
betamethasone valerate 0.1 % lotion	1	
betamethasone valerate 0.1 % topical cream	1	
betamethasone valerate 0.1 % topical ointment	1	
betamethasone valerate 0.12 % topical foam	1	ST
betamethasone, augmented 0.05 % lotion	1	
betamethasone, augmented 0.05 % topical cream	1	
betamethasone, augmented 0.05 % topical gel	1	
betamethasone, augmented 0.05 % topical ointment	1	
BETAPACE 120 MG TABLET ^{MM}	3	
BETAPACE 160 MG TABLET ^{MM}	3	
BETAPACE 240 MG TABLET ^{MM}	3	
BETAPACE 80 MG TABLET ^{MM}	3	
BETAPACE AF 120 MG TABLET ^{MM}	3	
BETAPACE AF 160 MG TABLET ^{MM}	3	
BETAPACE AF 80 MG TABLET ^{MM}	3	
BETASERON 0.3 MG SUBCUTANEOUS KIT ^{DL,MM,SP}	*	PA,QL(15 per 30 days)
BETASERON 0.3 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(15 per 30 days)
betaxolol 0.5 % eye drops ^{MM}	1	
betaxolol 10 mg tablet ^{MM}	1	
betaxolol 20 mg tablet ^{MM}	1	
bethanechol chloride 10 mg tablet ^{MM}	1	
bethanechol chloride 25 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
bethanechol chloride 5 mg tablet ^{MM}	1	
bethanechol chloride 50 mg tablet ^{MM}	1	
BETHKIS 300 MG/4 ML SOLUTION FOR NEBULIZATION ^{DL,LD,MM,SP}	*	PA,QL(224 per 28 days)
BETIMOL 0.25 % EYE DROPS ^{MM}	3	ST
BETIMOL 0.5 % EYE DROPS ^{MM}	3	ST
BETOPTIC S 0.25 % EYE DROPS,SUSPENSION ^{MM}	3	ST
BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER ^{MM}	3	ST,QL(10.7 per 30 days)
bexarotene 1 % topical gel ^{DL,SP}	*	PA,QL(240 per 30 days)
bexarotene 75 mg capsule ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
BEYAZ (28) 3 MG-0.02 MG-0.451 MG (24)/0.451 MG (4) TABLET ^{MM}	3	
bicalutamide 50 mg tablet ^{MM}	1	QL(30 per 30 days)
BIDIL 20 MG-37.5 MG TABLET ^{MM}	3	QL(180 per 30 days)
BIJUVA 1 MG-100 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
BIKTARVY 30 MG-120 MG-15 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
BIKTARVY 50 MG-200 MG-25 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
BILTRICIDE 600 MG TABLET	3	
bimatoprost 0.03 % eye drops ^{MM}	1	QL(2.5 per 25 days)
BINAXNOW COVID-19 AG CARD HOME TEST KIT	3	
BINAXNOW COVID-19 AG SELF TEST KIT	3	
BINOSTO 70 MG EFFERVESCENT TABLET ^{MM}	3	ST,QL(4 per 28 days)
BIONIME RIGHTEST GM300 SYSTEM KIT ^{MM}	3	ST
BIONIME RIGHTEST TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
BIOTEL CARE BGM-4 METER ^{MM}	3	ST
bismuth subcit k 140 mg-metronidazole 125 mg-tetracycline 125 mg cap ^{DL,SP}	*	QL(144 per 30 days)
bisoprolol 10 mg-hydrochlorothiazide 6.25 mg tablet ^{MM}	1	
bisoprolol 2.5 mg-hydrochlorothiazide 6.25 mg tablet ^{MM}	1	
bisoprolol 5 mg-hydrochlorothiazide 6.25 mg tablet ^{MM}	1	
bisoprolol fumarate 10 mg tablet ^{MM}	1	
bisoprolol fumarate 5 mg tablet ^{MM}	1	
BLEPH-10 10 % EYE DROPS	3	
BLEPHAMIDE 10 %-0.2 % EYE DROPS,SUSPENSION	3	
blisovi 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet ^{MM}	1	
blisovi fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet ^{MM}	1	
blisovi fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
BLOOD GLUCOSE CONTROL HIGH, NORMAL, AND LOW SOLUTION ^{MM}	3	
BLOOD GLUCOSE CONTROL, HIGH AND NORMAL SOLUTION ^{MM}	3	
BLOOD GLUCOSE CONTROL, NORMAL SOLUTION ^{MM}	3	
BLOOD GLUCOSE MONITORING KIT ^{MM}	3	ST
BLOOD GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
BLOOD-GLUCOSE METER ^{MM}	3	ST
BLOOD-GLUCOSE METER KIT ^{MM}	3	ST
BLUNT NEEDLE, DISPOSABLE 18 X 1 1/2"	3	
BONIVA 150 MG TABLET ^{MM}	3	QL(1 per 28 days)
BONJESTA 20 MG-20 MG TABLET,IMMEDIATE AND DELAY RELEASE	3	QL(60 per 30 days)
BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SUSPENSION	3	
BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SYRINGE	3	
BORTEZOMIB 1 MG INJECTION POWDER FOR SOLUTION ^{DL,MM,SP}	*	PA
BORTEZOMIB 2.5 MG INJECTION POWDER FOR SOLUTION ^{DL,MM,SP}	*	PA
bosentan 125 mg tablet ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
bosentan 62.5 mg tablet ^{DL,MM,SP}	*	PA,QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
BOSULIF 100 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
BOSULIF 400 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
BOSULIF 500 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
BRAFTOVI 50 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
BRAFTOVI 75 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
BREATHERITE MDI SPACER	2	
BREATHERITE SPACER AND MASK, ADULT	2	
BREATHERITE SPACER AND MASK, CHILD	2	
BREATHERITE SPACER AND MASK, INFANT	2	
BREATHERITE SPACER AND MASK, NEONATE	2	
BREATHERITE SPACER AND MASK, SMALL CHILD	2	
BREATHERITE VALVED MDI CHAMBER SPACER	3	
BREATHERITE VALVED MDI SPACER	3	
BREEZE 2 CONTROL SOLUTION, HIGH ^{MM}	3	
BREEZE 2 CONTROL SOLUTION, LOW ^{MM}	3	
BREEZE 2 CONTROL SOLUTION, NORMAL ^{MM}	3	
BREEZE 2 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
BREXAFEMME 150 MG TABLET	3	
BREZTRI AEROSPHERE 160 MCG-9MCG-4.8MCG/ACTUATION HFA AEROSOL INHALER ^{MM}	3	PA,QL(10.7 per 30 days)
briellyn 0.4 mg-35 mcg tablet ^{MM}	1	
BRILINTA 60 MG TABLET ^{MM}	2	QL(60 per 30 days)
BRILINTA 90 MG TABLET ^{MM}	2	QL(60 per 30 days)
brimonidine 0.15 % eye drops ^{MM}	1	QL(10 per 30 days)
brimonidine 0.2 % eye drops ^{MM}	1	QL(10 per 30 days)
brimonidine 0.2 %-timolol 0.5 % eye drops ^{MM}	1	ST,QL(5 per 25 days)
brimonidine 0.33 % topical gel with pump	1	ST
brinzolamide 1 % eye drops,suspension ^{MM}	1	ST,QL(10 per 28 days)
BRISDELLE 7.5 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
BRIVIACT 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
BRIVIACT 10 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(600 per 30 days)
BRIVIACT 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
BRIVIACT 25 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
BRIVIACT 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
BRIVIACT 75 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
bromfed dm 2 mg-30 mg-10 mg/5 ml oral syrup	1	
bromfenac 0.09 % eye drops	1	ST,QL(1.7 per 30 days)
bromocriptine 2.5 mg tablet ^{MM}	1	
bromocriptine 5 mg capsule ^{MM}	1	
brompheniramine-pseudoephedrine-dm 2 mg-30 mg-10 mg/5 ml oral syrup	1	
BROMSITE 0.075 % EYE DROPS	3	ST,QL(5 per 30 days)
BRONCHITOL 40 MG CAPSULE WITH INHALATION DEVICE ^{DL,MM,SP}	*	PA,QL(560 per 28 days)
BROVANA 15 MCG/2 ML SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
BRUKINSA 80 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
BRYHALI 0.01 % LOTION	3	ST
budesonide 0.25 mg/2 ml suspension for nebulization ^{MM}	1	QL(240 per 30 days)
budesonide 0.5 mg/2 ml suspension for nebulization ^{MM}	1	QL(240 per 30 days)
budesonide 1 mg/2 ml suspension for nebulization ^{MM}	1	QL(120 per 30 days)
budesonide 2 mg/actuation rectal foam	1	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
budesonide dr - er 3 mg capsule,delayed,extended release	1	
budesonide dr-er 9 mg tablet,delayed and extended release ^{DL,SP}	*	PA,QL(30 per 30 days)
budesonide-formoterol hfa 160 mcg-4.5 mcg/actuation aerosol inhaler ^{MM}	2	QL(10.2 per 30 days)
budesonide-formoterol hfa 80 mcg-4.5 mcg/actuation aerosol inhaler ^{MM}	2	QL(10.2 per 30 days)
BULLSEYE MINI SAFETY LANCETS 21 GAUGE ^{MM}	3	
BULLSEYE MINI SAFETY LANCETS 25 GAUGE ^{MM}	3	
BULLSEYE MINI SAFETY LANCETS 28 GAUGE ^{MM}	3	
bumetanide 0.5 mg tablet ^{MM}	1	
bumetanide 1 mg tablet ^{MM}	1	
bumetanide 2 mg tablet ^{MM}	1	
BUNAVAIL 4.2 MG-0.7 MG BUCCAL FILM ^{MM}	3	PA,QL(60 per 30 days)
bupap 50 mg-300 mg tablet	1	QL(180 per 30 days)
BUPHENYL 0.94 GRAM/GRAM ORAL POWDER ^{DL,MM,SP}	*	
BUPHENYL 500 MG TABLET ^{DL,MM,SP}	*	
buprenorphine 10 mcg/hour weekly transdermal patch ^{DL}	1	QL(4 per 28 days)
buprenorphine 12 mg-naloxone 3 mg sublingual film ^{MM}	1	QL(60 per 30 days)
buprenorphine 15 mcg/hour weekly transdermal patch ^{DL}	1	QL(4 per 28 days)
buprenorphine 2 mg-naloxone 0.5 mg sublingual film ^{MM}	1	QL(90 per 30 days)
buprenorphine 2 mg-naloxone 0.5 mg sublingual tablet ^{MM}	1	QL(90 per 30 days)
buprenorphine 20 mcg/hour weekly transdermal patch ^{DL}	1	QL(4 per 28 days)
buprenorphine 4 mg-naloxone 1 mg sublingual film ^{MM}	1	QL(90 per 30 days)
buprenorphine 5 mcg/hour weekly transdermal patch ^{DL}	1	QL(4 per 28 days)
buprenorphine 7.5 mcg/hour weekly transdermal patch ^{DL}	1	QL(4 per 28 days)
buprenorphine 8 mg-naloxone 2 mg sublingual film ^{MM}	1	QL(90 per 30 days)
buprenorphine 8 mg-naloxone 2 mg sublingual tablet ^{MM}	1	QL(90 per 30 days)
buprenorphine hcl 150 mcg buccal film ^{DL}	1	ST,QL(60 per 30 days)
buprenorphine hcl 2 mg sublingual tablet	1	QL(90 per 30 days)
buprenorphine hcl 300 mcg buccal film ^{DL}	1	ST,QL(60 per 30 days)
buprenorphine hcl 450 mcg buccal film ^{DL}	1	ST,QL(60 per 30 days)
buprenorphine hcl 600 mcg buccal film ^{DL}	1	ST,QL(60 per 30 days)
buprenorphine hcl 75 mcg buccal film ^{DL}	1	ST,QL(60 per 30 days)
buprenorphine hcl 750 mcg buccal film ^{DL}	1	ST,QL(60 per 30 days)
buprenorphine hcl 8 mg sublingual tablet	1	QL(90 per 30 days)
buprenorphine hcl 900 mcg buccal film ^{DL}	1	ST,QL(60 per 30 days)
bupropion hcl 100 mg tablet ^{MM}	1	QL(180 per 30 days)
bupropion hcl 150 mg tablet,12 hr sustained-release(smoking deterrent)	1	QL(90 per 30 days)
bupropion hcl 75 mg tablet ^{MM}	1	QL(180 per 30 days)
bupropion hcl sr 100 mg tablet,12 hr sustained-release ^{MM}	1	QL(120 per 30 days)
bupropion hcl sr 150 mg tablet,12 hr sustained-release ^{MM}	1	QL(90 per 30 days)
bupropion hcl sr 200 mg tablet,12 hr sustained-release ^{MM}	1	QL(60 per 30 days)
bupropion hcl xl 150 mg 24 hr tablet, extended release ^{MM}	1	QL(90 per 30 days)
bupropion hcl xl 300 mg 24 hr tablet, extended release ^{MM}	1	QL(30 per 30 days)
bupropion hcl xl 450 mg 24 hr tablet, extended release ^{MM}	3	PA,QL(30 per 30 days)
buspirone 10 mg tablet ^{MM}	1	
buspirone 15 mg tablet ^{MM}	1	
buspirone 30 mg tablet ^{MM}	1	
buspirone 5 mg tablet ^{MM}	1	
buspirone 7.5 mg tablet ^{MM}	1	
butalbital 50 mg-acetaminophen 300 mg capsule	1	QL(180 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
butalbital 50 mg-acetaminophen 300 mg tablet	1	QL(180 per 30 days)
butalbital 50 mg-acetaminophen 300 mg-caffeine 40 mg-codeine 30 mg cap ^{DL}	1	QL(180 per 30 days)
butalbital 50 mg-acetaminophen 325 mg tablet	1	QL(180 per 30 days)
butalbital 50 mg-acetaminophen 325 mg-caffeine 40 mg-codeine 30 mg cap ^{DL}	1	QL(360 per 30 days)
butalbital compound with codeine 30 mg-50 mg-325 mg-40 mg capsule ^{DL}	1	QL(360 per 30 days)
butalbital-acetaminophen-caffeine 50 mg-300 mg-40 mg capsule	1	QL(180 per 30 days)
butalbital-acetaminophen-caffeine 50 mg-325 mg-40 mg capsule	1	QL(180 per 30 days)
butalbital-acetaminophen-caffeine 50 mg-325 mg-40 mg tablet	1	QL(180 per 30 days)
butalbital-aspirin-caffeine 50 mg-325 mg-40 mg capsule	1	QL(180 per 30 days)
butalbital-aspirin-caffeine 50 mg-325 mg-40 mg tablet	1	QL(180 per 30 days)
butorphanol 10 mg/ml nasal spray ^{DL}	1	QL(5 per 28 days)
BUTRANS 10 MCG/HOUR TRANSDERMAL PATCH ^{DL}	3	ST,QL(4 per 28 days)
BUTRANS 15 MCG/HOUR TRANSDERMAL PATCH ^{DL}	3	ST,QL(4 per 28 days)
BUTRANS 20 MCG/HOUR TRANSDERMAL PATCH ^{DL}	3	ST,QL(4 per 28 days)
BUTRANS 5 MCG/HOUR TRANSDERMAL PATCH ^{DL}	3	ST,QL(4 per 28 days)
BUTRANS 7.5 MCG/HOUR TRANSDERMAL PATCH ^{DL}	3	ST,QL(4 per 28 days)
BUTTERFLY TOUCH LANCET 30 GAUGE ^{MM}	2	
BYDUREON BCISE 2 MG/0.85 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(3.4 per 28 days)
BYETTA 10 MCG/DOSE(250 MCG/ML)2.4 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	3	PA,QL(2.4 per 30 days)
BYETTA 5 MCG/DOSE (250 MCG/ML)1.2 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	3	PA,QL(2.4 per 30 days)
BYLVAY 1,200 MCG CAPSULE ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
BYLVAY 200 MCG ORAL PELLETT ^{DL,MM,SP}	*	PA,QL(360 per 30 days)
BYLVAY 400 MCG CAPSULE ^{DL,MM,SP}	*	PA,QL(420 per 30 days)
BYLVAY 600 MCG ORAL PELLETT ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
BYNFEZIA 2,500 MCG/ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA
BYSTOLIC 10 MG TABLET ^{MM}	3	ST,QL(120 per 30 days)
BYSTOLIC 2.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
BYSTOLIC 20 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
BYSTOLIC 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
c-nate dha 28 mg iron-1 mg-200 mg capsule ^{MM}	1	
cabergoline 0.5 mg tablet ^{MM}	1	QL(16 per 28 days)
CABLIVI 11 MG INJECTION KIT ^{DL,SP}	*	PA,QL(30 per 30 days)
CABOMETYX 20 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
CABOMETYX 40 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
CABOMETYX 60 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
CADEAU DHA 29 MG IRON-1 MG-150 MG CAPSULE ^{MM}	3	
CADUET 10 MG-10 MG TABLET ^{MM}	3	QL(30 per 30 days)
CADUET 10 MG-20 MG TABLET ^{MM}	3	QL(30 per 30 days)
CADUET 10 MG-40 MG TABLET ^{MM}	3	QL(30 per 30 days)
CADUET 10 MG-80 MG TABLET ^{MM}	3	QL(30 per 30 days)
CADUET 5 MG-10 MG TABLET ^{MM}	3	QL(30 per 30 days)
CADUET 5 MG-20 MG TABLET ^{MM}	3	QL(30 per 30 days)
CADUET 5 MG-40 MG TABLET ^{MM}	3	QL(30 per 30 days)
CADUET 5 MG-80 MG TABLET ^{MM}	3	QL(30 per 30 days)
CAFERGOT 1 MG-100 MG TABLET	3	
caffeine citrate 60 mg/3 ml (20 mg/ml) oral solution	1	
CALAN SR 120 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CALAN SR 180 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CALAN SR 240 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
calcipotriene 0.005 % scalp solution	1	PA,QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
calcipotriene 0.005 % topical cream	1	PA,QL(120 per 30 days)
calcipotriene 0.005 % topical foam ^{DL,SP}	*	QL(120 per 28 days)
calcipotriene 0.005 % topical ointment	1	PA
calcipotriene-betamethasone 0.005 %-0.064 % topical ointment	1	PA,QL(60 per 30 days)
calcipotriene-betamethasone 0.005 %-0.064 % topical suspension ^{DL,SP}	*	PA,QL(420 per 30 days)
calcitonin (salmon) 200 unit/actuation nasal spray ^{MM}	1	QL(3.7 per 28 days)
calcitonin (salmon) 200 unit/ml injection solution	1	QL(4 per 28 days)
calcitriol 0.25 mcg capsule ^{MM}	1	
calcitriol 0.5 mcg capsule ^{MM}	1	
calcitriol 1 mcg/ml oral solution ^{MM}	1	
calcitriol 3 mcg/gram topical ointment	1	PA,QL(800 per 28 days)
calcium acetate(phosphate binders) 667 mg capsule ^{MM}	1	
calcium acetate(phosphate binders) 667 mg tablet ^{MM}	1	
CALQUENCE (ACALABRUTINIB MALEATE) 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
CALQUENCE 100 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
CAMBIA 50 MG ORAL POWDER PACKET ^{DL,SP}	*	ST,QL(9 per 30 days)
CAMCEVI (6 MONTH) 42 MG SUBCUTANEOUS SYRINGE ^{MM}	3	PA,QL(1 per 180 days)
camila 0.35 mg tablet ^{MM}	1	
camrese 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack ^{MM}	3	QL(91 per 90 days)
camrese lo 0.1 mg-20 mcg (84)/10 mcg (7) tablets,3 month dose pack ^{MM}	3	QL(91 per 90 days)
CAMZYOS 10 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CAMZYOS 15 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CAMZYOS 2.5 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CAMZYOS 5 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CANASA 1,000 MG RECTAL SUPPOSITORY ^{MM}	3	ST,QL(30 per 30 days)
candesartan 16 mg tablet ^{MM}	1	ST,QL(60 per 30 days)
candesartan 16 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
candesartan 32 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
candesartan 32 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
candesartan 32 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
candesartan 4 mg tablet ^{MM}	1	ST,QL(60 per 30 days)
candesartan 8 mg tablet ^{MM}	1	ST,QL(60 per 30 days)
capecitabine 150 mg tablet	1	PA,QL(630 per 30 days)
capecitabine 500 mg tablet	1	PA,QL(189 per 30 days)
CAPEX 0.01 % SHAMPOO	3	
CAPLYTA 10.5 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CAPLYTA 21 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CAPLYTA 42 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CAPRELSA 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
CAPRELSA 300 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
captopril 100 mg tablet ^{MM}	1	
captopril 12.5 mg tablet ^{MM}	1	
captopril 25 mg tablet ^{MM}	1	
captopril 25 mg-hydrochlorothiazide 15 mg tablet ^{MM}	1	
captopril 25 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
captopril 50 mg tablet ^{MM}	1	
captopril 50 mg-hydrochlorothiazide 15 mg tablet ^{MM}	1	
captopril 50 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
CARAC 0.5 % TOPICAL CREAM	3	
CARAFATE 1 GRAM TABLET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CARAFATE 100 MG/ML ORAL SUSPENSION ^{MM}	3	
CARBAGLU 200 MG DISPERSIBLE TABLET ^{DL,MM,SP}	*	PA
carbamazepine 100 mg chewable tablet ^{MM}	1	
carbamazepine 100 mg/5 ml oral suspension ^{MM}	1	
carbamazepine 200 mg tablet ^{MM}	1	
carbamazepine 200 mg/10 ml oral suspension ^{MM}	1	
carbamazepine er 100 mg capsule,extended release mphase12hr ^{MM}	1	
carbamazepine er 100 mg tablet,extended release,12 hr ^{MM}	1	QL(120 per 30 days)
carbamazepine er 200 mg capsule,extended release mphase12hr ^{MM}	1	
carbamazepine er 200 mg tablet,extended release,12 hr ^{MM}	1	QL(120 per 30 days)
carbamazepine er 300 mg capsule,extended release mphase12hr ^{MM}	1	
carbamazepine er 400 mg tablet,extended release,12 hr ^{MM}	1	QL(120 per 30 days)
CARBATROL 100 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	
CARBATROL 200 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	
CARBATROL 300 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	
carbidopa 10 mg-levodopa 100 mg disintegrating tablet ^{MM}	1	
carbidopa 10 mg-levodopa 100 mg tablet ^{MM}	1	
carbidopa 12.5 mg-levodopa 50 mg-entacapone 200 mg tablet ^{MM}	1	
carbidopa 18.75 mg-levodopa 75 mg-entacapone 200 mg tablet ^{MM}	1	
carbidopa 25 mg tablet ^{MM}	1	
carbidopa 25 mg-levodopa 100 mg disintegrating tablet ^{MM}	1	
carbidopa 25 mg-levodopa 100 mg tablet ^{MM}	1	
carbidopa 25 mg-levodopa 100 mg-entacapone 200 mg tablet ^{MM}	1	
carbidopa 25 mg-levodopa 250 mg disintegrating tablet ^{MM}	1	
carbidopa 25 mg-levodopa 250 mg tablet ^{MM}	1	
carbidopa 31.25 mg-levodopa 125 mg-entacapone 200 mg tablet ^{MM}	1	
carbidopa 37.5 mg-levodopa 150 mg-entacapone 200 mg tablet ^{MM}	1	
carbidopa 50 mg-levodopa 200 mg-entacapone 200 mg tablet ^{MM}	1	
carbidopa er 25 mg-levodopa 100 mg tablet,extended release ^{MM}	1	
carbidopa er 50 mg-levodopa 200 mg tablet,extended release ^{MM}	1	
carbinoxamine 4 mg tablet	1	
carbinoxamine 4 mg/5 ml oral liquid	1	
carbinoxamine 6 mg tablet	1	ST,QL(120 per 30 days)
CARDIZEM 120 MG TABLET ^{MM}	3	
CARDIZEM 30 MG TABLET ^{MM}	3	
CARDIZEM 60 MG TABLET ^{MM}	3	
CARDIZEM CD 120 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
CARDIZEM CD 180 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
CARDIZEM CD 240 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
CARDIZEM CD 300 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CARDIZEM CD 360 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CARDIZEM LA 120 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CARDIZEM LA 180 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
CARDIZEM LA 240 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
CARDIZEM LA 300 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CARDIZEM LA 360 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CARDIZEM LA 420 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CARDURA 1 MG TABLET ^{MM}	3	
CARDURA 2 MG TABLET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CARDURA 4 MG TABLET ^{MM}	3	
CARDURA 8 MG TABLET ^{MM}	3	
CARDURA XL 4 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CARDURA XL 8 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
CAREFINE PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
CAREFINE PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
CAREFINE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
CAREFINE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
CAREFINE PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
CAREFINE PEN NEEDLE 32 GAUGE X 3/16" ^{MM}	2	
CAREFINE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
CARELANCE ULTIMATE COMFORT LANCING DEVICE	3	
CAREONE LANCING DEVICE	2	
CAREONE THIN LANCET ^{MM}	2	
CAREONE ULTRA THIN LANCET ^{MM}	2	
CARESENS CONTROL A AND B SOLUTION ^{MM}	3	
CARESENS CONTROL A NORMAL SOLUTION ^{MM}	3	
CARESENS LANCETS 30 GAUGE ^{MM}	3	
CARESENS N ^{MM}	3	ST
CARESENS N KIT ^{MM}	3	ST
CARESENS N TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
CARESENS N VOICE ^{MM}	3	ST
CARESENS N VOICE KIT ^{MM}	3	ST
CARESENS PREMIUM COMFORT LANCING DEVICE	3	
CARESTART COVID-19 ANTIGEN HOME TEST KIT	3	
CARETOUCH CONTROL SOLUTION L2-L3 ^{MM}	3	
CARETOUCH GLUCOSE MONITORING SYSTEM KIT ^{MM}	3	ST
CARETOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
CARETOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
CARETOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
CARETOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 5/16" ^{MM}	2	
CARETOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 5/16" ^{MM}	2	
CARETOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
CARETOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
CARETOUCH KETONE-GLUCOSE MONITOR ^{MM}	3	ST
CARETOUCH LANCING DEVICE	3	
CARETOUCH PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
CARETOUCH PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
CARETOUCH PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
CARETOUCH PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
CARETOUCH PEN NEEDLE 32 GAUGE X 3/16" ^{MM}	2	
CARETOUCH PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
CARETOUCH SAFETY LANCETS 26 GAUGE ^{MM}	2	
CARETOUCH SAFETY LANCETS 28 GAUGE ^{MM}	2	
CARETOUCH TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
CARETOUCH TWIST LANCET 28 GAUGE ^{MM}	2	
CARETOUCH TWIST LANCET 30 GAUGE ^{MM}	2	
CARETOUCH TWIST LANCET 33 GAUGE ^{MM}	2	
carglumic acid 200 mg dispersible tablet ^{DL,MM,SP}	*	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
carisoprodol 200 mg-aspirin 325 mg-codeine 16 mg tablet ^{DL}	1	QL(360 per 30 days)
carisoprodol 250 mg tablet	1	QL(120 per 30 days)
carisoprodol 350 mg tablet	1	QL(120 per 30 days)
carisoprodol-aspirin 200 mg-325 mg tablet	1	
CARNITOR (SUGAR-FREE) 100 MG/ML ORAL SOLUTION ^{MM}	3	
CARNITOR 100 MG/ML ORAL SOLUTION ^{MM}	3	
CARNITOR 330 MG TABLET ^{MM}	3	
CAROSPIR 25 MG/5 ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(450 per 30 days)
carteolol 1 % eye drops ^{MM}	1	
cartia xt 120 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
cartia xt 180 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
cartia xt 240 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
cartia xt 300 mg capsule,extended release ^{MM}	1	QL(30 per 30 days)
carvedilol 12.5 mg tablet ^{MM}	1	
carvedilol 25 mg tablet ^{MM}	1	
carvedilol 3.125 mg tablet ^{MM}	1	
carvedilol 6.25 mg tablet ^{MM}	1	
carvedilol phosphate er 10 mg capsule,ext.release24hr multiphase ^{MM}	1	ST,QL(30 per 30 days)
carvedilol phosphate er 20 mg capsule,ext.release24hr multiphase ^{MM}	1	ST,QL(30 per 30 days)
carvedilol phosphate er 40 mg capsule,ext.release24hr multiphase ^{MM}	1	ST,QL(30 per 30 days)
carvedilol phosphate er 80 mg capsule,ext.release24hr multiphase ^{MM}	1	ST,QL(30 per 30 days)
CASODEX 50 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
cataflam 50 mg tablet	1	
CATAPRES-TTS-1 0.1 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CATAPRES-TTS-2 0.2 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CATAPRES-TTS-3 0.3 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CAYA CONTOURED 65 MM-80 MM VAGINAL DIAPHRAGM	3	
CAYSTON 75 MG/ML SOLUTION FOR NEBULIZATION ^{DL,SP}	*	PA,QL(84 per 28 days)
caziant (28) 0.1 mg/0.125 mg/0.15 mg-25 mcg tablet ^{MM}	1	
cefaclor 125 mg/5 ml oral suspension	1	
cefaclor 250 mg capsule	1	
cefaclor 250 mg/5 ml oral suspension	1	
cefaclor 375 mg/5 ml oral suspension	1	
cefaclor 500 mg capsule	1	
cefaclor er 500 mg tablet,extended release,12 hr	1	
cefadroxil 1 gram tablet	1	
cefadroxil 250 mg/5 ml oral suspension	1	
cefadroxil 500 mg capsule	1	
cefadroxil 500 mg/5 ml oral suspension	1	
cefdinir 125 mg/5 ml oral suspension	1	
cefdinir 250 mg/5 ml oral suspension	1	
cefdinir 300 mg capsule	1	
cefixime 100 mg/5 ml oral suspension	1	
cefixime 200 mg/5 ml oral suspension	1	
cefixime 400 mg capsule	1	
cefpodoxime 100 mg tablet	1	
cefpodoxime 100 mg/5 ml oral suspension	1	
cefpodoxime 200 mg tablet	1	
cefpodoxime 50 mg/5 ml oral suspension	1	
cefprozil 125 mg/5 ml oral suspension	1	
cefprozil 250 mg tablet	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
cefprozil 250 mg/5 ml oral suspension	1	
cefprozil 500 mg tablet	1	
cefuroxime axetil 250 mg tablet	1	
cefuroxime axetil 500 mg tablet	1	
CELEBREX 100 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
CELEBREX 200 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
CELEBREX 400 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
CELEBREX 50 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
celecoxib 100 mg capsule ^{MM}	1	QL(60 per 30 days)
celecoxib 200 mg capsule ^{MM}	1	QL(60 per 30 days)
celecoxib 400 mg capsule ^{MM}	1	QL(60 per 30 days)
celecoxib 50 mg capsule ^{MM}	1	QL(60 per 30 days)
CELEXA 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
CELEXA 20 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
CELEXA 40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
CELLCEPT 200 MG/ML ORAL SUSPENSION ^{MM}	3	
CELLCEPT 250 MG CAPSULE ^{MM}	3	QL(360 per 30 days)
CELLCEPT 500 MG TABLET ^{MM}	3	QL(180 per 30 days)
CELLTRION DIATRUST COVID-19 AG HOME TEST KIT	3	
CELONTIN 300 MG CAPSULE ^{MM}	3	
CENTANY 2 % TOPICAL OINTMENT	3	
cephalexin 125 mg/5 ml oral suspension	1	
cephalexin 250 mg capsule	1	
cephalexin 250 mg tablet	1	
cephalexin 250 mg/5 ml oral suspension	1	
cephalexin 500 mg capsule	1	
cephalexin 500 mg tablet	1	
cephalexin 750 mg capsule	1	
CEQUA 0.09 % EYE DROPS IN A DROPPERETTE ^{MM}	3	PA,QL(60 per 30 days)
CERDELGA 84 MG CAPSULE ^{DL,MM,SP}	*	PA
cetirizine 1 mg/ml oral solution	1	QL(300 per 30 days)
CETRAXAL 0.2 % EAR DROPS IN A DROPPERETTE	3	ST
cevimeline 30 mg capsule ^{MM}	1	
charlotte 24 fe 1 mg-20 mcg (24)/75 mg (4) chewable tablet ^{MM}	1	
chateal (28) 0.15 mg-0.03 mg tablet ^{MM}	1	
chateal eq (28) 0.15 mg-0.03 mg tablet ^{MM}	1	
CHEMET 100 MG CAPSULE	3	
CHEMSTRIP 10 MD	2	
CHENODAL 250 MG TABLET ^{DL,SP}	*	
chlordiazepoxide 10 mg capsule ^{DL}	1	QL(120 per 30 days)
chlordiazepoxide 25 mg capsule ^{DL}	1	QL(120 per 30 days)
chlordiazepoxide 5 mg capsule ^{DL}	1	QL(120 per 30 days)
chlordiazepoxide-clidinium 5 mg-2.5 mg capsule	1	
chlorhexidine gluconate 0.12 % mouthwash	1	
chloroquine 250 mg tablet	1	
chloroquine 500 mg tablet	1	
chlorpromazine 10 mg tablet ^{MM}	1	
chlorpromazine 100 mg tablet ^{MM}	1	
chlorpromazine 100 mg/ml oral concentrate ^{MM}	1	
chlorpromazine 200 mg tablet ^{MM}	1	
chlorpromazine 25 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
chlorpromazine 30 mg/ml oral concentrate ^{MM}	1	
chlorpromazine 50 mg tablet ^{MM}	1	
chlorthalidone 25 mg tablet ^{MM}	1	
chlorthalidone 50 mg tablet ^{MM}	1	
chlorzoxazone 250 mg tablet	1	ST,QL(120 per 30 days)
chlorzoxazone 375 mg tablet	1	ST,QL(120 per 30 days)
chlorzoxazone 500 mg tablet	1	ST,QL(120 per 30 days)
chlorzoxazone 750 mg tablet	1	ST,QL(120 per 30 days)
CHOICE DM CLARUS NORMAL CONTROL SOLUTION ^{MM}	3	
CHOICEDM CLARUS ^{MM}	3	ST
CHOICEDM CLARUS STRIPS ^{MM}	3	ST,QL(150 per 30 days)
CHOLBAM 250 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
CHOLBAM 50 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
cholestyramine (with sugar) 4 gram oral powder ^{MM}	1	
cholestyramine (with sugar) 4 gram powder for susp in a packet ^{MM}	1	
cholestyramine light 4 gram oral powder ^{MM}	1	
cholestyramine light 4 gram powder for susp in a packet ^{MM}	1	
cholestyramine-aspartame 4 gram oral powder for susp in a packet ^{MM}	1	
CIBINQO 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CIBINQO 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
CIBINQO 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ciclodan 0.77 % topical cream	1	
ciclopirox 0.77 % topical cream	1	
ciclopirox 0.77 % topical gel	1	
ciclopirox 0.77 % topical suspension	1	
ciclopirox 1 % shampoo	1	
cilostazol 100 mg tablet ^{MM}	1	
cilostazol 50 mg tablet ^{MM}	1	
CILOXAN 0.3 % EYE DROPS	3	
CILOXAN 0.3 % EYE OINTMENT	3	
CIMDUO 300 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
cimetidine 200 mg tablet ^{MM}	1	
cimetidine 300 mg tablet ^{MM}	1	
cimetidine 300 mg/5 ml oral solution ^{MM}	1	
cimetidine 400 mg tablet ^{MM}	1	
cimetidine 800 mg tablet ^{MM}	1	
CIMZIA 400 MG/2 ML (200 MG/ML X 2) SUBCUTANEOUS SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(3 per 30 days)
CIMZIA STARTER KIT 400 MG/2 ML (200 MG/ML X2) SUBCUTANEOUS SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(3 per 30 days)
cinacalcet 30 mg tablet ^{MM}	1	QL(60 per 30 days)
cinacalcet 60 mg tablet ^{MM}	1	QL(60 per 30 days)
cinacalcet 90 mg tablet ^{MM}	1	QL(120 per 30 days)
CIPRO 250 MG TABLET	3	
CIPRO 250 MG/5 ML ORAL SUSPENSION	3	
CIPRO 500 MG TABLET	3	
CIPRO 500 MG/5 ML ORAL SUSPENSION	3	
CIPRO HC 0.2 %-1 % EAR DROPS,SUSPENSION	3	ST
CIPRODEX 0.3 %-0.1 % EAR DROPS,SUSPENSION	3	ST,QL(7.5 per 30 days)
ciprofloxacin 0.2 % ear drops in a dropperette	1	
ciprofloxacin 0.3 % eye drops	1	
ciprofloxacin 0.3 %-dexamethasone 0.1 % ear drops,suspension	1	QL(7.5 per 30 days)
ciprofloxacin 0.3 %-fluocinolone 0.025 % (0.25 ml) ear solution	1	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ciprofloxacin 100 mg tablet	1	
ciprofloxacin 250 mg tablet	1	
ciprofloxacin 250 mg/5 ml oral suspension	1	
ciprofloxacin 500 mg tablet	1	
ciprofloxacin 500 mg/5 ml oral suspension	1	
ciprofloxacin 750 mg tablet	1	
citalopram 10 mg tablet ^{MM}	1	QL(30 per 30 days)
citalopram 10 mg/5 ml oral solution ^{MM}	1	
citalopram 20 mg tablet ^{MM}	1	QL(60 per 30 days)
CITALOPRAM 30 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
citalopram 40 mg tablet ^{MM}	1	QL(30 per 30 days)
CITRANATAL B-CALM (FE GLUC) 20 MG IRON-1 MG-25 MG/25 MG TABLETS ^{MM}	3	
claravis 10 mg capsule	1	QL(60 per 30 days)
claravis 20 mg capsule	1	QL(60 per 30 days)
claravis 30 mg capsule	1	QL(60 per 30 days)
claravis 40 mg capsule	1	QL(120 per 30 days)
CLARINEX 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
CLARINEX-D 12 HOUR 2.5 MG-120 MG TABLET,EXTENDED RELEASE	3	ST,QL(60 per 30 days)
clarithromycin 125 mg/5 ml oral suspension	1	
clarithromycin 250 mg tablet	1	
clarithromycin 250 mg/5 ml oral suspension	1	
clarithromycin 500 mg tablet	1	
clarithromycin er 500 mg tablet,extended release 24 hr	1	
clemastine 0.5 mg/5 ml oral syrup ^{DL,SP}	*	PA,QL(1800 per 30 days)
clemastine 2.68 mg tablet	1	
CLENPIQ 10 MG-3.5 GRAM-12 GRAM/160 ML ORAL SOLUTION	2	
CLENPIQ 10 MG-3.5 GRAM-12 GRAM/175 ML ORAL SOLUTION	2	
CLEOCIN 100 MG VAGINAL SUPPOSITORY	3	
CLEOCIN 2 % VAGINAL CREAM	3	
CLEOCIN HCL 150 MG CAPSULE	3	
CLEOCIN HCL 300 MG CAPSULE	3	
CLEOCIN HCL 75 MG CAPSULE	3	
CLEOCIN PEDIATRIC 75 MG/5 ML ORAL SOLUTION	3	
CLEOCIN T 1 % LOTION	3	
CLEOCIN T 1 % SOLUTION	3	
CLEVER CHEK BLOOD GLUCOSE ^{MM}	3	ST
CLEVER CHEK BLOOD GLUCOSE SYST KIT ^{MM}	3	ST
CLEVER CHEK LANCETS 30 GAUGE ^{MM}	2	
CLEVER CHOICE BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
CLEVER CHOICE HOLDING CHAMBER-LARGE MASK	3	
CLEVER CHOICE HOLDING CHAMBER-MEDIUM MASK	3	
CLEVER CHOICE HOLDING CHAMBER-SMALL MASK	3	
CLEVER CHOICE LEVEL 1 CONTROL SOLUTION ^{MM}	3	
CLEVER CHOICE LEVEL 2 CONTROL SOLUTION ^{MM}	3	
CLEVER CHOICE LEVEL 3 CONTROL SOLUTION ^{MM}	3	
CLEVER CHOICE MICRO ^{MM}	3	ST
CLEVER CHOICE MICRO TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
CLEVER CHOICE MINI BLOOD GLUCOSE MONITOR ^{MM}	3	ST
CLEVER CHOICE PRO BLOOD GLUCOSE MONITOR ^{MM}	3	ST
CLEVER CHOICE PRO BLOOD GLUCOSE MONITOR STRIPS ^{MM}	3	ST,QL(150 per 30 days)
CLEVER CHOICE TALK BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
CLEVER CHOICE TALK TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CLEVER CHOICE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
CLEVER CHOICE VOICE PLUS TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
CLICKFINE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
CLICKFINE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
CLICKFINE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
CLIMARA 0.025 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CLIMARA 0.0375 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CLIMARA 0.05 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CLIMARA 0.06 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CLIMARA 0.075 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CLIMARA 0.1 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
CLIMARA PRO 0.045 MG-0.015 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(4 per 28 days)
clindacin 1 % topical foam	1	ST
clindacin etz 1 % topical swab	1	
clindacin p 1 % topical swab	1	
CLINDAGEL 1 % TOPICAL GEL, ONCE DAILY ^{DL,SP}	*	PA
clindamycin 1 % lotion	1	
clindamycin 1 % topical foam	1	ST
clindamycin 1 % topical gel	1	PA
clindamycin 1 % topical gel, once daily ^{DL,SP}	*	PA
clindamycin 1 %-benzoyl peroxide 5 % topical gel	1	
clindamycin 1 %-benzoyl peroxide 5 % topical gel with pump	1	
clindamycin 1.2 % (1 % base)-benzoyl peroxide 5 % topical gel	1	
clindamycin 1.2 %-benzoyl peroxide 2.5 % topical gel with pump	1	ST
clindamycin 2 % vaginal cream	1	
clindamycin hcl 150 mg capsule	1	
clindamycin hcl 300 mg capsule	1	
clindamycin hcl 75 mg capsule	1	
clindamycin pediatric 75 mg/5 ml oral solution	1	
clindamycin phosphate 1 % topical solution	1	
clindamycin phosphate 1 % topical swab	1	
clindamycin-tretinoin 1.2 %-0.025 % topical gel	1	ST
CLINDESSE 2 % VAGINAL CREAM,EXTENDED RELEASE	3	
CLINIMIX 4.25 % IN 10 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINIMIX 4.25 % IN 5 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINIMIX 5 % IN 15 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINIMIX 5 % IN 20 % DEXTROSE (SULFITE-FREE) INTRAVENOUS SOLUTION	3	
CLINIMIX E 2.75 % IN 5 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINIMIX E 4.25 % IN 10 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINIMIX E 4.25 % IN 5 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINIMIX E 5 % IN 15 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINIMIX E 5 % IN 20 % DEXTROSE SULFITE FREE INTRAVENOUS SOLUTION	3	
CLINITEST COVID-19 HOME TEST KIT	3	
clobazam 10 mg tablet ^{DL,MM}	1	PA,QL(60 per 30 days)
clobazam 2.5 mg/ml oral suspension ^{DL,MM}	1	PA,QL(480 per 30 days)
clobazam 20 mg tablet ^{DL,MM}	1	PA,QL(60 per 30 days)
clobetasol 0.05 % lotion	1	
clobetasol 0.05 % scalp solution	1	
clobetasol 0.05 % shampoo	1	
clobetasol 0.05 % topical cream	1	
clobetasol 0.05 % topical foam	1	ST
clobetasol 0.05 % topical gel	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
clobetasol 0.05 % topical ointment	1	
clobetasol 0.05 % topical spray	1	ST
clobetasol-emollient 0.05 % topical cream	1	
clobetasol-emollient 0.05 % topical foam	1	ST
CLOBEX 0.05 % LOTION	3	ST
CLOBEX 0.05 % SHAMPOO	3	ST
CLOBEX 0.05 % TOPICAL SPRAY	3	ST
clocortolone pivalate 0.1 % topical cream	1	ST
clodan 0.05 % shampoo	1	
CLODERM 0.1 % TOPICAL CREAM	3	ST
clomipramine 25 mg capsule ^{MM}	1	
clomipramine 50 mg capsule ^{MM}	1	
clomipramine 75 mg capsule ^{MM}	1	
clonazepam 0.125 mg disintegrating tablet ^{DL,MM}	1	
clonazepam 0.25 mg disintegrating tablet ^{DL,MM}	1	
clonazepam 0.5 mg disintegrating tablet ^{DL,MM}	1	
clonazepam 0.5 mg tablet ^{DL,MM}	1	
clonazepam 1 mg disintegrating tablet ^{DL,MM}	1	
clonazepam 1 mg tablet ^{DL,MM}	1	
clonazepam 2 mg disintegrating tablet ^{DL,MM}	1	
clonazepam 2 mg tablet ^{DL,MM}	1	
clonidine 0.1 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
clonidine 0.2 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
clonidine 0.3 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
clonidine hcl 0.1 mg tablet ^{MM}	1	
clonidine hcl 0.2 mg tablet ^{MM}	1	
clonidine hcl 0.3 mg tablet ^{MM}	1	
clonidine hcl er 0.1 mg tablet,extended release,12 hr ^{MM}	1	ST,QL(120 per 30 days)
clonidine hcl er 0.17 mg tablet,extended release 24 hr ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
clopidogrel 300 mg tablet	1	QL(1 per 30 days)
clopidogrel 75 mg tablet ^{MM}	1	QL(30 per 30 days)
clorazepate dipotassium 15 mg tablet ^{DL}	1	
clorazepate dipotassium 3.75 mg tablet ^{DL}	1	
clorazepate dipotassium 7.5 mg tablet ^{DL}	1	
clotrimazole 1 % topical cream	1	
clotrimazole 1 % topical solution	1	
clotrimazole 10 mg troche	1	
clotrimazole-betamethasone 1 %-0.05 % lotion	1	
clotrimazole-betamethasone 1 %-0.05 % topical cream	1	
clovique 250 mg capsule ^{DL,SP}	*	PA
clozapine 100 mg disintegrating tablet ^{MM}	1	
clozapine 100 mg tablet ^{MM}	1	
clozapine 12.5 mg disintegrating tablet ^{MM}	1	
clozapine 150 mg disintegrating tablet ^{MM}	1	
clozapine 200 mg disintegrating tablet ^{MM}	1	
clozapine 200 mg tablet ^{MM}	1	
clozapine 25 mg disintegrating tablet ^{MM}	1	
clozapine 25 mg tablet ^{MM}	1	
clozapine 50 mg tablet ^{MM}	1	
CLOZARIL 100 MG TABLET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CLOZARIL 200 MG TABLET ^{MM}	3	
CLOZARIL 25 MG TABLET ^{MM}	3	
CLOZARIL 50 MG TABLET ^{MM}	3	
COAGUCHEK LANCETS ^{MM}	2	
COARTEM 20 MG-120 MG TABLET	3	QL(24 per 30 days)
codeine sulfate 15 mg tablet ^{DL}	1	QL(360 per 30 days)
codeine sulfate 30 mg tablet ^{DL}	1	QL(360 per 30 days)
codeine sulfate 60 mg tablet ^{DL}	1	QL(180 per 30 days)
codeine-butalbital-asa-caffeine 30 mg-50 mg-325 mg-40 mg capsule ^{DL}	1	QL(360 per 30 days)
COLAZAL 750 MG CAPSULE	3	ST,QL(270 per 30 days)
colchicine 0.6 mg capsule ^{MM}	2	QL(60 per 30 days)
colchicine 0.6 mg tablet ^{MM}	1	QL(120 per 30 days)
COLCRYS 0.6 MG TABLET ^{MM}	3	ST,QL(120 per 30 days)
colesevelam 3.75 gram oral powder packet ^{MM}	1	PA
colesevelam 625 mg tablet ^{MM}	1	
COLESTID 1 GRAM TABLET ^{MM}	3	
COLESTID 5 GRAM ORAL GRANULES ^{MM}	3	
COLESTID 5 GRAM ORAL PACKET ^{MM}	3	
COLESTID FLAVORED 5 GRAM ORAL GRANULES ^{MM}	3	
COLESTID FLAVORED 7.5 GRAM PACKET ^{MM}	3	
colestipol 1 gram tablet ^{MM}	1	
colestipol 5 gram oral granules ^{MM}	1	
colestipol 5 gram oral packet ^{MM}	1	
COLOR LANCETS 21 GAUGE ^{MM}	2	
COMBIGAN 0.2 %-0.5 % EYE DROPS ^{MM}	2	QL(5 per 25 days)
COMBIPATCH 0.05 MG-0.14 MG/24 HR TRANSDERMAL ^{MM}	3	QL(8 per 28 days)
COMBIPATCH 0.05 MG-0.25 MG/24 HR TRANSDERMAL ^{MM}	3	QL(8 per 28 days)
COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION ^{MM}	3	ST,QL(4 per 20 days)
COMBIVIR 150 MG-300 MG TABLET ^{MM}	3	QL(60 per 30 days)
COMETRIQ 100 MG/DAY (80 MG X 1-20 MG X 1) CAPSULES ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
COMETRIQ 140 MG/DAY (80 MG X 1-20 MG X 3) CAPSULES ^{DL,MM,SP}	*	PA,QL(112 per 28 days)
COMETRIQ 60 MG/DAY (20 MG X 3/DAY) CAPSULES ^{DL,MM,SP}	*	PA,QL(84 per 28 days)
COMFORT EZ INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
COMFORT EZ INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
COMFORT EZ LANCETS 21 GAUGE ^{MM}	2	
COMFORT EZ LANCETS 23 GAUGE ^{MM}	2	
COMFORT EZ LANCETS 28 GAUGE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
COMFORT EZ PEN NEEDLES 29 GAUGE X 1/2"MM	2	
COMFORT EZ PEN NEEDLES 31 GAUGE X 1/4"MM	2	
COMFORT EZ PEN NEEDLES 31 GAUGE X 3/16"MM	2	
COMFORT EZ PEN NEEDLES 31 GAUGE X 5/16"MM	2	
COMFORT EZ PEN NEEDLES 32 GAUGE X 1/4"MM	2	
COMFORT EZ PEN NEEDLES 32 GAUGE X 3/16"MM	2	
COMFORT EZ PEN NEEDLES 32 GAUGE X 5/16"MM	2	
COMFORT EZ PEN NEEDLES 32 GAUGE X 5/32"MM	2	
COMFORT EZ PEN NEEDLES 33 GAUGE X 1/4"MM	2	
COMFORT EZ PEN NEEDLES 33 GAUGE X 3/16"MM	2	
COMFORT EZ PEN NEEDLES 33 GAUGE X 5/16"MM	2	
COMFORT EZ PEN NEEDLES 33 GAUGE X 5/32"MM	2	
COMFORT LANCETSMM	3	
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 1/4"MM	2	
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 3/16"MM	2	
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/16"MM	2	
COMFORT TOUCH PEN NEEDLE 31 GAUGE X 5/32"MM	2	
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 1/4"MM	2	
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 3/16"MM	2	
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/16"MM	2	
COMFORT TOUCH PEN NEEDLE 32 GAUGE X 5/32"MM	2	
COMFORT TOUCH PEN NEEDLE 33 GAUGE X 1/4"MM	2	
COMFORT TOUCH PEN NEEDLE 33 GAUGE X 3/16"MM	2	
COMFORT TOUCH PEN NEEDLE 33 GAUGE X 5/32"MM	2	
COMFORT TOUCH PLUS PRESSURE ACTIVATED SAFETY LANCETS 30 GAUGE ^{MM}	2	
COMFORT TOUCH ULTRA THIN LANCETS 31 GAUGE ^{MM}	2	
COMIRNATY TRIS VACCINE(PF) 30 MCG/0.3 ML INTRAMUSCULAR SUSPENSION	3	
COMPACT SPACE CHAMBER	2	
COMPACT SPACE CHAMBER PLUS	2	
COMPACT SPACE CHAMBER-LRG MASK	2	
COMPACT SPACE CHAMBER-MED MASK	2	
COMPACT SPACE CHAMBER-SM MASK	2	
COMPAZINE 10 MG TABLET	3	
COMPAZINE 25 MG RECTAL SUPPOSITORY	3	
COMPAZINE 5 MG TABLET	3	
COMPLERA 200 MG-25 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
complete natal dha 29 mg-1 mg-250 mg-200 mg oral pack ^{MM}	1	
completenate 29 mg iron-1 mg chewable tablet ^{MM}	1	
compro 25 mg rectal suppository	1	
COMTAN 200 MG TABLET ^{MM}	3	QL(300 per 30 days)
CONCEPT DHA 35 MG-1 MG-200 MG CAPSULE ^{MM}	3	
CONCEPT OB 85 MG-1 MG CAPSULE ^{MM}	3	
CONCERTA 18 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
CONCERTA 27 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
CONCERTA 36 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
CONCERTA 54 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
CONDYLOX 0.5 % TOPICAL GEL	3	
CONJUPRI 2.5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
CONJUPRI 5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
CONSENSI 10 MG-200 MG TABLET ^{DL,MM,SP}	*	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CONSENSI 2.5 MG-200 MG TABLET ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
CONSENSI 5 MG-200 MG TABLET ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
constulose 10 gram/15 ml oral solution ^{MM}	1	
CONTOUR CONTROL SOLUTION, HIGH ^{MM}	3	
CONTOUR CONTROL SOLUTION, LOW ^{MM}	3	
CONTOUR CONTROL SOLUTION, NORMAL ^{MM}	3	
CONTOUR METER ^{MM}	3	ST
CONTOUR METER KIT ^{MM}	3	ST
CONTOUR NEXT EZ METER ^{MM}	3	ST
CONTOUR NEXT EZ METER KIT ^{MM}	3	ST
CONTOUR NEXT GEN METER ^{MM}	3	ST
CONTOUR NEXT GEN METER KIT ^{MM}	3	ST
CONTOUR NEXT GLUCOSE METER KIT ^{MM}	3	ST
CONTOUR NEXT LEVEL 1 CONTROL SOLUTION ^{MM}	3	
CONTOUR NEXT LEVEL 2 CONTROL SOLUTION ^{MM}	3	
CONTOUR NEXT LINK 2.4 KIT ^{MM}	3	ST
CONTOUR NEXT LINK KIT ^{MM}	3	ST
CONTOUR NEXT METER ^{MM}	3	ST
CONTOUR NEXT ONE METER ^{MM}	3	ST
CONTOUR NEXT TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
CONTOUR TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
CONTROL AST MONITORING SYSTEM ^{MM}	3	ST
CONZIP 100 MG CAPSULE,EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
CONZIP 200 MG CAPSULE,EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
CONZIP 300 MG CAPSULE, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
COOL BLOOD GLUCOSE METER ^{MM}	3	ST
COOL BLOOD GLUCOSE METER KIT ^{MM}	3	ST
COOL CONTROL A SOLUTION ^{MM}	3	
COOL CONTROL B SOLUTION ^{MM}	3	
COOL GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
COPAXONE 20 MG/ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
COPAXONE 40 MG/ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(12 per 28 days)
COPIKTRA 15 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
COPIKTRA 25 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
CORDRAN 0.025 % TOPICAL CREAM	3	ST
CORDRAN 0.05 % LOTION ^{DL,SP}	*	ST
CORDRAN 0.05 % TOPICAL CREAM	3	ST
CORDRAN 0.05 % TOPICAL OINTMENT	3	ST
COREG 12.5 MG TABLET ^{MM}	3	
COREG 25 MG TABLET ^{MM}	3	
COREG 3.125 MG TABLET ^{MM}	3	
COREG 6.25 MG TABLET ^{MM}	3	
COREG CR 10 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
COREG CR 20 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
COREG CR 40 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
COREG CR 80 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
coremino 135 mg tablet,extended release	1	ST,QL(30 per 30 days)
coremino 45 mg tablet,extended release	1	ST,QL(30 per 30 days)
coremino 90 mg tablet,extended release	1	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CORGARD 20 MG TABLET ^{MM}	3	
CORGARD 40 MG TABLET ^{MM}	3	
CORGARD 80 MG TABLET ^{MM}	3	
CORLANOR 5 MG TABLET ^{MM}	2	PA,QL(60 per 30 days)
CORLANOR 5 MG/5 ML ORAL SOLUTION ^{MM}	2	PA,QL(560 per 28 days)
CORLANOR 7.5 MG TABLET ^{MM}	2	PA,QL(60 per 30 days)
CORTEF 10 MG TABLET ^{MM}	3	
CORTEF 20 MG TABLET ^{MM}	3	
CORTEF 5 MG TABLET ^{MM}	3	
CORTENEMA 100 MG/60 ML	3	
CORTIFOAM 10 % (80 MG) RECTAL	3	
CORTISPORIN-TC 3.3 MG-3 MG-10 MG-0.5 MG/ML EAR DROPS,SUSPENSION	3	
CORTROPHIN GEL 80 UNIT/ML INJECTION ^{DL,SP}	*	PA,QL(30 per 30 days)
corvita 150 150 mg-1.25 mg-120 mg-10 mg tablet	1	
CORVITE 150 150 MG IRON-1 MG TABLET	3	
CORVITE FE 150 MG IRON-1 MG TABLET	3	
COSENTYX 150 MG/ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(32 per 365 days)
COSENTYX 300 MG/2 SYRINGES (150 MG/ML) SUBCUTANEOUS ^{DL,LD,MM,SP}	*	PA,QL(32 per 365 days)
COSENTYX 75 MG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(8.5 per 365 days)
COSENTYX PEN 150 MG/ML SUBCUTANEOUS ^{DL,LD,MM,SP}	*	PA,QL(32 per 365 days)
COSENTYX PEN 300 MG/2 PENS (150 MG/ML) SUBCUTANEOUS ^{DL,LD,MM,SP}	*	PA,QL(32 per 365 days)
COSOPT (PF) 2 %-0.5 % EYE DROPS IN A DROPPERETTE ^{MM}	3	ST,QL(60 per 30 days)
COSOPT 22.3 MG-6.8 MG/ML EYE DROPS ^{MM}	3	ST,QL(10 per 30 days)
COTELLIC 20 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(63 per 28 days)
COTEMPLA XR-ODT 17.3 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
COTEMPLA XR-ODT 25.9 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(60 per 30 days)
COTEMPLA XR-ODT 8.6 MG EXTENDED RELEASE DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
covaryx 1.25 mg-2.5 mg tablet ^{MM}	1	
covaryx h.s. 0.625 mg-1.25 mg tablet ^{MM}	1	
COVID-19 AT-HOME TEST KIT	3	
COZAAR 100 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
COZAAR 25 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
COZAAR 50 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
CREON 12,000-38,000-60,000 UNIT CAPSULE,DELAYED RELEASE ^{MM}	2	
CREON 24,000-76,000-120,000 UNIT CAPSULE,DELAYED RELEASE ^{MM}	2	
CREON 3,000 UNIT-9,500 UNIT-15,000 UNIT CAPSULE,DELAYED RELEASE ^{MM}	2	
CREON 36,000 UNIT-114,000 UNIT-180,000 UNIT CAPSULE,DELAYED RELEASE ^{MM}	2	
CREON 6,000-19,000-30,000 UNIT CAPSULE,DELAYED RELEASE ^{MM}	2	
CRESEMBA 186 MG CAPSULE ^{DL,SP}	*	PA
CRESTOR 10 MG TABLET ^{MM}	3	ST
CRESTOR 20 MG TABLET ^{MM}	3	ST
CRESTOR 40 MG TABLET ^{MM}	3	ST
CRESTOR 5 MG TABLET ^{MM}	3	ST
CRINONE 4 % VAGINAL GEL	3	QL(8.7 per 30 days)
cromolyn 100 mg/5 ml oral concentrate ^{DL,SP}	*	
cromolyn 20 mg/2 ml solution for nebulization ^{DL,MM,SP}	*	
cromolyn 4 % eye drops	1	
croton 10 % lotion ^{DL,SP}	*	PA
cryselle (28) 0.3 mg-30 mcg tablet ^{MM}	1	
CUE COVID-19 HOME TEST KIT	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CUPRIMINE 250 MG CAPSULE ^{DL,MM,SP}	*	PA
CUROSURF 120 MG/1.5 ML INTRATRACHEAL SUSPENSION	3	
CUROSURF 240 MG/3 ML INTRATRACHEAL SUSPENSION	3	
CUTAQUIG 16.5 % SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
CUTIVATE 0.05 % LOTION	3	ST
CUTIVATE 0.05 % TOPICAL CREAM	3	
CUVITRU 1 GRAM/5 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
CUVITRU 10 GRAM/50 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
CUVITRU 2 GRAM/10 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
CUVITRU 4 GRAM/20 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
CUVITRU 8 GRAM/40 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
CUVPOSA 1 MG/5 ML (0.2 MG/ML) ORAL SOLUTION ^{MM}	3	
CUVRIOR 300 MG TABLET ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
cyanocobalamin (vit b-12) 1,000 mcg/ml injection solution ^{MM}	1	QL(30 per 30 days)
cyclafem 1/35 (28) 1 mg-35 mcg tablet ^{MM}	1	
cyclafem 7/7/7 (28) 0.5 mg/0.75 mg/1 mg-35 mcg tablet ^{MM}	1	
cyclobenzaprine 10 mg tablet	1	
cyclobenzaprine 5 mg tablet	1	
cyclobenzaprine 7.5 mg tablet	1	PA,QL(90 per 30 days)
cyclobenzaprine er 15 mg capsule,extended release 24 hr	1	PA,QL(21 per 30 days)
cyclobenzaprine er 30 mg capsule,extended release 24 hr	1	PA,QL(21 per 30 days)
CYCLOGYL 0.5 % EYE DROPS	3	
CYCLOGYL 1 % EYE DROPS	3	
CYCLOGYL 2 % EYE DROPS	3	
CYCLOMYDRIL 0.2 %-1 % EYE DROPS	3	
cyclopentolate 0.5 % eye drops	1	
cyclopentolate 1 % eye drops	1	
cyclopentolate 2 % eye drops	1	
cyclophosphamide 25 mg capsule ^{DL,SP}	*	QL(960 per 30 days)
cyclophosphamide 25 mg tablet ^{DL,SP}	*	QL(960 per 30 days)
cyclophosphamide 50 mg capsule ^{DL,SP}	*	QL(480 per 30 days)
cyclophosphamide 50 mg tablet ^{DL,SP}	*	QL(480 per 30 days)
cyclorine 250 mg capsule	1	
CYCLOSET 0.8 MG TABLET ^{MM}	3	ST,QL(180 per 30 days)
cyclosporine 0.05 % eye drops in a dropperette ^{MM}	1	PA,QL(60 per 30 days)
cyclosporine 100 mg capsule ^{MM}	1	QL(720 per 30 days)
cyclosporine 25 mg capsule ^{MM}	1	
cyclosporine modified 100 mg capsule ^{MM}	1	QL(720 per 30 days)
cyclosporine modified 100 mg/ml oral solution ^{MM}	1	
cyclosporine modified 25 mg capsule ^{MM}	1	
cyclosporine modified 50 mg capsule ^{MM}	1	
CYMBALTA 20 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
CYMBALTA 30 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(90 per 30 days)
CYMBALTA 60 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
cyproheptadine 2 mg/5 ml oral syrup	1	
cyproheptadine 4 mg tablet	1	
cyred 0.15 mg-0.03 mg tablet ^{MM}	1	
cyred eq 0.15 mg-0.03 mg tablet ^{MM}	1	
CYSTADANE 1 GRAM/SCOOP ORAL POWDER ^{DL,MM,SP}	*	
CYSTADROPS 0.37 % EYE DROPS ^{DL,MM,SP}	*	PA,QL(20 per 28 days)
CYSTAGON 150 MG CAPSULE ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
CYSTAGON 50 MG CAPSULE ^{MM}	3	
CYSTARAN 0.44 % EYE DROPS ^{DL,MM,SP}	*	PA,QL(60 per 28 days)
CYTOMEL 25 MCG TABLET ^{MM}	3	
CYTOMEL 5 MCG TABLET ^{MM}	3	
CYTOMEL 50 MCG TABLET ^{MM}	3	
CYTOTEC 100 MCG TABLET ^{MM}	3	
CYTOTEC 200 MCG TABLET ^{MM}	3	
D.H.E.45 1 MG/ML INJECTION SOLUTION ^{DL,SP}	*	
dabigatran etexilate 150 mg capsule ^{MM}	1	QL(60 per 30 days)
dabigatran etexilate 75 mg capsule ^{MM}	1	QL(60 per 30 days)
dalfampridine er 10 mg tablet,extended release,12 hr ^{MM}	1	PA,QL(60 per 30 days)
DALIRESP 250 MCG TABLET ^{MM}	3	QL(28 per 365 days)
DALIRESP 500 MCG TABLET ^{MM}	3	QL(30 per 30 days)
danazol 100 mg capsule	1	
danazol 200 mg capsule	1	
danazol 50 mg capsule	1	
DANTRIUM 25 MG CAPSULE ^{MM}	3	
DANTRIUM 50 MG CAPSULE ^{MM}	3	
dantrolene 100 mg capsule ^{MM}	1	
dantrolene 25 mg capsule ^{MM}	1	
dantrolene 50 mg capsule ^{MM}	1	
dapsone 100 mg tablet ^{MM}	1	
dapsone 25 mg tablet ^{MM}	1	
dapsone 5 % topical gel	1	ST
dapsone 7.5 % topical gel with pump	1	ST
DARAPRIM 25 MG TABLET ^{DL,SP}	*	ST
darifenacin er 15 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
darifenacin er 7.5 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
DARIO BLOOD GLUCOSE MONITOR ^{MM}	3	ST
DARIO BLOOD GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
DARTISLA 1.7 MG DISINTEGRATING TABLET	3	ST,QL(120 per 30 days)
dasetta 1/35 (28) 1 mg-35 mcg tablet ^{MM}	1	
dasetta 7/7/7 (28) 0.5 mg(7)/0.75 mg(7)/1 mg(7)-35 mcg tablet ^{MM}	1	
DAURISMO 100 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
DAURISMO 25 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
DAYBUE 200 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(3600 per 30 days)
DAYPRO 600 MG TABLET	3	
daysee 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
DAYTRANA 10 MG/9 HR DAILY PATCH ^{MM}	3	ST,QL(30 per 30 days)
DAYTRANA 15 MG/9 HR DAILY PATCH ^{MM}	3	ST,QL(30 per 30 days)
DAYTRANA 20 MG/9 HR DAILY PATCH ^{MM}	3	ST,QL(30 per 30 days)
DAYTRANA 30 MG/9 HR DAILY PATCH ^{MM}	3	ST,QL(30 per 30 days)
DAYVIGO 10 MG TABLET	3	ST,QL(30 per 30 days)
DAYVIGO 5 MG TABLET	3	ST,QL(30 per 30 days)
DDAVP 0.1 MG TABLET ^{MM}	3	QL(180 per 30 days)
DDAVP 0.1 MG/ML (REFRIGERATE) NASAL SOLUTION ^{MM}	3	QL(10 per 25 days)
DDAVP 0.2 MG TABLET ^{MM}	3	QL(180 per 30 days)
DDAVP 4 MCG/ML INJECTION SOLUTION	3	
deblitane 0.35 mg tablet ^{MM}	1	
deferasirox 125 mg dispersible tablet ^{DL,MM,SP}	*	PA,QL(150 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
deferasirox 180 mg oral granules in packet ^{DL,MM,SP}	*	PA,QL(600 per 30 days)
deferasirox 180 mg tablet ^{DL,MM,SP}	*	PA,QL(600 per 30 days)
deferasirox 250 mg dispersible tablet ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
deferasirox 360 mg oral granules in packet ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
deferasirox 360 mg tablet ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
deferasirox 500 mg dispersible tablet ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
deferasirox 90 mg oral granules in packet ^{DL,MM,SP}	*	PA,QL(1200 per 30 days)
deferasirox 90 mg tablet ^{DL,MM,SP}	*	PA,QL(1200 per 30 days)
deferiprone 1,000 mg tablet ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
deferiprone 500 mg tablet ^{DL,MM,SP}	*	PA,QL(720 per 30 days)
DELSTRIGO 100 MG-300 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
DELZICOL 400 MG CAPSULE (DR TABLETS INSIDE) ^{MM}	3	ST,QL(180 per 30 days)
demeclocycline 150 mg tablet	1	
demeclocycline 300 mg tablet	1	
DEMSER 250 MG CAPSULE ^{LD}	3	
DENA VIR 1 % TOPICAL CREAM ^{DL,SP}	*	PA
DEPAKOTE 125 MG TABLET,DELAYED RELEASE ^{MM}	3	ST
DEPAKOTE 250 MG TABLET,DELAYED RELEASE ^{MM}	3	ST
DEPAKOTE 500 MG TABLET,DELAYED RELEASE ^{MM}	3	ST
DEPAKOTE ER 250 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
DEPAKOTE ER 500 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
DEPAKOTE SPRINKLES 125 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST
DEPEN TITRATABS 250 MG TABLET ^{DL,MM,SP}	*	PA
DEPO-PROVERA 150 MG/ML INTRAMUSCULAR SUSPENSION ^{MM}	3	QL(1 per 90 days)
DEPO-PROVERA 150 MG/ML INTRAMUSCULAR SYRINGE ^{MM}	3	QL(1 per 90 days)
DEPO-SUBQ PROVERA 104 104 MG/0.65 ML SUBCUTANEOUS SYRINGE ^{MM}	3	QL(0.65 per 90 days)
DEPO-TESTOSTERONE 100 MG/ML INTRAMUSCULAR OIL ^{MM}	3	QL(24 per 90 days)
DEPO-TESTOSTERONE 200 MG/ML INTRAMUSCULAR OIL ^{MM}	3	QL(24 per 90 days)
DERMA-SMOOTHIE/FS BODY OIL 0.01 %	3	ST
DERMA-SMOOTHIE/FS SCALP OIL 0.01 %	3	ST
DERMOTIC OIL 0.01 % EAR DROPS	3	
DESCOVY 120 MG-15 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
DESCOVY 200 MG-25 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
desflurane 100 % inhalation liquid	1	
desipramine 10 mg tablet ^{MM}	1	
desipramine 100 mg tablet ^{MM}	1	
desipramine 150 mg tablet ^{MM}	1	
desipramine 25 mg tablet ^{MM}	1	
desipramine 50 mg tablet ^{MM}	1	
desipramine 75 mg tablet ^{MM}	1	
desloratadine 2.5 mg disintegrating tablet ^{MM}	1	ST,QL(30 per 30 days)
desloratadine 5 mg disintegrating tablet ^{MM}	1	ST,QL(30 per 30 days)
desloratadine 5 mg tablet ^{MM}	1	QL(30 per 30 days)
desmopressin 0.1 mg tablet ^{MM}	1	QL(180 per 30 days)
desmopressin 0.2 mg tablet ^{MM}	1	QL(180 per 30 days)
desmopressin 10 mcg/spray (0.1 ml) nasal spray ^{MM}	1	QL(25 per 30 days)
desmopressin 10 mcg/spray (0.1 ml) nasal spray (non-refrigerated) ^{MM}	1	QL(25 per 30 days)
desmopressin 4 mcg/ml injection solution	1	
desogestrel 0.15 mg-ethinyl estradiol 0.03 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
desogestrel-e.estradiol 0.15 mg-0.02 mg(21)/e.estrad 0.01 mg(5) tablet ^{MM}	1	
desonide 0.05 % lotion	1	
desonide 0.05 % topical cream	1	
desonide 0.05 % topical gel	1	
desonide 0.05 % topical ointment	1	
DESOWEN 0.05 % TOPICAL CREAM	3	
desoximetasone 0.05 % topical cream	1	
desoximetasone 0.05 % topical gel	1	
desoximetasone 0.05 % topical ointment	1	
desoximetasone 0.25 % topical cream	1	
desoximetasone 0.25 % topical ointment	1	
desoximetasone 0.25 % topical spray	1	ST
DESOXYN 5 MG TABLET ^{MM}	3	ST,QL(150 per 30 days)
desrx 0.05 % topical gel	1	
desvenlafaxine er 100 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
desvenlafaxine er 50 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
desvenlafaxine succinate er 100 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
desvenlafaxine succinate er 25 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
desvenlafaxine succinate er 50 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
DETROL 1 MG TABLET ^{MM}	3	QL(60 per 30 days)
DETROL 2 MG TABLET ^{MM}	3	QL(60 per 30 days)
DETROL LA 2 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
DETROL LA 4 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
dexabliss 1.5 mg (39 tabs) tablets in a dose pack	1	
dexamethasone 0.5 mg tablet	1	
dexamethasone 0.5 mg/5 ml oral elixir	1	
dexamethasone 0.5 mg/5 ml oral solution	1	
dexamethasone 0.75 mg tablet	1	
dexamethasone 1 mg tablet	1	
dexamethasone 1.5 mg (21 tabs) tablets in a dose pack	1	
dexamethasone 1.5 mg (35 tabs) tablets in a dose pack	1	
dexamethasone 1.5 mg (51 tabs) tablets in a dose pack	1	
dexamethasone 1.5 mg tablet	1	
dexamethasone 2 mg tablet	1	
dexamethasone 4 mg tablet	1	
dexamethasone 6 mg tablet	1	
dexamethasone intensol 1 mg/ml drops (concentrate)	1	
dexamethasone sodium phosphate 0.1 % eye drops	1	
dexchlorpheniramine maleate 2 mg/5 ml oral solution ^{DL}	1	PA
DEXCOM G4 RECEIVER ^{MM}	3	PA
DEXCOM G4 RECEIVER PEDIATRIC ^{MM}	3	PA
DEXCOM G4 RECEIVER WITH SHARE (PEDIATRIC) ^{MM}	3	PA
DEXCOM G4 RECEIVER WITH SHARE KIT ^{MM}	3	PA
DEXCOM G4 TRANSMITTER DEVICE ^{MM}	3	PA
DEXCOM G5 RECEIVER ^{MM}	3	PA
DEXCOM G5 TRANSMITTER DEVICE ^{MM}	3	PA
DEXCOM G5-G4 SENSOR DEVICE ^{MM}	3	PA
DEXCOM G6 RECEIVER ^{MM}	3	PA
DEXCOM G6 SENSOR DEVICE ^{MM}	3	PA
DEXCOM G6 TRANSMITTER DEVICE ^{MM}	3	PA
DEXCOM G7 RECEIVER ^{MM}	3	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
DEXCOM G7 SENSOR DEVICE ^{MM}	3	PA
DEXCOM RECEIVER ^{MM}	3	PA
DEXEDRINE SPANSULE 10 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(180 per 30 days)
DEXEDRINE SPANSULE 15 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(120 per 30 days)
DEXEDRINE SPANSULE 5 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
DEXILANT 30 MG CAPSULE, DELAYED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
DEXILANT 60 MG CAPSULE, DELAYED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
dexlansoprazole 30 mg capsule,biphase delayed release ^{MM}	3	ST,QL(30 per 30 days)
dexlansoprazole 60 mg capsule,biphase delayed release ^{MM}	3	ST,QL(30 per 30 days)
dexmethylphenidate 10 mg tablet ^{MM}	1	QL(60 per 30 days)
dexmethylphenidate 2.5 mg tablet ^{MM}	1	QL(60 per 30 days)
dexmethylphenidate 5 mg tablet ^{MM}	1	QL(60 per 30 days)
dexmethylphenidate er 10 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dexmethylphenidate er 15 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dexmethylphenidate er 20 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dexmethylphenidate er 25 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dexmethylphenidate er 30 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dexmethylphenidate er 35 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dexmethylphenidate er 40 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dexmethylphenidate er 5 mg capsule,extended release biphasic50-50 ^{MM}	1	QL(30 per 30 days)
dextroamphetamine sulfate 10 mg tablet ^{MM}	1	QL(180 per 30 days)
dextroamphetamine sulfate 15 mg tablet ^{MM}	1	ST,QL(120 per 30 days)
dextroamphetamine sulfate 20 mg tablet ^{MM}	1	ST,QL(90 per 30 days)
dextroamphetamine sulfate 30 mg tablet ^{MM}	1	ST,QL(60 per 30 days)
dextroamphetamine sulfate 5 mg tablet ^{MM}	1	QL(150 per 30 days)
dextroamphetamine sulfate 5 mg/5 ml oral solution ^{MM}	1	ST,QL(1800 per 30 days)
dextroamphetamine sulfate er 10 mg capsule,extended release ^{MM}	1	ST,QL(180 per 30 days)
dextroamphetamine sulfate er 15 mg capsule,extended release ^{MM}	1	ST,QL(120 per 30 days)
dextroamphetamine sulfate er 5 mg capsule,extended release ^{MM}	1	ST,QL(60 per 30 days)
dextroamphetamine-amphetamine 10 mg tablet ^{MM}	1	QL(90 per 30 days)
dextroamphetamine-amphetamine 12.5 mg tablet ^{MM}	1	QL(90 per 30 days)
dextroamphetamine-amphetamine 15 mg tablet ^{MM}	1	QL(90 per 30 days)
dextroamphetamine-amphetamine 20 mg tablet ^{MM}	1	QL(90 per 30 days)
dextroamphetamine-amphetamine 30 mg tablet ^{MM}	1	QL(60 per 30 days)
dextroamphetamine-amphetamine 5 mg tablet ^{MM}	1	QL(90 per 30 days)
dextroamphetamine-amphetamine 7.5 mg tablet ^{MM}	1	QL(90 per 30 days)
dextroamphetamine-amphetamine er 10 mg 24hr capsule,extend release ^{MM}	1	QL(30 per 30 days)
dextroamphetamine-amphetamine er 15 mg 24hr capsule,extend release ^{MM}	1	QL(30 per 30 days)
dextroamphetamine-amphetamine er 20 mg 24hr capsule,extend release ^{MM}	1	QL(60 per 30 days)
dextroamphetamine-amphetamine er 25 mg 24hr capsule,extend release ^{MM}	1	QL(60 per 30 days)
dextroamphetamine-amphetamine er 30 mg 24hr capsule,extend release ^{MM}	1	QL(60 per 30 days)
dextroamphetamine-amphetamine er 5 mg 24hr capsule,extend release ^{MM}	1	QL(30 per 30 days)
dextrose 40 % oral gel	1	
DHIVY 25 MG-100 MG TABLET ^{MM}	3	
DIACOMIT 250 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
DIACOMIT 250 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
DIACOMIT 500 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
DIACOMIT 500 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
DIASTAT 2.5 MG RECTAL KIT ^{DL}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
DIASTAT ACUDIAL 12.5 MG-15 MG-17.5 MG-20 MG RECTAL KIT ^{DL}	3	
DIASTAT ACUDIAL 5 MG-7.5 MG-10 MG RECTAL KIT ^{DL}	3	
DIATRUE CONTROL SOLUTION HIGH ^{MM}	3	
DIATRUE CONTROL SOLUTION LOW ^{MM}	3	
DIATRUE CONTROL SOLUTION NORMAL ^{MM}	3	
DIATRUE PLUS BLOOD GLUCOSE METER SYSTEM ^{MM}	3	ST
DIATRUE PLUS TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
diazepam 10 mg tablet ^{DL}	1	QL(120 per 30 days)
diazepam 12.5 mg-15 mg-17.5 mg-20 mg rectal kit ^{DL}	1	
diazepam 2 mg tablet ^{DL}	1	QL(90 per 30 days)
diazepam 2.5 mg rectal kit ^{DL}	1	
diazepam 5 mg tablet ^{DL}	1	QL(90 per 30 days)
diazepam 5 mg-7.5 mg-10 mg rectal kit ^{DL}	1	
diazepam 5 mg/5 ml (1 mg/ml) oral solution ^{DL}	1	QL(1200 per 30 days)
diazepam 5 mg/5 ml (1 mg/ml, 5 ml) oral solution ^{DL}	1	QL(1200 per 30 days)
diazepam 5 mg/ml oral concentrate ^{DL}	1	QL(240 per 30 days)
diazepam intensol 5 mg/ml oral concentrate ^{DL}	1	QL(240 per 30 days)
diazoxide 50 mg/ml oral suspension ^{MM}	1	
DIBENZYLIN 10 MG CAPSULE ^{DL,SP}	*	
dichlorphenamide 50 mg tablet ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
DICLEGIS 10 MG-10 MG TABLET,DELAYED RELEASE	3	ST,QL(120 per 30 days)
diclofenac 0.1 % eye drops	1	QL(5 per 30 days)
diclofenac 1 % topical gel ^{MM}	1	QL(500 per 30 days)
diclofenac 1.5 % topical drops ^{MM}	1	PA
diclofenac 20 mg/gram/actuation (2 %) topical soln metered-dose pump ^{DL,SP}	*	PA
diclofenac 3 % topical gel	1	PA
diclofenac 50 mg-misoprostol 200 mcg tablet,imed.and delayed release	1	ST
diclofenac 75 mg-misoprostol 200 mcg tablet,immediate,delayed release	1	ST
diclofenac epolamine 1.3 % transdermal 12 hour patch ^{DL,SP}	*	PA,QL(60 per 30 days)
diclofenac er 100 mg tablet,extended release 24 hr	1	
diclofenac potassium 25 mg capsule ^{DL,SP}	*	ST,QL(120 per 30 days)
diclofenac potassium 25 mg tablet ^{DL,SP}	*	
diclofenac potassium 50 mg oral powder packet ^{DL,SP}	*	ST,QL(9 per 30 days)
diclofenac potassium 50 mg tablet	1	
diclofenac sodium 25 mg tablet,delayed release	1	
diclofenac sodium 50 mg tablet,delayed release	1	
diclofenac sodium 75 mg tablet,delayed release	1	
diclofenac submicronized 35 mg capsule	3	ST,QL(90 per 30 days)
dicloxacillin 250 mg capsule	1	
dicloxacillin 500 mg capsule	1	
dicyclomine 10 mg capsule ^{MM}	1	
dicyclomine 10 mg/5 ml oral solution ^{MM}	1	
dicyclomine 20 mg tablet ^{MM}	1	
didanosine 250 mg capsule,delayed release ^{MM}	1	QL(30 per 30 days)
didanosine 400 mg capsule,delayed release ^{MM}	1	QL(30 per 30 days)
DIFFERIN 0.1 % LOTION	3	ST
DIFFERIN 0.1 % TOPICAL CREAM	3	ST
DIFFERIN 0.3 % TOPICAL GEL WITH PUMP	3	ST
DIFICID 200 MG TABLET ^{DL,SP}	*	QL(20 per 10 days)
DIFICID 40 MG/ML ORAL SUSPENSION ^{DL,SP}	*	QL(100 per 10 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
diflorasone 0.05 % topical cream	1	PA
diflorasone 0.05 % topical ointment	1	PA
DIFLUCAN 10 MG/ML ORAL SUSPENSION	3	
DIFLUCAN 100 MG TABLET	3	
DIFLUCAN 150 MG TABLET	3	
DIFLUCAN 200 MG TABLET	3	
DIFLUCAN 40 MG/ML ORAL SUSPENSION	3	
DIFLUCAN 50 MG TABLET	3	
diflunisal 500 mg tablet	1	
difluprednate 0.05 % eye drops	1	ST
digitek 125 mcg (0.125 mg) tablet ^{MM}	1	QL(30 per 30 days)
digitek 250 mcg (0.25 mg) tablet ^{MM}	1	QL(30 per 30 days)
digox 125 mcg (0.125 mg) tablet ^{MM}	1	QL(30 per 30 days)
digox 250 mcg (0.25 mg) tablet ^{MM}	1	QL(30 per 30 days)
digoxin 125 mcg (0.125 mg) tablet ^{MM}	1	QL(30 per 30 days)
digoxin 250 mcg (0.25 mg) tablet ^{MM}	1	QL(30 per 30 days)
digoxin 50 mcg/ml (0.05 mg/ml) oral solution ^{MM}	1	
digoxin 62.5 mcg (0.0625 mg) tablet ^{MM}	1	QL(30 per 30 days)
dihydroergotamine 0.5 mg/pump act. (4 mg/ml) nasal spray ^{DL,SP}	*	PA,QL(8 per 30 days)
dihydroergotamine 1 mg/ml injection solution ^{DL,SP}	*	PA
DILANTIN 30 MG CAPSULE ^{MM}	1	
DILANTIN EXTENDED 100 MG CAPSULE ^{MM}	3	
DILANTIN INFATABS 50 MG CHEWABLE TABLET ^{MM}	3	
DILANTIN-125 125 MG/5 ML ORAL SUSPENSION ^{MM}	3	
DILATRATE-SR 40 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
DILAUDID 1 MG/ML ORAL LIQUID ^{DL}	3	QL(2400 per 30 days)
DILAUDID 2 MG TABLET ^{DL}	3	QL(360 per 30 days)
DILAUDID 4 MG TABLET ^{DL}	3	QL(360 per 30 days)
DILAUDID 8 MG TABLET ^{DL}	3	QL(240 per 30 days)
dilt-xr 120 mg capsule, extended release ^{MM}	1	QL(60 per 30 days)
dilt-xr 180 mg capsule, extended release ^{MM}	1	QL(60 per 30 days)
dilt-xr 240 mg capsule, extended release ^{MM}	1	QL(60 per 30 days)
diltiazem 120 mg tablet ^{MM}	1	
diltiazem 30 mg tablet ^{MM}	1	
diltiazem 60 mg tablet ^{MM}	1	
diltiazem 90 mg tablet ^{MM}	1	
diltiazem cd 120 mg capsule,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
diltiazem cd 180 mg capsule,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
diltiazem cd 240 mg capsule,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
diltiazem cd 300 mg capsule,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
diltiazem cd 360 mg capsule,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
diltiazem er (xr/xt) 120 mg capsule,extended release 24 hr, controlled ^{MM}	1	QL(60 per 30 days)
diltiazem er (xr/xt) 180 mg capsule,extended release 24 hr, controlled ^{MM}	1	QL(60 per 30 days)
diltiazem er (xr/xt) 240 mg capsule,extended release 24 hr, controlled ^{MM}	1	QL(60 per 30 days)
diltiazem er 120 mg capsule,24 hr,extended release ^{MM}	1	QL(60 per 30 days)
diltiazem er 120 mg capsule,extended release 12 hr ^{MM}	1	QL(90 per 30 days)
diltiazem er 120 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
diltiazem er 180 mg capsule,24 hr,extended release ^{MM}	1	QL(60 per 30 days)
diltiazem er 180 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
diltiazem er 240 mg capsule,24 hr,extended release ^{MM}	1	QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
diltiazem er 240 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
diltiazem er 300 mg capsule,24 hr,extended release ^{MM}	1	QL(30 per 30 days)
diltiazem er 300 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
diltiazem er 360 mg capsule,24 hr,extended release ^{MM}	1	QL(30 per 30 days)
diltiazem er 360 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
diltiazem er 420 mg capsule,24 hr,extended release ^{MM}	1	QL(30 per 30 days)
diltiazem er 420 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
diltiazem er 60 mg capsule,extended release 12 hr ^{MM}	1	QL(60 per 30 days)
diltiazem er 90 mg capsule,extended release 12 hr ^{MM}	1	QL(60 per 30 days)
dimethyl fumarate 120 mg (14)-240 mg (46) capsule,delayed release ^{DL,SP}	*	PA,QL(60 per 30 days)
dimethyl fumarate 120 mg capsule,delayed release ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
dimethyl fumarate 240 mg capsule,delayed release ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
DIOVAN 160 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
DIOVAN 320 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
DIOVAN 40 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
DIOVAN 80 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
DIOVAN HCT 160 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
DIOVAN HCT 160 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
DIOVAN HCT 320 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
DIOVAN HCT 320 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
DIOVAN HCT 80 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
DIPENTUM 250 MG CAPSULE ^{MM}	3	ST,QL(120 per 30 days)
DIPHEN 12.5 MG/5 ML ORAL ELIXIR	3	
diphenhydramine 12.5 mg/5 ml oral elixir	1	
diphenoxylate-atropine 2.5 mg-0.025 mg tablet	1	
diphenoxylate-atropine 2.5 mg-0.025 mg/5 ml oral liquid	1	
DIPROLENE (AUGMENTED) 0.05 % TOPICAL OINTMENT	3	
dipyridamole 25 mg tablet ^{MM}	1	
dipyridamole 50 mg tablet ^{MM}	1	
dipyridamole 75 mg tablet ^{MM}	1	
DISKETS 40 MG SOLUBLE TABLET ^{DL}	2	QL(90 per 30 days)
disopyramide phosphate 100 mg capsule ^{MM}	1	
disopyramide phosphate 150 mg capsule ^{MM}	1	
disulfiram 250 mg tablet ^{MM}	1	
disulfiram 500 mg tablet ^{MM}	1	
DITHOL 1.5 %-10 % TOPICAL COMBO PACK ^{DL,SP}	*	PA
DITROPAN XL 10 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
DITROPAN XL 5 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
DIURIL 250 MG/5 ML ORAL SUSPENSION ^{MM}	3	
divalproex 125 mg capsule,delayed release sprinkle ^{MM}	1	
divalproex 125 mg tablet,delayed release ^{MM}	1	
divalproex 250 mg tablet,delayed release ^{MM}	1	
divalproex 500 mg tablet,delayed release ^{MM}	1	
divalproex er 250 mg tablet,extended release 24 hr ^{MM}	1	
divalproex er 500 mg tablet,extended release 24 hr ^{MM}	1	
DIVIGEL 0.25 MG/0.25 GRAM (0.1 %) TRANSDERMAL GEL PACKET ^{MM}	3	
DIVIGEL 0.5 MG/0.5 GRAM (0.1 %) TRANSDERMAL GEL PACKET ^{MM}	3	
DIVIGEL 0.75 MG/0.75 GRAM (0.1%) TRANSDERMAL GEL PACKET ^{MM}	3	
DIVIGEL 1 MG/GRAM (0.1 %) TRANSDERMAL GEL PACKET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
DIVIGEL 1.25 MG/1.25 GRAM (0.1 %) TRANSDERMAL GEL PACKET ^{MM}	3	
dodex 1,000 mcg/ml injection solution ^{MM}	1	QL(30 per 30 days)
dofetilide 125 mcg capsule ^{MM}	1	QL(240 per 30 days)
dofetilide 250 mcg capsule ^{MM}	1	QL(120 per 30 days)
dofetilide 500 mcg capsule ^{MM}	1	QL(60 per 30 days)
DOJOLVI 8.3 KCAL/ML ORAL LIQUID ^{MM}	3	PA
dolishale 90 mcg-20 mcg (28) tablet ^{MM}	1	
donepezil 10 mg disintegrating tablet ^{MM}	1	QL(30 per 30 days)
donepezil 10 mg tablet ^{MM}	1	QL(60 per 30 days)
donepezil 23 mg tablet ^{MM}	1	QL(30 per 30 days)
donepezil 5 mg disintegrating tablet ^{MM}	1	QL(30 per 30 days)
donepezil 5 mg tablet ^{MM}	1	QL(30 per 30 days)
DOPTELET (10 TAB PACK) 20 MG TABLET ^{DL,SP}	*	PA,QL(60 per 30 days)
DOPTELET (15 TAB PACK) 20 MG TABLET ^{DL,SP}	*	PA,QL(60 per 30 days)
DOPTELET (30 TAB PACK) 20 MG TABLET ^{DL,SP}	*	PA,QL(60 per 30 days)
DORAL 15 MG TABLET ^{DL}	3	QL(30 per 30 days)
DORYX 200 MG TABLET,DELAYED RELEASE	3	ST,QL(30 per 30 days)
DORYX 50 MG TABLET,DELAYED RELEASE ^{DL,SP}	*	ST,QL(60 per 30 days)
DORYX 80 MG TABLET,DELAYED RELEASE ^{DL,SP}	*	ST,QL(60 per 30 days)
DORYX MPC 120 MG TABLET, DELAYED RELEASE	3	ST,QL(60 per 30 days)
DORYX MPC 60 MG TABLET,DELAYED RELEASE ^{DL,SP}	*	ST,QL(60 per 30 days)
dorzolamide 2 % eye drops ^{MM}	1	QL(10 per 30 days)
dorzolamide 22.3 mg-timolol 6.8 mg/ml eye drops ^{MM}	1	QL(10 per 30 days)
dorzolamide-timolol (pf) 2 %-0.5 % eye drops in a dropperette ^{MM}	1	ST,QL(60 per 30 days)
dotti 0.025 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
dotti 0.0375 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
dotti 0.05 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
dotti 0.075 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
dotti 0.1 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
DOVATO 50 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
DOVONEX 0.005 % TOPICAL CREAM	3	PA,QL(120 per 30 days)
doxazosin 1 mg tablet ^{MM}	1	
doxazosin 2 mg tablet ^{MM}	1	
doxazosin 4 mg tablet ^{MM}	1	
doxazosin 8 mg tablet ^{MM}	1	
doxepin 10 mg capsule ^{MM}	1	
doxepin 10 mg/ml oral concentrate ^{MM}	1	
doxepin 100 mg capsule ^{MM}	1	
doxepin 150 mg capsule ^{MM}	1	
doxepin 25 mg capsule ^{MM}	1	
doxepin 3 mg tablet	1	ST,QL(30 per 30 days)
doxepin 5 % topical cream	1	PA,QL(45 per 30 days)
doxepin 50 mg capsule ^{MM}	1	
doxepin 6 mg tablet	1	ST,QL(30 per 30 days)
doxepin 75 mg capsule ^{MM}	1	
doxercalciferol 0.5 mcg capsule ^{MM}	1	
doxercalciferol 1 mcg capsule ^{MM}	1	
doxercalciferol 2.5 mcg capsule ^{MM}	1	
doxycycline hyclate 100 mg capsule	1	QL(90 per 30 days)
doxycycline hyclate 100 mg tablet	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
doxycycline hyclate 100 mg tablet,delayed release	1	ST,QL(90 per 30 days)
doxycycline hyclate 150 mg tablet	1	ST,QL(30 per 30 days)
doxycycline hyclate 150 mg tablet,delayed release	1	ST,QL(60 per 30 days)
doxycycline hyclate 20 mg tablet	1	
doxycycline hyclate 200 mg tablet,delayed release	1	ST,QL(30 per 30 days)
doxycycline hyclate 50 mg capsule	1	
doxycycline hyclate 50 mg tablet ^{DL,SP}	*	ST,QL(180 per 30 days)
doxycycline hyclate 50 mg tablet,delayed release ^{DL,SP}	*	ST,QL(60 per 30 days)
doxycycline hyclate 75 mg tablet	1	ST,QL(60 per 30 days)
doxycycline hyclate 75 mg tablet,delayed release	1	ST,QL(60 per 30 days)
doxycycline hyclate 80 mg tablet,delayed release ^{DL,SP}	*	ST,QL(60 per 30 days)
doxycycline monohydrate 100 mg capsule	1	QL(90 per 30 days)
doxycycline monohydrate 100 mg tablet	1	
doxycycline monohydrate 150 mg capsule	1	ST,QL(30 per 30 days)
doxycycline monohydrate 150 mg tablet	1	ST
doxycycline monohydrate 25 mg/5 ml oral suspension	1	
doxycycline monohydrate 40 mg capsule,immediate - delay release ^{DL,SP}	*	ST,QL(30 per 30 days)
doxycycline monohydrate 50 mg capsule	1	QL(60 per 30 days)
doxycycline monohydrate 50 mg tablet	1	
doxycycline monohydrate 75 mg capsule	1	ST,QL(60 per 30 days)
doxycycline monohydrate 75 mg tablet	1	ST
doxylamine 10 mg-pyridoxine (vit b6) 10 mg tablet,delayed release	1	QL(120 per 30 days)
DRISDOL 1,250 MCG (50,000 UNIT) CAPSULE ^{MM}	3	
DRIZALMA SPRINKLE 20 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
DRIZALMA SPRINKLE 30 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
DRIZALMA SPRINKLE 40 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
DRIZALMA SPRINKLE 60 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
dronabinol 10 mg capsule	1	PA,QL(120 per 30 days)
dronabinol 2.5 mg capsule	1	PA,QL(120 per 30 days)
dronabinol 5 mg capsule	1	PA,QL(120 per 30 days)
DROPLET GENTEEL LANCING DEVICE	3	
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 15/64" ^{MM}	2	
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64" ^{MM}	2	
DROPLET INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2" ^{MM}	2	
DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 15/64" ^{MM}	2	
DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64" ^{MM}	2	
DROPLET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
DROPLET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 15/64" ^{MM}	2	
DROPLET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 15/64" ^{MM}	2	
DROPLET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
DROPLET LANCETS 30 GAUGE ^{MM}	2	
DROPLET LANCING DEVICE	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
DROPLET MICRON PEN NEEDLE 34 GAUGE X 9/64 ^{MM}	2	
DROPLET PEN NEEDLE 29 GAUGE X 1/2 ^{MM}	2	
DROPLET PEN NEEDLE 29 GAUGE X 3/8 ^{MM}	2	
DROPLET PEN NEEDLE 30 GAUGE X 5/16 ^{MM}	2	
DROPLET PEN NEEDLE 31 GAUGE X 1/4 ^{MM}	2	
DROPLET PEN NEEDLE 31 GAUGE X 3/16 ^{MM}	2	
DROPLET PEN NEEDLE 31 GAUGE X 5/16 ^{MM}	2	
DROPLET PEN NEEDLE 32 GAUGE X 1/4 ^{MM}	2	
DROPLET PEN NEEDLE 32 GAUGE X 3/16 ^{MM}	2	
DROPLET PEN NEEDLE 32 GAUGE X 5/16 ^{MM}	2	
DROPLET PEN NEEDLE 32 GAUGE X 5/32 ^{MM}	2	
DROPSAFE PEN NEEDLE 31 GAUGE X 1/4 ^{MM}	2	
DROPSAFE PEN NEEDLE 31 GAUGE X 3/16 ^{MM}	2	
DROPSAFE PEN NEEDLE 31 GAUGE X 5/16 ^{MM}	2	
drosipren-e.estradi-l.mefol 3 mg-0.02 mg-0.451 mg(24)/0.451 mg(4)tablet ^{MM}	1	
drosipren-e.estradi-l.mefol 3 mg-0.03 mg-0.451 mg(21)/0.451 mg(7)tablet ^{MM}	1	
drosiprenone 3 mg-ethinyl estradiol 0.02 mg tablet ^{MM}	1	
drosiprenone 3 mg-ethinyl estradiol 0.03 mg tablet ^{MM}	1	
DROXIA 200 MG CAPSULE ^{MM}	2	
DROXIA 300 MG CAPSULE ^{MM}	2	
DROXIA 400 MG CAPSULE ^{MM}	2	
droxidopa 100 mg capsule ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
droxidopa 200 mg capsule ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
droxidopa 300 mg capsule ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
DUAKLIR PRESSAIR 400 MCG-12 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(1 per 30 days)
DUAVEE 0.45 MG-20 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
DUET DHA BALANCED 25 MG IRON-1 MG-267 MG-233 MG ORAL PACK ^{MM}	3	
DUET DHA WITH OMEGA-3 25 MG IRON-1 MG-400 MG ORAL PACK ^{MM}	3	
DUETACT 30 MG-2 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
DUETACT 30 MG-4 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
DUEXIS 800 MG-26.6 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
DULERA 100 MCG-5 MCG/ACTUATION HFA AEROSOL INHALER ^{MM}	3	ST,QL(13 per 30 days)
DULERA 200 MCG-5 MCG/ACTUATION HFA AEROSOL INHALER ^{MM}	3	ST,QL(13 per 30 days)
DULERA 50 MCG-5 MCG/ACTUATION HFA AEROSOL INHALER ^{MM}	3	ST,QL(13 per 30 days)
duloxetine 20 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
duloxetine 30 mg capsule,delayed release ^{MM}	1	QL(90 per 30 days)
duloxetine 40 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
duloxetine 60 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
DUOBRII 0.01 %-0.045 % LOTION ^{DL,SP}	*	PA,QL(200 per 28 days)
DUPIXENT 100 MG/0.67 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(17.42 per 365 days)
DUPIXENT 200 MG/1.14 ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(31.92 per 365 days)
DUPIXENT 200 MG/1.14 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(31.92 per 365 days)
DUPIXENT 300 MG/2 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(104 per 365 days)
DUPIXENT 300 MG/2 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(104 per 365 days)
DURAGESIC 100 MCG/HR TRANSDERMAL PATCH ^{DL}	3	QL(20 per 30 days)
DURAGESIC 12 MCG/HR TRANSDERMAL PATCH ^{DL}	3	QL(20 per 30 days)
DURAGESIC 25 MCG/HR TRANSDERMAL PATCH ^{DL}	3	QL(20 per 30 days)
DURAGESIC 50 MCG/HR TRANSDERMAL PATCH ^{DL}	3	QL(20 per 30 days)
DURAGESIC 75 MCG/HR TRANSDERMAL PATCH ^{DL}	3	QL(20 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
DUREZOL 0.05 % EYE DROPS	3	ST
DURLAZA 162.5 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
dutasteride 0.5 mg capsule ^{MM}	1	QL(30 per 30 days)
dutasteride 0.5 mg-tamsulosin er 0.4 mg capsule ext.release 24hr mphas ^{MM}	1	ST,QL(30 per 30 days)
DUTOPROL 100 MG-12.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(120 per 30 days)
DUTOPROL 25 MG-12.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
DUTOPROL 50 MG-12.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
DUZALLO 200 MG-200 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
DUZALLO 200 MG-300 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
dvorah 325 mg-30 mg-16 mg tablet ^{DL}	1	QL(300 per 30 days)
DXEVO 1.5 MG (39 TABS) TABLETS IN A DOSE PACK	3	
DYANAVEL XR 10 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
DYANAVEL XR 15 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
DYANAVEL XR 2.5 MG/ML ORAL 24 HR EXTENDED RELEASE SUSPENSION ^{MM}	2	QL(240 per 30 days)
DYANAVEL XR 20 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
DYANAVEL XR 5 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
DYMISTA 137 MCG-50 MCG/SPRAY NASAL SPRAY	3	ST,QL(23 per 28 days)
DYRENIUM 100 MG CAPSULE ^{MM}	3	
DYRENIUM 50 MG CAPSULE ^{MM}	3	
E-Z JECT LANCETS ^{MM}	3	
E-Z JECT LANCETS 26 GAUGE ^{MM}	2	
E-Z JECT LANCETS 30 GAUGE ^{MM}	2	
E-Z JECT LANCETS 32 GAUGE ^{MM}	2	
E-Z JECT LANCETS 33 GAUGE ^{MM}	2	
E-Z JECT THIN LANCETS 28 GAUGE ^{MM}	2	
E.E.S. 400 MG TABLET	3	
E.E.S. GRANULES 200 MG/5 ML ORAL SUSPENSION	3	
EASIVENT HOLDING CHAMBER	2	
EASIVENT MASK LARGE	2	
EASIVENT MASK MEDIUM	2	
EASIVENT MASK SMALL	2	
EASY COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 1 ML 32 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT INSULIN SYRINGE 1/2 ML 32 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT LANCETS 30 GAUGE ^{MM}	2	
EASY COMFORT PEN NEEDLES 31 GAUGE X 1/4" ^{MM}	2	
EASY COMFORT PEN NEEDLES 31 GAUGE X 3/16" ^{MM}	2	
EASY COMFORT PEN NEEDLES 31 GAUGE X 5/16" ^{MM}	2	
EASY COMFORT PEN NEEDLES 32 GAUGE X 5/32" ^{MM}	2	
EASY COMFORT PEN NEEDLES 33 GAUGE X 1/4" ^{MM}	2	
EASY COMFORT PEN NEEDLES 33 GAUGE X 3/16" ^{MM}	2	
EASY COMFORT PEN NEEDLES 33 GAUGE X 5/32" ^{MM}	2	
EASY GLIDE INSULIN SYRINGE 0.3 ML 31 GAUGE X 15/64" ^{MM}	2	
EASY GLIDE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
EASY GLIDE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64" ^{MM}	2	
EASY GLIDE PEN NEEDLE 33 GAUGE X 5/32" ^{MM}	2	
EASY GLUCO G2 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASY MINI EJECT LANCING DEVICE	3	
EASY PLUS II BLOOD GLUCOSE METER ^{MM}	3	ST
EASY PLUS II HIGH CONTROL SOLUTION ^{MM}	3	
EASY PLUS II LOW CONTROL SOLUTION ^{MM}	3	
EASY PLUS II TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASY STEP BLOOD GLUCOSE METER ^{MM}	3	ST
EASY STEP HIGH CONTROL SOLUTION ^{MM}	3	
EASY STEP LOW CONTROL SOLUTION ^{MM}	3	
EASY STEP NORMAL CONTROL SOLN SOLUTION ^{MM}	3	
EASY STEP STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASY TALK BLOOD GLUCOSE METER ^{MM}	3	ST
EASY TALK GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASY TALK HIGH CONTROL SOLUTION ^{MM}	3	
EASY TALK LOW CONTROL SOLUTION ^{MM}	3	
EASY TALK PLUS II HIGH CONTROL SOLUTION ^{MM}	3	
EASY TALK PLUS II LOW CONTROL SOLUTION ^{MM}	3	
EASY TALK PLUS II TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
EASY TOUCH 29 GAUGE X 1/2" NEEDLE ^{MM}	2	
EASY TOUCH 31 GAUGE X 1/4" NEEDLE ^{MM}	2	
EASY TOUCH 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
EASY TOUCH 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
EASY TOUCH 32 GAUGE X 1/4" NEEDLE ^{MM}	2	
EASY TOUCH 32 GAUGE X 3/16" NEEDLE ^{MM}	2	
EASY TOUCH 32 GAUGE X 5/32" NEEDLE ^{MM}	3	
EASY TOUCH BLU CTRL SOLN-L1,L3 SOLUTION ^{MM}	3	
EASY TOUCH BLU LINK GLUCOSE SYSTEM ^{MM}	3	ST
EASY TOUCH BLU LINK TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
EASY TOUCH FLIPLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
EASY TOUCH FLIPLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH GLUCOSE MONITOR ^{MM}	3	ST
EASY TOUCH HIGH-LOW CONTROL SOLUTION ^{MM}	3	
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1 ML 27 GAUGE X 5/8" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
EASY TOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH LANCETS 26 GAUGE ^{MM}	3	
EASY TOUCH LANCETS 28 GAUGE ^{MM}	2	
EASY TOUCH LANCETS 30 GAUGE ^{MM}	3	
EASY TOUCH LANCETS 32 GAUGE ^{MM}	3	
EASY TOUCH LANCING DEVICE	3	
EASY TOUCH LUER LOCK INSULIN 1 ML SYRINGE ^{MM}	2	
EASY TOUCH PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH SAFETY LANCETS 21 GAUGE ^{MM}	2	
EASY TOUCH SAFETY LANCETS 23 GAUGE ^{MM}	2	
EASY TOUCH SAFETY LANCETS 26 GAUGE ^{MM}	2	
EASY TOUCH SAFETY LANCETS 28 GAUGE ^{MM}	2	
EASY TOUCH SAFETY LANCETS 30 GAUGE ^{MM}	2	
EASY TOUCH SAFETY LANCETS 32 GAUGE ^{MM}	2	
EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 3/16" ^{MM}	2	
EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 1/4" ^{MM}	2	
EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 3/16" ^{MM}	2	
EASY TOUCH SAFETY PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
EASY TOUCH SHEATHLOCK INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
EASY TOUCH SHEATHLOCK INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
EASY TOUCH SHEATHLOCK INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
EASY TOUCH TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
EASY TOUCH TWIST LANCETS 26 GAUGE ^{MM}	2	
EASY TOUCH TWIST LANCETS 28 GAUGE ^{MM}	2	
EASY TOUCH TWIST LANCETS 30 GAUGE ^{MM}	2	
EASY TOUCH TWIST LANCETS 32 GAUGE ^{MM}	2	
EASY TOUCH TWIST LANCETS 33 GAUGE ^{MM}	2	
EASY TOUCH UNI-SLIP 1 ML SYRINGE ^{MM}	3	
EASY TRAK BLOOD GLUCOSE METER ^{MM}	3	ST
EASY TRAK GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASY TRAK HIGH CONTROL SOLUTION ^{MM}	3	
EASY TRAK II BLOOD GLUCOSE METER ^{MM}	3	ST
EASY TRAK II CONTROL SOLUTION-NORMAL ^{MM}	3	
EASY TRAK II TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
EASY TRAK LOW CONTROL SOLUTION ^{MM}	3	
EASY TWIST AND CAP LANCETS 28 GAUGE ^{MM}	2	
EASY-TOUCH BLOOD GLUCOSE METER ^{MM}	3	ST
EASYGLUCO METER KIT ^{MM}	3	ST
EASYGLUCO MONITORING SYSTEM KIT ^{MM}	3	ST
EASYGLUCO PLUS NORMAL CONTROL SOLUTION ^{MM}	3	
EASYGLUCO PLUS STRIPS ^{MM}	3	ST,QL(150 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
EASYGLUCO TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASYMAX 15 LEVEL 2 SOLUTION ^{MM}	3	
EASYMAX 15 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASYMAX NG KIT ^{MM}	3	ST
EASYMAX NG METER ^{MM}	3	ST
EASYMAX NORMAL CONTROL SOLUTION ^{MM}	3	
EASYMAX STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EASYMAX V SPEAKING BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
EC-NAPROSYN 375 MG TABLET,DELAYED RELEASE ^{MM}	3	
EC-NAPROSYN 500 MG TABLET,DELAYED RELEASE ^{MM}	3	
ec-naproxen 375 mg tablet,delayered release ^{MM}	1	
ec-naproxen 500 mg tablet,delayered release ^{MM}	1	
ECLIPSE NEEDLE 23 GAUGE X 1"	3	
ECLIPSE NEEDLE 25 GAUGE X 5/8"	3	
ECLIPSE NEEDLE 27 GAUGE X 1/2"	3	
ECLIPSE SYRINGE 3 ML 21 GAUGE X 1"	3	
ECLIPSE SYRINGE 3 ML 25 GAUGE X 1"	3	
econazole 1 % topical cream	1	
ECOZA 1 % TOPICAL FOAM ^{DL,SP}	*	
ed-spaz 0.125 mg disintegrating tablet ^{MM}	1	
EDARBI 40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EDARBI 80 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EDARBYCLOR 40 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EDARBYCLOR 40 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EDECIN 25 MG TABLET ^{DL,MM,SP}	*	
EDLUAR 10 MG SUBLINGUAL TABLET	3	ST,QL(30 per 30 days)
EDLUAR 5 MG SUBLINGUAL TABLET	3	ST,QL(30 per 30 days)
EDURANT 25 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
eemt 1.25 mg-2.5 mg tablet ^{MM}	1	
eemt hs 0.625 mg-1.25 mg tablet ^{MM}	1	
efavirenz 200 mg capsule ^{MM}	1	QL(120 per 30 days)
efavirenz 400 mg-lamivudine 300 mg-tenofovir disoproxil 300 mg tablet ^{MM,SP}	*	QL(30 per 30 days)
efavirenz 50 mg capsule ^{MM}	1	QL(480 per 30 days)
efavirenz 600 mg tablet ^{MM}	1	QL(30 per 30 days)
efavirenz 600 mg-emtricitabine 200 mg-tenofovir disoproxil 300 mg tablet ^{MM}	1	QL(30 per 30 days)
efavirenz 600 mg-lamivudine 300 mg-tenofovir disoproxil 300 mg tablet ^{MM,SP}	*	QL(30 per 30 days)
EFFER-K 10 MEQ EFFERVESCENT TABLET ^{MM}	3	
EFFER-K 20 MEQ EFFERVESCENT TABLET ^{MM}	3	
effer-k 25 meq effervescent tablet ^{MM}	1	
EFFEXOR XR 150 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
EFFEXOR XR 37.5 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(90 per 30 days)
EFFEXOR XR 75 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(90 per 30 days)
EFFIENT 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EFFIENT 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EFUDEX 5 % TOPICAL CREAM	3	
EGATEN 250 MG TABLET	3	
EGRIFTA SV 2 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
ELCYS 50 MG/ML INTRAVENOUS SOLUTION	3	
ELEMENT COMPACT GLUCOSE METER ^{MM}	3	ST
ELEMENT COMPACT HIGH CONTROL SOLUTION ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ELEMENT COMPACT NORMAL CONTROL SOLUTION ^{MM}	3	
ELEMENT COMPACT TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ELEMENT COMPACT V GLUCOSE METER ^{MM}	3	ST
ELEMENT HIGH CONTROL SOLUTION ^{MM}	3	
ELEMENT LOW CONTROL SOLUTION ^{MM}	3	
ELEMENT NORMAL CONTROL SOLUTION ^{MM}	3	
ELEMENT PLUS BLOOD GLUCOSE KIT ^{MM}	3	ST
ELEMENT TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ELEPSIA XR 1,000 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ELEPSIA XR 1,500 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ELESTRIN 0.87 GRAM/ACTUATION (0.06%) TRANSDERMAL GEL PUMP ^{MM}	3	ST,QL(52 per 30 days)
eletriptan 20 mg tablet	1	ST,QL(9 per 30 days)
eletriptan 40 mg tablet	1	ST,QL(9 per 30 days)
ELIDEL 1 % TOPICAL CREAM	3	
ELIGARD 22.5 MG (3 MONTH) SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(1 per 90 days)
ELIGARD 30 MG (4 MONTH) SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(1 per 120 days)
ELIGARD 45 MG (6 MONTH) SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(1 per 180 days)
ELIGARD 7.5 MG (1 MONTH) SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(1 per 30 days)
ELIMITE 5 % TOPICAL CREAM	3	
elimest 0.3 mg-30 mcg tablet ^{MM}	1	
ELIQUIS 2.5 MG TABLET ^{MM}	2	QL(60 per 30 days)
ELIQUIS 5 MG TABLET ^{MM}	2	QL(74 per 30 days)
ELIQUIS DVT-PE TREATMENT 30-DAY STARTER 5 MG (74 TABLETS) IN DOSE PACK	2	QL(74 per 30 days)
ELIXOPHYLLIN 80 MG/15 ML ORAL ELIXIR ^{MM}	3	
ELLA 30 MG TABLET	2	QL(1 per 30 days)
ELLUME COVID-19 HOME TEST KIT	3	
ELMIRON 100 MG CAPSULE ^{DL,SP}	*	QL(90 per 30 days)
eluryng 0.12 mg-0.015 mg/24 hr vaginal ring ^{MM}	1	QL(1 per 28 days)
ELYXYB 120 MG/4.8 ML (25 MG/ML) ORAL SOLUTION ^{DL,SP}	*	ST,QL(43.2 per 30 days)
EMBRACE BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
EMBRACE BLOOD GLUCOSE SYSTEM STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EMBRACE EVO BLOOD GLUCOSE KIT ^{MM}	3	ST
EMBRACE EVO GLUCOSE MONITOR ^{MM}	3	ST
EMBRACE EVO LEVEL 1 SOLUTION ^{MM}	3	
EMBRACE EVO TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EMBRACE GLUCOSE CONTROL HIGH SOLUTION ^{MM}	3	
EMBRACE GLUCOSE CONTROL LOW SOLUTION ^{MM}	3	
EMBRACE LANCETS 30 GAUGE ^{MM}	3	
EMBRACE LANCING DEVICE WITH EJECTOR	3	
EMBRACE PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
EMBRACE PEN NEEDLE 30 GAUGE X 3/16" ^{MM}	2	
EMBRACE PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
EMBRACE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
EMBRACE PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
EMBRACE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
EMBRACE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
EMBRACE PRO BLOOD GLUCOSE METER ^{MM}	3	ST
EMBRACE PRO SOLUTION ^{MM}	3	
EMBRACE PRO TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EMBRACE SAFETY LANCET 21 GAUGE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
EMBRACE SAFETY LANCET 28 GAUGE ^{MM}	2	
EMBRACE TALK BLOOD GLUCOSE MONITORING SYSTEM KIT ^{MM}	3	ST
EMBRACE TALK CONTROL-HIGH (L2) SOLUTION ^{MM}	3	
EMBRACE TALK CONTROL-LOW (L1) SOLUTION ^{MM}	3	
EMBRACE TALK GLUCOSE MONITOR ^{MM}	3	ST
EMBRACE TALK TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EMCYT 140 MG CAPSULE	3	QL(540 per 30 days)
EMEND 125 MG (1)-80 MG (2) CAPSULES IN A DOSE PACK	3	PA,QL(6 per 28 days)
EMEND 125 MG (25 MG/ML FINAL CONC.) ORAL SUSPENSION	3	PA,QL(3 per 28 days)
EMEND 80 MG CAPSULE	3	PA,QL(4 per 28 days)
EMFLAZA 18 MG TABLET ^{DL,MM,SP}	*	PA
EMFLAZA 22.75 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA
EMFLAZA 30 MG TABLET ^{DL,MM,SP}	*	PA
EMFLAZA 36 MG TABLET ^{DL,MM,SP}	*	PA
EMFLAZA 6 MG TABLET ^{DL,MM,SP}	*	PA
EMGALITY 120 MG/ML SUBCUTANEOUS SYRINGE ^{MM}	3	PA,QL(2 per 30 days)
EMGALITY 300 MG/3 ML (100 MG/ML X 3) SUBCUTANEOUS SYRINGE	3	PA,QL(3 per 30 days)
EMGALITY PEN 120 MG/ML SUBCUTANEOUS PEN INJECTOR ^{MM}	3	PA,QL(2 per 30 days)
emoquette 0.15 mg-0.03 mg tablet ^{MM}	1	
EMPAVELI 1,080 MG/20 ML SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(160 per 28 days)
EMSAM 12 MG/24 HR TRANSDERMAL 24 HOUR PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
EMSAM 6 MG/24 HR TRANSDERMAL 24 HOUR PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
EMSAM 9 MG/24 HR TRANSDERMAL 24 HOUR PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
emtricitabine 100 mg-tenofovir disoproxil fumarate 150 mg tablet ^{MM,SP}	*	QL(30 per 30 days)
emtricitabine 133 mg-tenofovir disoproxil fumarate 200 mg tablet ^{MM,SP}	*	QL(30 per 30 days)
emtricitabine 167 mg-tenofovir disoproxil fumarate 250 mg tablet ^{MM,SP}	*	QL(30 per 30 days)
emtricitabine 200 mg capsule ^{MM}	1	QL(30 per 30 days)
emtricitabine 200 mg-tenofovir disoproxil fumarate 300 mg tablet ^{MM}	1	QL(30 per 30 days)
EMTRIVA 10 MG/ML ORAL SOLUTION ^{MM}	3	QL(680 per 28 days)
EMTRIVA 200 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
emverm 100 mg chewable tablet ^{DL,SP}	*	
enalapril 10 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
enalapril 5 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
enalapril maleate 1 mg/ml oral solution ^{MM}	1	
enalapril maleate 10 mg tablet ^{MM}	1	
enalapril maleate 2.5 mg tablet ^{MM}	1	
enalapril maleate 20 mg tablet ^{MM}	1	
enalapril maleate 5 mg tablet ^{MM}	1	
ENBREL 25 MG (1 ML) SUBCUTANEOUS POWDER FOR SOLUTION ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
ENBREL 25 MG/0.5 ML (0.5 ML) SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(8.16 per 28 days)
ENBREL 25 MG/0.5 ML SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
ENBREL 50 MG/ML (1 ML) SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(78 per 365 days)
ENBREL MINI 50 MG/ML (1 ML) SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
ENBREL SURECLICK 50 MG/ML (1 ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(78 per 365 days)
ENDARI 5 GRAM ORAL POWDER PACKET ^{MM}	3	PA
endocet 10 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)
endocet 2.5 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)
endocet 5 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)
endocet 7.5 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ENGERIX-B (PF) 20 MCG/ML INTRAMUSCULAR SUSPENSION	3	
ENGERIX-B (PF) 20 MCG/ML INTRAMUSCULAR SYRINGE	3	
ENLITE GLUCOSE SENSOR DEVICE ^{MM}	3	PA
ENLITE SYSTEM ^{MM}	3	PA
enoxaparin 100 mg/ml subcutaneous syringe	1	QL(28 per 28 days)
enoxaparin 120 mg/0.8 ml subcutaneous syringe	1	QL(22.4 per 28 days)
enoxaparin 150 mg/ml subcutaneous syringe	1	QL(28 per 28 days)
enoxaparin 30 mg/0.3 ml subcutaneous syringe	1	QL(16.8 per 28 days)
enoxaparin 300 mg/3 ml subcutaneous solution	1	QL(84 per 28 days)
enoxaparin 40 mg/0.4 ml subcutaneous syringe	1	QL(11.2 per 28 days)
enoxaparin 60 mg/0.6 ml subcutaneous syringe	1	QL(16.8 per 28 days)
enoxaparin 80 mg/0.8 ml subcutaneous syringe	1	QL(22.4 per 28 days)
enpresse 50-30 (6)/75-40(5)/125-30(10) tablet ^{MM}	1	
enskyce 0.15 mg-0.03 mg tablet ^{MM}	1	
ENSPRYNG 120 MG/ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(2 per 28 days)
ENSTILAR 0.005 %-0.064 % TOPICAL FOAM ^{DL,SP}	*	PA,QL(120 per 30 days)
entacapone 200 mg tablet ^{MM}	1	QL(300 per 30 days)
ENTADFI 5 MG-5 MG CAPSULE	3	ST,QL(182 per 365 days)
entecavir 0.5 mg tablet ^{MM}	1	QL(30 per 30 days)
entecavir 1 mg tablet ^{MM}	1	QL(30 per 30 days)
ENTEREG 12 MG CAPSULE	3	QL(15 per 365 days)
ENTOCORT EC 3 MG CAPSULE,DELAYED,EXTENDED RELEASE	3	
ENTRESTO 24 MG-26 MG TABLET ^{MM}	2	QL(60 per 30 days)
ENTRESTO 49 MG-51 MG TABLET ^{MM}	2	QL(60 per 30 days)
ENTRESTO 97 MG-103 MG TABLET ^{MM}	2	QL(60 per 30 days)
enulose 10 gram/15 ml oral solution ^{MM}	1	
ENVARUSUS XR 0.75 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA
ENVARUSUS XR 1 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA
ENVARUSUS XR 4 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA
EPANED 1 MG/ML ORAL SOLUTION ^{MM}	3	
EPCLUSA 150 MG-37.5 MG ORAL PELLETS IN PACKET ^{DL,SP}	*	PA,QL(28 per 28 days)
EPCLUSA 200 MG-50 MG ORAL PELLETS IN PACKET ^{DL,SP}	*	PA,QL(56 per 28 days)
EPCLUSA 200 MG-50 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
EPCLUSA 400 MG-100 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
EPIDIOLEX 100 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA
EPIDUO 0.1 %-2.5 % TOPICAL GEL WITH PUMP	3	ST
EPIDUO FORTE 0.3 %-2.5 % TOPICAL GEL WITH PUMP	3	ST
EPIFOAM 1 %-1 % TOPICAL	3	
epinastine 0.05 % eye drops	1	QL(5 per 25 days)
epinephrine (jr) 0.15 mg/0.3 ml injection,auto-injector	1	QL(4 per 30 days)
epinephrine 0.15 mg/0.15 ml auto-injector (for 33 to 66 lb patients)	1	QL(4 per 30 days)
epinephrine 0.3 mg/0.3 ml injection, auto-injector	1	QL(4 per 30 days)
EPIPEN 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR	3	ST,QL(4 per 30 days)
EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR	3	ST,QL(4 per 30 days)
EPIPEN JR 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR	3	ST,QL(4 per 30 days)
EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR	3	ST,QL(4 per 30 days)
epitol 200 mg tablet ^{MM}	1	
EPIVIR 10 MG/ML ORAL SOLUTION ^{MM}	3	QL(960 per 30 days)
EPIVIR 150 MG TABLET ^{MM}	3	QL(60 per 30 days)
EPIVIR 300 MG TABLET ^{MM}	3	QL(30 per 30 days)
EPIVIR HBV 100 MG TABLET ^{MM}	3	QL(90 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
EPIVIR HBV 25 MG/5 ML (5 MG/ML) ORAL SOLUTION ^{MM}	3	QL(1680 per 28 days)
eplerenone 25 mg tablet ^{MM}	1	
eplerenone 50 mg tablet ^{MM}	1	
EPOGEN 10,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
EPOGEN 2,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
EPOGEN 20,000 UNIT/2 ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
EPOGEN 20,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
EPOGEN 3,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
EPOGEN 4,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
EPRONTIA 25 MG/ML ORAL SOLUTION ^{MM}	3	PA,QL(480 per 30 days)
eprosartan 600 mg tablet ^{MM}	1	ST,QL(60 per 30 days)
EPSOLAY 5 % TOPICAL CREAM	3	ST,QL(30 per 30 days)
EPZICOM 600 MG-300 MG TABLET ^{MM}	3	QL(30 per 30 days)
EQUETRO 100 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	PA
EQUETRO 200 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	PA
EQUETRO 300 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	PA
ergocalciferol (vitamin d2) 1,250 mcg (50,000 unit) capsule ^{MM}	1	
ergoloid 1 mg tablet ^{MM}	1	
ERGOMAR 2 MG SUBLINGUAL TABLET	3	
ergotamine 1 mg-caffeine 100 mg tablet	1	
ERIVEDGE 150 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
ERLEADA 240 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ERLEADA 60 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
erlotinib 100 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
erlotinib 150 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
erlotinib 25 mg tablet ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ERMEZA 30 MCG/ML ORAL SOLUTION ^{MM}	3	ST
errin 0.35 mg tablet ^{MM}	1	
ERTACZO 2 % TOPICAL CREAM	3	ST
ery pads 2 % topical swab	1	
ERY-TAB 250 MG TABLET,DELAYED RELEASE	3	
ERY-TAB 333 MG TABLET,DELAYED RELEASE	3	
ERY-TAB 500 MG TABLET,DELAYED RELEASE	3	
ERYGEL 2 % TOPICAL	3	
ERYPED 200 200 MG/5 ML ORAL SUSPENSION	3	
ERYPED 400 MG/5 ML ORAL SUSPENSION	3	
ERYTHROCIN (AS STEARATE) 250 MG TABLET	3	
erythromycin 250 mg capsule,delayed release	1	
erythromycin 250 mg tablet	1	
erythromycin 250 mg tablet,delayed release	1	
erythromycin 333 mg tablet,delayed release	1	
erythromycin 5 mg/gram (0.5 %) eye ointment	1	QL(3.5 per 28 days)
erythromycin 500 mg tablet	1	
erythromycin 500 mg tablet,delayed release	1	
erythromycin ethylsuccinate 200 mg/5 ml oral powder for suspension	1	
erythromycin ethylsuccinate 400 mg tablet	1	
erythromycin ethylsuccinate 400 mg/5 ml oral powder for suspension	1	
erythromycin with ethanol 2 % topical gel	1	
erythromycin with ethanol 2 % topical solution	1	
erythromycin-benzoyl peroxide 3 %-5 % topical gel	1	
ESBRIET 267 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(270 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ESBRIET 267 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(270 per 30 days)
ESBRIET 801 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(90 per 30 days)
escitalopram 10 mg tablet ^{MM}	1	QL(45 per 30 days)
escitalopram 20 mg tablet ^{MM}	1	QL(30 per 30 days)
escitalopram 5 mg tablet ^{MM}	1	QL(30 per 30 days)
escitalopram 5 mg/5 ml oral solution ^{MM}	1	QL(600 per 30 days)
ESGIC 50 MG-325 MG-40 MG CAPSULE	3	QL(180 per 30 days)
ESGIC 50 MG-325 MG-40 MG TABLET	3	QL(180 per 30 days)
esomeprazole magnesium 20 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
esomeprazole magnesium 40 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
esomeprazole magnesium dr 10 mg granules delayed release for susp ^{MM}	1	QL(30 per 30 days)
esomeprazole magnesium dr 20 mg granules delayed release for susp ^{MM}	1	QL(30 per 30 days)
esomeprazole magnesium dr 40 mg granules delayed release for susp ^{MM}	1	QL(30 per 30 days)
ESOMEPRAZOLE STRONTIUM 49.3 MG CAPSULE,DELAYED RELEASE ^{MM}	1	ST,QL(30 per 30 days)
estarylla 0.25 mg-35 mcg tablet ^{MM}	1	
estazolam 1 mg tablet ^{DL}	1	QL(30 per 30 days)
estazolam 2 mg tablet ^{DL}	1	QL(30 per 30 days)
esterified estrogens-methyltestosterone 0.625 mg-1.25 mg tablet ^{MM}	1	
esterified estrogens-methyltestosterone 1.25 mg-2.5 mg tablet ^{MM}	1	
ESTRACE 0.01% (0.1 MG/GRAM) VAGINAL CREAM ^{MM}	3	
ESTRACE 0.5 MG TABLET ^{MM}	3	
ESTRACE 1 MG TABLET ^{MM}	3	
ESTRACE 2 MG TABLET ^{MM}	3	
estradiol 0.01% (0.1 mg/gram) vaginal cream ^{MM}	1	
estradiol 0.025 mg/24 hr semiweekly transdermal patch ^{MM}	1	QL(8 per 28 days)
estradiol 0.025 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
estradiol 0.0375 mg/24 hr semiweekly transdermal patch ^{MM}	1	QL(8 per 28 days)
estradiol 0.0375 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
estradiol 0.05 mg/24 hr semiweekly transdermal patch ^{MM}	1	QL(8 per 28 days)
estradiol 0.05 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
estradiol 0.06 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
estradiol 0.075 mg/24 hr semiweekly transdermal patch ^{MM}	1	QL(8 per 28 days)
estradiol 0.075 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
estradiol 0.1 mg/24 hr semiweekly transdermal patch ^{MM}	1	QL(8 per 28 days)
estradiol 0.1 mg/24 hr weekly transdermal patch ^{MM}	1	QL(4 per 28 days)
estradiol 0.25 mg/0.25 gram (0.1 %) transdermal gel packet ^{MM}	1	
estradiol 0.5 mg tablet ^{MM}	1	
estradiol 0.5 mg/0.5 gram (0.1 %) transdermal gel packet ^{MM}	1	
estradiol 0.75 mg/0.75 gram (0.1%) transdermal gel packet ^{MM}	1	
estradiol 1 mg tablet ^{MM}	1	
estradiol 1 mg/gram (0.1 %) transdermal gel packet ^{MM}	1	
estradiol 1.25 mg/1.25 gram (0.1 %) transdermal gel packet ^{MM}	1	
estradiol 10 mcg vaginal tablet ^{MM}	1	
estradiol 2 mg tablet ^{MM}	1	
estradiol-norethindrone acet 0.5 mg-0.1 mg tablet ^{MM}	1	
estradiol-norethindrone acet 1 mg-0.5 mg tablet ^{MM}	1	
ESTRING 2 MG (7.5 MCG/24 HOUR) VAGINAL RING ^{MM}	3	QL(1 per 90 days)
ESTROGEL 1.25 GRAM/ACTUATION (0.06%) TRANSDERMAL GEL PUMP ^{MM}	3	ST,QL(50 per 30 days)
ESTROSTEP FE-28 1-20 (5)/1-30(7)/1MG-35MCG(9) TABLET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
eszopiclone 1 mg tablet	1	QL(30 per 30 days)
eszopiclone 2 mg tablet	1	QL(30 per 30 days)
eszopiclone 3 mg tablet	1	QL(30 per 30 days)
ethacrynic acid 25 mg tablet ^{DL,MM,SP}	*	
ethambutol 100 mg tablet	1	
ethambutol 400 mg tablet	1	
ethosuximide 250 mg capsule ^{MM}	1	
ethosuximide 250 mg/5 ml oral solution ^{MM}	1	
ethynodiol diacetate-ethinyl estradiol 1 mg-35 mcg tablet ^{MM}	1	
ethynodiol diacetate-ethinyl estradiol 1 mg-50 mcg tablet ^{MM}	1	
etodolac 200 mg capsule ^{MM}	1	
etodolac 300 mg capsule ^{MM}	1	
etodolac 400 mg tablet ^{MM}	1	
etodolac 500 mg tablet ^{MM}	1	
etodolac er 400 mg tablet,extended release 24 hr ^{MM}	1	
etodolac er 500 mg tablet,extended release 24 hr ^{MM}	1	
etodolac er 600 mg tablet,extended release 24 hr ^{MM}	1	
etonogestrel 0.12 mg-ethinyl estradiol 0.015 mg/24 hr vaginal ring ^{MM}	1	QL(1 per 28 days)
etoposide 50 mg capsule ^{DL,SP}	*	QL(100 per 30 days)
etravirine 100 mg tablet ^{MM,SP}	*	QL(120 per 30 days)
etravirine 200 mg tablet ^{MM,SP}	*	QL(60 per 30 days)
EUCRISA 2 % TOPICAL OINTMENT ^{DL,SP}	*	PA
EULEXIN 125 MG CAPSULE ^{MM}	3	PA,QL(180 per 30 days)
EURAX 10 % LOTION ^{DL,SP}	*	PA
EURAX 10 % TOPICAL CREAM ^{DL,SP}	*	PA
EUTHYROX 100 MCG TABLET ^{MM}	1	
EUTHYROX 112 MCG TABLET ^{MM}	1	
EUTHYROX 125 MCG TABLET ^{MM}	1	
EUTHYROX 137 MCG TABLET ^{MM}	1	
EUTHYROX 150 MCG TABLET ^{MM}	1	
EUTHYROX 175 MCG TABLET ^{MM}	1	
EUTHYROX 200 MCG TABLET ^{MM}	1	
EUTHYROX 25 MCG TABLET ^{MM}	1	
EUTHYROX 50 MCG TABLET ^{MM}	1	
EUTHYROX 75 MCG TABLET ^{MM}	1	
EUTHYROX 88 MCG TABLET ^{MM}	1	
EVAMIST 1.53 MG/SPRAY (1.7 %) TRANSDERMAL SPRAY ^{MM}	3	
EVEKEO 10 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
EVEKEO 5 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
EVEKEO ODT 10 MG DISINTEGRATING TABLET ^{MM}	3	ST,QL(90 per 30 days)
EVEKEO ODT 15 MG DISINTEGRATING TABLET ^{MM}	3	ST,QL(60 per 30 days)
EVEKEO ODT 20 MG DISINTEGRATING TABLET ^{MM}	3	ST,QL(60 per 30 days)
EVEKEO ODT 5 MG DISINTEGRATING TABLET ^{MM}	3	ST,QL(90 per 30 days)
EVENCARE G2 ^{MM}	3	ST
EVENCARE G2 SOLUTION ^{MM}	3	
EVENCARE G2 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EVENCARE G3 CONTROL SOLUTION ^{MM}	3	
EVENCARE G3 GLUCOSE METER KIT ^{MM}	3	ST
EVENCARE G3 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
EVENCARE KIT ^{MM}	3	ST
EVENCARE MINI GLUCOSE CONTROL SOLUTION ^{MM}	3	
EVENCARE MINI GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EVENCARE MINI MONITOR SYSTEM ^{MM}	3	ST
EVENCARE PROVIEW CONTROL-L2,L3 SOLUTION ^{MM}	3	
EVENCARE PROVIEW TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
EVENCARE SOLUTION ^{MM}	3	
EVENCARE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
everolimus (antineoplastic) 10 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
everolimus (antineoplastic) 2 mg tablet for oral suspension ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
everolimus (antineoplastic) 2.5 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
everolimus (antineoplastic) 3 mg tablet for oral suspension ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
everolimus (antineoplastic) 5 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
everolimus (antineoplastic) 5 mg tablet for oral suspension ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
everolimus (antineoplastic) 7.5 mg tablet ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
everolimus (immunosuppressive) 0.25 mg tablet ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
everolimus (immunosuppressive) 0.5 mg tablet ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
everolimus (immunosuppressive) 0.75 mg tablet ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
everolimus (immunosuppressive) 1 mg tablet ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
EVERSENSE E3 SENSOR-HOLDER SUBCUTANEOUS DEVICE	3	PA
EVERSENSE E3 SMART TRANSMITTER DEVICE ^{MM}	3	PA
EVERSENSE SENSOR-HOLDER SUBCUTANEOUS DEVICE	3	PA
EVERSENSE SMART TRANSMITTER DEVICE ^{MM}	3	PA
EVISTA 60 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EVOCLIN 1 % TOPICAL FOAM	3	ST
EVOLUTION BLOOD GLUCOSE METER KIT ^{MM}	3	ST
EVOLUTION NORMAL CONTROL SOLUTION ^{MM}	3	
EVOLUTION TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EVOTAZ 300 MG-150 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
EVOXAC 30 MG CAPSULE ^{MM}	3	
EVRYSDI 0.75 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
EXEL INSULIN 0.3 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
EXEL INSULIN 0.5 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
EXEL INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
EXEL INSULIN 1/2 ML 28 GAUGE X 1/2" SYRINGE ^{MM}	2	
EXELDERM 1 % TOPICAL CREAM	3	ST
EXELDERM 1 % TOPICAL SOLUTION	3	ST
EXELON PATCH 13.3 MG/24 HOUR TRANSDERMAL ^{MM}	3	QL(30 per 30 days)
EXELON PATCH 4.6 MG/24 HOUR TRANSDERMAL ^{MM}	3	QL(30 per 30 days)
EXELON PATCH 9.5 MG/24 HOUR TRANSDERMAL ^{MM}	3	QL(30 per 30 days)
exemestane 25 mg tablet ^{MM}	1	QL(60 per 30 days)
EXFORGE 10 MG-160 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXFORGE 10 MG-320 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXFORGE 5 MG-160 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXFORGE 5 MG-320 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXFORGE HCT 10 MG-160 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXFORGE HCT 10 MG-160 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXFORGE HCT 10 MG-320 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXFORGE HCT 5 MG-160 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
EXFORGE HCT 5 MG-160 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
EXJADE 125 MG DISPERSIBLE TABLET ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
EXJADE 250 MG DISPERSIBLE TABLET ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
EXJADE 500 MG DISPERSIBLE TABLET ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
EXKIVITY 40 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
EXSERVAN 50 MG ORAL FILM ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
EXTAVIA 0.3 MG SUBCUTANEOUS KIT ^{DL,MM,SP}	*	PA,QL(15 per 30 days)
EXTAVIA 0.3 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(15 per 30 days)
EXTENDED RESERVOIR 3 ML MISC ^{MM}	3	
EXTINA 2 % TOPICAL FOAM ^{DL,SP}	*	ST
EYSUVIS 0.25 % EYE DROPS,SUSPENSION	3	PA,QL(16.6 per 30 days)
EZ SMART CONTROL SOLUTION ^{MM}	3	
EZ SMART LANCETS 28 GAUGE ^{MM}	2	
EZ SMART PLUS SYSTEM KIT ^{MM}	3	ST
EZ SMART PLUS TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EZ SMART SYSTEM KIT ^{MM}	3	ST
EZ SMART TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
EZ-LETS 26 GAUGE ^{MM}	2	
EZALLOR SPRINKLE 10 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
EZALLOR SPRINKLE 20 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
EZALLOR SPRINKLE 40 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
EZALLOR SPRINKLE 5 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
ezetimibe 10 mg tablet ^{MM}	1	QL(30 per 30 days)
ezetimibe 10 mg-atorvastatin 10 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
ezetimibe 10 mg-atorvastatin 20 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
ezetimibe 10 mg-atorvastatin 40 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
ezetimibe 10 mg-atorvastatin 80 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
ezetimibe 10 mg-rosuvastatin 10 mg tablet ^{MM}	3	ST,QL(30 per 30 days)
ezetimibe 10 mg-rosuvastatin 20 mg tablet ^{MM}	3	ST,QL(30 per 30 days)
ezetimibe 10 mg-rosuvastatin 40 mg tablet ^{MM}	3	ST,QL(30 per 30 days)
ezetimibe 10 mg-rosuvastatin 5 mg tablet ^{MM}	3	ST,QL(30 per 30 days)
ezetimibe 10 mg-simvastatin 10 mg tablet ^{MM}	1	QL(30 per 30 days)
ezetimibe 10 mg-simvastatin 20 mg tablet ^{MM}	1	QL(30 per 30 days)
ezetimibe 10 mg-simvastatin 40 mg tablet ^{MM}	1	QL(30 per 30 days)
ezetimibe 10 mg-simvastatin 80 mg tablet ^{MM}	1	QL(30 per 30 days)
FABIOR 0.1 % TOPICAL FOAM	3	PA
FACTIVE 320 MG TABLET	3	
falmina (28) 0.1 mg-20 mcg tablet ^{MM}	1	
famciclovir 125 mg tablet ^{MM}	1	QL(90 per 30 days)
famciclovir 250 mg tablet ^{MM}	1	QL(90 per 30 days)
famciclovir 500 mg tablet ^{MM}	1	QL(90 per 30 days)
famotidine 20 mg tablet ^{MM}	1	
famotidine 40 mg tablet ^{MM}	1	
famotidine 40 mg/5 ml (8 mg/ml) oral suspension ^{MM}	1	
FANAPT 1 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
FANAPT 10 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
FANAPT 12 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
FANAPT 1MG(2)-2 MG(2)-4MG(2)-6 MG(2) TABLETS IN A DOSE PACK ^{SP}	*	PA,QL(60 per 30 days)
FANAPT 2 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
FANAPT 4 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
FANAPT 6 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
FANAPT 8 MG TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
FARESTON 60 MG TABLET ^{DL,MM,SP}	*	QL(30 per 30 days)
FARXIGA 10 MG TABLET ^{MM}	2	QL(30 per 30 days)
FARXIGA 5 MG TABLET ^{MM}	2	QL(30 per 30 days)
FARYDAK 10 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(6 per 21 days)
FARYDAK 15 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(6 per 21 days)
FARYDAK 20 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(6 per 21 days)
FASENRA PEN 30 MG/ML SUBCUTANEOUS AUTO-INJECTOR ^{LD,MM,SP}	*	PA,QL(2 per 56 days)
FASTEP COVID-19 AG HOME TEST KIT	3	
fe c plus 100 mg-250 mg-25 mcg-1 mg tablet	1	
febuxostat 40 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
febuxostat 80 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
felbamate 400 mg tablet ^{MM}	1	
felbamate 600 mg tablet ^{MM}	1	
felbamate 600 mg/5 ml oral suspension ^{MM}	1	
FELBATOL 400 MG TABLET ^{MM}	3	
FELBATOL 600 MG TABLET ^{MM}	3	
FELBATOL 600 MG/5 ML ORAL SUSPENSION ^{MM}	3	
FELDENE 10 MG CAPSULE	3	
FELDENE 20 MG CAPSULE	3	
felodipine er 10 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
felodipine er 2.5 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
felodipine er 5 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
FEMARA 2.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
FEMCAP 22 MM VAGINAL DEVICE	3	
FEMCAP 26 MM VAGINAL DEVICE	3	
FEMCAP 30 MM VAGINAL DEVICE	3	
FEMHRT LOW DOSE 0.5 MG-2.5 MCG TABLET ^{MM}	3	
FEMRING 0.05 MG/24 HR VAGINAL ^{MM}	3	QL(1 per 90 days)
FEMRING 0.1 MG/24 HR VAGINAL ^{MM}	3	QL(1 per 90 days)
femynor 0.25 mg-35 mcg tablet ^{MM}	1	
fenofibrate 120 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
fenofibrate 150 mg capsule ^{MM}	1	ST,QL(30 per 30 days)
fenofibrate 160 mg tablet ^{MM}	1	QL(30 per 30 days)
fenofibrate 40 mg tablet ^{MM}	1	ST,QL(60 per 30 days)
fenofibrate 50 mg capsule ^{MM}	1	ST,QL(60 per 30 days)
fenofibrate 54 mg tablet ^{MM}	1	QL(60 per 30 days)
fenofibrate micronized 130 mg capsule ^{MM}	1	ST,QL(30 per 30 days)
fenofibrate micronized 134 mg capsule ^{MM}	1	QL(30 per 30 days)
fenofibrate micronized 200 mg capsule ^{MM}	1	QL(30 per 30 days)
fenofibrate micronized 30 mg capsule ^{MM}	3	ST,QL(30 per 30 days)
fenofibrate micronized 43 mg capsule ^{MM}	1	ST,QL(30 per 30 days)
fenofibrate micronized 67 mg capsule ^{MM}	1	QL(60 per 30 days)
fenofibrate micronized 90 mg capsule ^{MM}	3	ST,QL(30 per 30 days)
fenofibrate nanocrystallized 145 mg tablet ^{MM}	1	QL(30 per 30 days)
fenofibrate nanocrystallized 48 mg tablet ^{MM}	1	QL(60 per 30 days)
fenofibric acid (choline) 135 mg capsule,delayed release ^{MM}	1	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
fenofibric acid (choline) 45 mg capsule,delayed release ^{MM}	1	ST,QL(30 per 30 days)
fenofibric acid 105 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
fenofibric acid 35 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
FENOGLIDE 120 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
FENOGLIDE 40 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
fenoprofen 200 mg capsule ^{DL,SP}	*	PA,QL(180 per 30 days)
fenoprofen 400 mg capsule	1	PA,QL(240 per 30 days)
fenoprofen 600 mg tablet	1	PA
fenortho 200 mg capsule ^{DL,SP}	*	PA,QL(180 per 30 days)
fentanyl 1,200 mcg lozenge on a handle ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 1,600 mcg lozenge on a handle ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 100 mcg buccal tablet, effervescent ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 100 mcg/hr transdermal patch ^{DL}	1	QL(20 per 30 days)
fentanyl 12 mcg/hr transdermal patch ^{DL}	1	QL(20 per 30 days)
fentanyl 200 mcg buccal tablet, effervescent ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 200 mcg lozenge on a handle ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 25 mcg/hr transdermal patch ^{DL}	1	QL(20 per 30 days)
fentanyl 37.5 mcg/hour transdermal patch ^{DL}	1	QL(20 per 30 days)
fentanyl 400 mcg buccal tablet, effervescent ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 400 mcg lozenge on a handle ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 50 mcg/hr transdermal patch ^{DL}	1	QL(20 per 30 days)
fentanyl 600 mcg buccal tablet, effervescent ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 600 mcg lozenge on a handle ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 62.5 mcg/hour transdermal patch ^{DL}	1	QL(20 per 30 days)
fentanyl 75 mcg/hr transdermal patch ^{DL}	1	QL(20 per 30 days)
fentanyl 800 mcg buccal tablet, effervescent ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 800 mcg lozenge on a handle ^{DL}	1	PA,QL(120 per 30 days)
fentanyl 87.5 mcg/hour transdermal patch ^{DL}	1	QL(20 per 30 days)
FENTORA 100 MCG BUCCAL TABLET, EFFERVESCENT ^{DL}	3	PA,QL(120 per 30 days)
FENTORA 200 MCG BUCCAL TABLET, EFFERVESCENT ^{DL}	3	PA,QL(120 per 30 days)
FENTORA 400 MCG BUCCAL TABLET, EFFERVESCENT ^{DL}	3	PA,QL(120 per 30 days)
FENTORA 600 MCG BUCCAL TABLET, EFFERVESCENT ^{DL}	3	PA,QL(120 per 30 days)
FENTORA 800 MCG BUCCAL TABLET, EFFERVESCENT ^{DL}	3	PA,QL(120 per 30 days)
ferocon 110 mg-0.5 mg capsule	1	
ferrex 150 forte plus 150 mg-60 mg-25 mcg-1 mg capsule	1	
FERRIPROX (2 TIMES A DAY) 1,000 MG TABLET ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
FERRIPROX 1,000 MG TABLET ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
FERRIPROX 100 MG/ML ORAL SOLUTION ^{DL,SP}	*	PA,QL(3600 per 30 days)
FERRIPROX 500 MG TABLET ^{DL,MM,SP}	*	PA,QL(720 per 30 days)
fesoterodine er 4 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
fesoterodine er 8 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
FETZIMA 120 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
FETZIMA 20 MG (2)-40 MG (26) CAPSULE,EXTENDED RELEASE,24 HR,DOSE PACK	3	PA,QL(28 per 28 days)
FETZIMA 20 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
FETZIMA 40 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
FETZIMA 80 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
FEXMID 7.5 MG TABLET	3	PA,QL(90 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS CARTRIDGE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
FIASP U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	
FIBRICOR 105 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
FIBRICOR 35 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
FIFTY50 SAFETY SEAL LANCETS 30 GAUGE ^{MM}	2	
FIFTY50 SAFETY SEAL LANCETS 32 GAUGE ^{MM}	2	
FIFTY50 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
FILSPARI 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
FILSPARI 400 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
FILTER NEEDLES 19 X 1 1/2"	3	
FILTER NEEDLES 19 X 1"	3	
FINACEA 15 % TOPICAL FOAM	3	PA
FINACEA 15 % TOPICAL GEL	3	ST
finasteride 5 mg tablet ^{MM}	1	QL(30 per 30 days)
FINE 30 UNIVERSAL LANCETS 30 GAUGE ^{MM}	3	
FINGERSTIX LANCETS ^{MM}	2	
fingolimod 0.5 mg capsule ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
FINTEPLA 2.2 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(360 per 30 days)
finzala 1 mg-20 mcg (24)/75 mg (4) chewable tablet ^{MM}	1	
fioricet 50 mg-300 mg-40 mg capsule	1	QL(180 per 30 days)
FIORICET WITH CODEINE 50 MG-300 MG-40 MG-30 MG CAPSULE ^{DL}	3	QL(180 per 30 days)
FIRAZYR 30 MG/3 ML SUBCUTANEOUS SYRINGE ^{DL,LD,SP}	*	PA,QL(9 per 30 days)
FIRDAPSE 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
FIRMAGON 120 MG SUBCUTANEOUS SOLUTION	3	PA
FIRMAGON KIT WITH DILUENT SYRINGE 120 MG SUBCUTANEOUS SOLUTION	3	PA
FIRMAGON KIT WITH DILUENT SYRINGE 80 MG SUBCUTANEOUS SOLUTION ^{MM}	3	PA
FIRVANQ 25 MG/ML ORAL SOLUTION	3	PA
FIRVANQ 50 MG/ML ORAL SOLUTION	3	PA
flac otic (ear) oil 0.01 % drops	1	
FLAGYL 375 MG CAPSULE	3	
FLAGYL 500 MG TABLET	3	
FLAREX 0.1 % EYE DROPS,SUSPENSION	3	ST
flavoxate 100 mg tablet ^{MM}	1	
flecainide 100 mg tablet ^{MM}	1	
flecainide 150 mg tablet ^{MM}	1	
flecainide 50 mg tablet ^{MM}	1	
FLECTOR 1.3 % TRANSDERMAL 12 HOUR PATCH ^{DL,SP}	*	PA,QL(60 per 30 days)
FLEQSUVY 25 MG/5 ML (5 MG/ML) ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(480 per 30 days)
FLEXICHAMBER SPACER	3	
FLEXICHAMBER-LARGE CHILD MASK	2	
FLEXICHAMBER-SMALL ADULT MASK	2	
FLEXICHAMBER-SMALL CHILD MASK	2	
FLOLIPID 20 MG/5 ML (4 MG/ML) ORAL SUSPENSION ^{MM}	3	ST,QL(150 per 30 days)
FLOLIPID 40 MG/5 ML (8 MG/ML) ORAL SUSPENSION ^{MM}	3	ST,QL(150 per 30 days)
FLOMAX 0.4 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
FLOVENT DISKUS 100 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
FLOVENT DISKUS 250 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
FLOVENT DISKUS 50 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
FLOVENT HFA 110 MCG/ACTUATION AEROSOL INHALER ^{MM}	2	QL(24 per 30 days)
FLOVENT HFA 220 MCG/ACTUATION AEROSOL INHALER ^{MM}	2	QL(24 per 30 days)
FLOVENT HFA 44 MCG/ACTUATION AEROSOL INHALER ^{MM}	2	QL(10.6 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
FLOWFLEX COVID-19 ANTIGEN HOME TEST KIT	3	
FLUAD QUAD 2022-2023(65YR UP)(PF) 60 MCG (15 MCG X 4)/0.5ML IM SYRINGE	3	
FLUARIX QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	3	
FLUBLOK QUAD 2022-2023 (PF) 180 MCG (45 MCG X 4)/0.5 ML IM SYRINGE	3	
FLUCELVAX QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	3	
FLUCELVAX QUAD 2022-2023 60 MCG (15 MCG X 4)/0.5 ML IM SUSPENSION	3	
fluconazole 10 mg/ml oral suspension	1	
fluconazole 100 mg tablet	1	
fluconazole 150 mg tablet	1	
fluconazole 200 mg tablet	1	
fluconazole 40 mg/ml oral suspension	1	
fluconazole 50 mg tablet	1	
flucytosine 250 mg capsule	1	
flucytosine 500 mg capsule	1	
fludrocortisone 0.1 mg tablet ^{MM}	1	
FLULAVAL QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	3	
FLUMADINE 100 MG TABLET	3	
FLUMIST QUAD 2022-2023 10EXP6.5-7.5 FF UNIT/0.2 ML NASAL SPRAY SYRINGE	3	
flunisolide 25 mcg (0.025 %) nasal spray ^{MM}	1	QL(50 per 30 days)
fluocinolone 0.01 % scalp oil and shower cap	1	ST
fluocinolone 0.01 % topical body oil	1	ST
fluocinolone 0.01 % topical cream	1	
fluocinolone 0.01 % topical solution	1	ST
fluocinolone 0.025 % topical cream	1	
fluocinolone 0.025 % topical ointment	1	
fluocinolone acetonide oil 0.01 % ear drops	1	
fluocinonide 0.05 % topical cream	1	
fluocinonide 0.05 % topical gel	1	
fluocinonide 0.05 % topical ointment	1	
fluocinonide 0.05 % topical solution	1	
fluocinonide 0.1 % topical cream	1	
fluocinonide-e 0.05 % topical cream	1	
fluocinonide-emollient 0.05 % topical cream	1	
fluorometholone 0.1 % eye drops,suspension	1	
FLUOROPLEX 1 % TOPICAL CREAM ^{DL,SP}	*	
fluorouracil 0.5 % topical cream	1	
fluorouracil 2 % topical solution	1	QL(30 per 30 days)
fluorouracil 5 % topical cream	1	
fluorouracil 5 % topical solution	1	QL(60 per 30 days)
fluoxetine 10 mg capsule ^{MM}	1	QL(60 per 30 days)
fluoxetine 10 mg tablet ^{MM}	1	QL(60 per 30 days)
fluoxetine 20 mg capsule ^{MM}	1	QL(120 per 30 days)
fluoxetine 20 mg tablet ^{MM}	1	QL(120 per 30 days)
fluoxetine 20 mg/5 ml (4 mg/ml) oral solution ^{MM}	1	
fluoxetine 40 mg capsule ^{MM}	1	QL(60 per 30 days)
fluoxetine 60 mg tablet ^{MM}	1	QL(30 per 30 days)
fluoxetine 90 mg capsule,delayed release ^{MM}	1	QL(4 per 28 days)
fluphenazine 1 mg tablet ^{MM}	1	
fluphenazine 10 mg tablet ^{MM}	1	
fluphenazine 2.5 mg tablet ^{MM}	1	
fluphenazine 2.5 mg/5 ml oral elixir ^{MM}	1	
fluphenazine 5 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
fluphenazine 5 mg/ml oral concentrate ^{MM}	1	
fluphenazine decanoate 25 mg/ml injection solution ^{MM}	1	
flurandrenolide 0.05 % lotion ^{DL,SP}	*	ST
flurandrenolide 0.05 % topical cream	1	ST
flurandrenolide 0.05 % topical ointment	1	ST
flurazepam 15 mg capsule ^{DL}	1	QL(60 per 30 days)
flurazepam 30 mg capsule ^{DL}	1	QL(30 per 30 days)
flurbiprofen 0.03 % eye drops	1	
flurbiprofen 100 mg tablet	1	
flutamide 125 mg capsule ^{MM}	1	QL(180 per 30 days)
fluticasone 100 mcg-salmeterol 50 mcg/dose blistr powdr for inhalation ^{MM}	1	QL(60 per 30 days)
fluticasone 113 mcg-salmeterol 14 mcg/actuation breath activated powdr ^{MM}	1	QL(1 per 30 days)
fluticasone 232 mcg-salmeterol 14 mcg/actuation breath activated powdr ^{MM}	1	QL(1 per 30 days)
fluticasone 250 mcg-salmeterol 50 mcg/dose blistr powdr for inhalation ^{MM}	1	QL(60 per 30 days)
fluticasone 500 mcg-salmeterol 50 mcg/dose blistr powdr for inhalation ^{MM}	1	QL(60 per 30 days)
fluticasone 55 mcg-salmeterol 14 mcg/actuation breath activated powder ^{MM}	1	QL(1 per 30 days)
fluticasone furoate 100 mcg-vilanterol 25 mcg/dose inhalation powder ^{MM}	3	ST,QL(60 per 30 days)
fluticasone furoate 200 mcg-vilanterol 25 mcg/dose inhalation powder ^{MM}	3	ST,QL(60 per 30 days)
fluticasone propionate 0.005 % topical ointment	1	
fluticasone propionate 0.05 % lotion	1	ST
fluticasone propionate 0.05 % topical cream	1	
fluticasone propionate 110 mcg/actuation hfa aerosol inhaler ^{MM}	3	PA,QL(24 per 30 days)
fluticasone propionate 115 mcg-salmeterol 21 mcg/actuation hfa inhaler ^{MM}	3	ST,QL(12 per 30 days)
fluticasone propionate 220 mcg/actuation hfa aerosol inhaler ^{MM}	3	PA,QL(24 per 30 days)
fluticasone propionate 230 mcg-salmeterol 21 mcg/actuation hfa inhaler ^{MM}	3	ST,QL(12 per 30 days)
fluticasone propionate 44 mcg/actuation hfa aerosol inhaler ^{MM}	3	PA,QL(10.6 per 30 days)
fluticasone propionate 45 mcg-salmeterol 21 mcg/actuation hfa inhaler ^{MM}	3	ST,QL(12 per 30 days)
fluticasone propionate 50 mcg/actuation nasal spray,suspension ^{MM}	1	QL(16 per 30 days)
fluvastatin 20 mg capsule ^{MM}	1	ST,QL(60 per 30 days)
fluvastatin 40 mg capsule ^{MM}	1	ST,QL(60 per 30 days)
fluvastatin er 80 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
fluvoxamine 100 mg tablet ^{MM}	1	QL(90 per 30 days)
fluvoxamine 25 mg tablet ^{MM}	1	QL(90 per 30 days)
fluvoxamine 50 mg tablet ^{MM}	1	QL(90 per 30 days)
fluvoxamine er 100 mg capsule,extended release 24 hr ^{MM}	1	ST,QL(60 per 30 days)
fluvoxamine er 150 mg capsule,extended release 24 hr ^{MM}	1	ST,QL(60 per 30 days)
FLUZONE HIGH-DOSE QUAD 2022-2023 (PF) 240 MCG/0.7 ML IM SYRINGE	3	
FLUZONE QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SUSPENSION	3	
FLUZONE QUAD 2022-2023 (PF) 60 MCG (15 MCG X 4)/0.5 ML IM SYRINGE	3	
FLUZONE QUAD 2022-2023 60 MCG (15 MCG X 4)/0.5 ML INTRAMUSCULAR SUSP.	3	
FML FORTE 0.25 % EYE DROPS,SUSPENSION	3	ST
FML LIQUIFILM 0.1 % EYE DROPS,SUSPENSION	3	ST
FOCALIN 10 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
FOCALIN 2.5 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
FOCALIN 5 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
FOCALIN XR 10 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
FOCALIN XR 15 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
FOCALIN XR 20 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
FOCALIN XR 25 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
FOCALIN XR 30 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
FOCALIN XR 35 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
FOCALIN XR 40 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
FOCALIN XR 5 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
folbee 2.5 mg-25 mg-1 mg tablet	1	
folic acid 1 mg tablet ^{MM}	1	
folivane-f 125 mg-1 mg-40 mg-3 mg capsule	1	
folivane-plus 125 mg iron-1 mg capsule	1	
folplex 2.2 mg-25 mg-0.5 mg tablet	1	
fondaparinux 10 mg/0.8 ml subcutaneous solution syringe ^{DL,SP}	*	QL(24 per 30 days)
fondaparinux 2.5 mg/0.5 ml subcutaneous solution syringe ^{DL,SP}	*	QL(15 per 30 days)
fondaparinux 5 mg/0.4 ml subcutaneous solution syringe ^{DL,SP}	*	QL(12 per 30 days)
fondaparinux 7.5 mg/0.6 ml subcutaneous solution syringe ^{DL,SP}	*	QL(18 per 30 days)
FORA 6 CONNECT GLUCOSE STRIP ^{MM}	3	ST,QL(150 per 30 days)
FORA 6 CONNECT MULTIFUNCTION MONITOR ^{MM}	3	ST
FORA D10 KIT ^{MM}	3	ST
FORA D15 GLUCOSE-BP MONITOR ^{MM}	3	ST
FORA D15G STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA D20 KIT ^{MM}	3	ST
FORA D20 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA D40-G31 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA D40D GLUCOSE-BP MONITOR ^{MM}	3	ST
FORA D40G GLUCOSE-BP MONITOR ^{MM}	3	ST
FORA G20 KIT ^{MM}	3	ST
FORA G20 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA G30-PREMIUM V10 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
FORA G30A ^{MM}	3	ST
FORA GD50 BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
FORA GD50 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA GTEL GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
FORA GTEL MULTI-FUNCTIONAL MONITOR ^{MM}	3	ST
FORA HIGH CONTROL SOLUTION ^{MM}	3	
FORA KETONE CONTROL SOLUTION-L1 ^{MM}	3	
FORA LANCING DEVICE	3	
FORA LOW CONTROL SOLUTION ^{MM}	3	
FORA NORMAL CONTROL SOLUTION ^{MM}	3	
FORA PREMIUM V10 GLUCOSE METER ^{MM}	3	ST
FORA TEST N'GO ADVANCE MONITOR ^{MM}	3	ST
FORA TEST N'GO ADVANCE PRO MONITOR ^{MM}	3	ST
FORA TEST N'GO ADVANCE PRO TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
FORA TEST N'GO VOICE METER ^{MM}	3	ST
FORA TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
FORA TN'G VOICE METER ^{MM}	3	ST
FORA TN'G VOICE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA V10 KIT ^{MM}	3	ST
FORA V10 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA V10-V12-D10-D20 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA V10-V12-D10-D20 STRIPS-LANCETS 30 GAUGE COMBO PACK ^{MM}	3	ST
FORA V12 BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
FORA V12 BLOOD GLUCOSE SYSTEM KIT ^{MM}	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
FORA V12 GLUCOSE STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA V20 KIT ^{MM}	3	ST
FORA V20 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORA V30A ^{MM}	3	ST
FORA V30A KIT ^{MM}	3	ST
FORA V30A STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORACARE GD20 GLUCOSE METER ^{MM}	3	ST
FORACARE GD20 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORACARE GD40 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORACARE GD40A GLUCOSE METER ^{MM}	3	ST
FORACARE GD40B GLUCOSE METER ^{MM}	3	ST
FORACARE GDH HIGH CONTROL SOLUTION ^{MM}	3	
FORACARE GDH LOW CONTROL SOLUTION ^{MM}	3	
FORACARE GDH NORMAL CONTROL SOLUTION ^{MM}	3	
FORACARE LANCETS 30 GAUGE ^{MM}	2	
FORFIVO XL 450 MG 24 HR TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
formoterol fumarate 20 mcg/2 ml solution for nebulization ^{DL,MM,SP}	*	QL(120 per 30 days)
FORTAMET 1,000 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
FORTAMET 500 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(150 per 30 days)
FORTEO 20 MCG/DOSE (600 MCG/2.4 ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM}	3	PA,QL(2.48 per 30 days)
FORTESTA 10 MG/0.5 GRAM/ACTUATION TRANSDERMAL GEL PUMP ^{MM}	3	PA,QL(120 per 30 days)
FORTISCARE G1 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
FORTISCARE GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FORTISCARE HIGH SOLUTION ^{MM}	3	
FORTISCARE LOW SOLUTION ^{MM}	3	
FORTISCARE NORMAL SOLUTION ^{MM}	3	
FORTISCARE T1 BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
FOSAMAX 70 MG TABLET ^{MM}	3	ST,QL(4 per 28 days)
FOSAMAX PLUS D 70 MG-2,800 UNIT TABLET ^{MM}	3	ST,QL(4 per 28 days)
FOSAMAX PLUS D 70 MG-5,600 UNIT TABLET ^{MM}	3	ST,QL(4 per 28 days)
fosamprenavir 700 mg tablet ^{MM,SP}	*	QL(120 per 30 days)
fosfomycin tromethamine 3 gram oral packet	1	
fosinopril 10 mg tablet ^{MM}	1	
fosinopril 10 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
fosinopril 20 mg tablet ^{MM}	1	
fosinopril 20 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
fosinopril 40 mg tablet ^{MM}	1	
FOSRENOL 1,000 MG CHEWABLE TABLET ^{DL,MM,SP}	*	ST
FOSRENOL 1,000 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	ST
FOSRENOL 500 MG CHEWABLE TABLET ^{DL,MM,SP}	*	ST
FOSRENOL 750 MG CHEWABLE TABLET ^{DL,MM,SP}	*	ST
FOSRENOL 750 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	ST
FOTIVDA 0.89 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(21 per 28 days)
FOTIVDA 1.34 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(21 per 28 days)
FRAGMIN 10,000 ANTI-XA UNIT/ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	QL(30 per 30 days)
FRAGMIN 12,500 ANTI-XA UNIT/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	QL(15 per 30 days)
FRAGMIN 15,000 ANTI-XA UNIT/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	QL(18 per 30 days)
FRAGMIN 18,000 ANTI-XA UNIT/0.72 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	QL(21.6 per 30 days)
FRAGMIN 2,500 ANTI-XA UNIT/0.2 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	QL(6 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
FRAGMIN 2,500 ANTI-XA UNIT/ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	QL(120 per 30 days)
FRAGMIN 25,000 ANTI-XA UNIT/ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	QL(22.8 per 30 days)
FRAGMIN 5,000 ANTI-XA UNIT/0.2 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	QL(6 per 30 days)
FRAGMIN 7,500 ANTI-XA UNIT/0.3 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	QL(9 per 30 days)
FREESTYLE CONTROL SOLUTION ^{MM}	3	
FREESTYLE FLASH SYSTEM KIT ^{MM}	3	ST
FREESTYLE FREEDOM KIT ^{MM}	3	ST
FREESTYLE FREEDOM LITE KIT ^{MM}	3	ST
FREESTYLE INSULINX METER ^{MM}	3	ST
FREESTYLE INSULINX STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FREESTYLE INSULINX TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FREESTYLE LANCETS 28 GAUGE ^{MM}	3	
FREESTYLE LIBRE 14 DAY READER ^{MM}	3	PA
FREESTYLE LIBRE 14 DAY SENSOR KIT ^{MM}	3	PA
FREESTYLE LIBRE 2 READER ^{MM}	3	PA
FREESTYLE LIBRE 2 SENSOR KIT ^{MM}	3	PA
FREESTYLE LIBRE 3 SENSOR DEVICE ^{MM}	3	PA
FREESTYLE LITE METER KIT ^{MM}	3	ST
FREESTYLE LITE STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FREESTYLE PRECISION 0.5 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
FREESTYLE PRECISION 0.5 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
FREESTYLE PRECISION 1 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
FREESTYLE PRECISION 1 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
FREESTYLE PRECISION NEO METER ^{MM}	3	ST
FREESTYLE PRECISION NEO STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FREESTYLE SIDEKICK II KIT ^{MM}	3	ST
FREESTYLE SYSTEM KIT ^{MM}	3	ST
FREESTYLE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
FREESTYLE UNISTIK 2 ^{MM}	3	
FROVA 2.5 MG TABLET	3	ST,QL(12 per 30 days)
frovatriptan 2.5 mg tablet	1	ST,QL(12 per 30 days)
FULPHILA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.2 per 28 days)
FURADANTIN 25 MG/5 ML ORAL SUSPENSION	3	QL(2400 per 30 days)
FUROSCIX 80 MG/10 ML SUBCUTANEOUS WEARABLE INJECTOR KIT ^{DL,SP}	*	PA
furosemide 10 mg/ml oral solution ^{MM}	1	
furosemide 20 mg tablet ^{MM}	1	
furosemide 40 mg tablet ^{MM}	1	
furosemide 40 mg/5 ml (8 mg/ml) oral solution ^{MM}	1	
furosemide 80 mg tablet ^{MM}	1	
FUZEON 90 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	QL(60 per 30 days)
fyavolv 0.5 mg-2.5 mcg tablet ^{MM}	1	
fyavolv 1 mg-5 mcg tablet ^{MM}	1	
FYCOMPA 0.5 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	QL(680 per 28 days)
FYCOMPA 10 MG TABLET ^{DL,MM,SP}	*	QL(30 per 30 days)
FYCOMPA 12 MG TABLET ^{DL,MM,SP}	*	QL(30 per 30 days)
FYCOMPA 2 MG TABLET ^{DL,MM,SP}	*	QL(30 per 30 days)
FYCOMPA 4 MG TABLET ^{DL,MM,SP}	*	QL(30 per 30 days)
FYCOMPA 6 MG TABLET ^{DL,MM,SP}	*	QL(30 per 30 days)
FYCOMPA 8 MG TABLET ^{DL,MM,SP}	*	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
FYLNETRA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.2 per 28 days)
gabapentin 100 mg capsule ^{MM}	1	QL(270 per 30 days)
gabapentin 250 mg/5 ml (5 ml) oral solution ^{MM}	1	QL(2250 per 30 days)
gabapentin 250 mg/5 ml oral solution ^{MM}	1	QL(2250 per 30 days)
gabapentin 300 mg capsule ^{MM}	1	QL(270 per 30 days)
gabapentin 300 mg/6 ml (6 ml) oral solution ^{MM}	1	QL(2250 per 30 days)
gabapentin 400 mg capsule ^{MM}	1	QL(270 per 30 days)
gabapentin 600 mg tablet ^{MM}	1	QL(180 per 30 days)
gabapentin 800 mg tablet ^{MM}	1	QL(180 per 30 days)
GABITRIL 12 MG TABLET ^{DL,MM,SP}	*	QL(140 per 30 days)
GABITRIL 16 MG TABLET ^{DL,MM,SP}	*	QL(105 per 30 days)
GABITRIL 2 MG TABLET ^{DL,MM,SP}	*	QL(840 per 30 days)
GABITRIL 4 MG TABLET ^{DL,MM,SP}	*	QL(120 per 30 days)
GALAFOLD 123 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(14 per 28 days)
galantamine 12 mg tablet ^{MM}	1	QL(60 per 30 days)
galantamine 4 mg tablet ^{MM}	1	QL(60 per 30 days)
galantamine 4 mg/ml oral solution ^{MM}	1	QL(200 per 30 days)
galantamine 8 mg tablet ^{MM}	1	QL(60 per 30 days)
galantamine er 16 mg 24 hr capsule,extended release ^{MM}	1	QL(30 per 30 days)
galantamine er 24 mg 24 hr capsule,extended release ^{MM}	1	QL(30 per 30 days)
galantamine er 8 mg 24 hr capsule,extended release ^{MM}	1	QL(30 per 30 days)
GALZIN 25 MG (ZINC) CAPSULE	3	
GALZIN 50 MG (ZINC) CAPSULE	3	
GASTROCROM 100 MG/5 ML ORAL CONCENTRATE ^{DL,SP}	*	
gatifloxacin 0.5 % eye drops	1	QL(2.5 per 25 days)
GATTEX 30-VIAL 5 MG SUBCUTANEOUS KIT ^{DL,MM,SP}	*	PA,QL(1 per 30 days)
GATTEX ONE-VIAL 5 MG SUBCUTANEOUS KIT ^{DL,MM,SP}	*	PA,QL(1 per 30 days)
gavilyte-c 240 gram-22.72 gram-6.72 gram-5.84 gram oral solution	1	
gavilyte-g 236 gram-22.74 gram-6.74 gram-5.86 gram oral solution	1	
gavilyte-n 420 gram oral solution	1	
GAVRETO 100 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
GDRIVE KIT ^{MM}	3	ST
GE100 BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
GE100 BLOOD GLUCOSE SYSTEM KIT ^{MM}	3	ST
GE100 BLOOD GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
GE100 CONTROL SOLUTION NORMAL ^{MM}	3	
GE333 BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
GE333 BLOOD GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
GE333 CONTROL SOLUTION NORMAL ^{MM}	3	
GELNIQUE 10 % (100 MG/GRAM) TRANSDERMAL GEL PACKET ^{MM}	3	ST,QL(30 per 30 days)
gemfibrozil 600 mg tablet ^{MM}	1	QL(60 per 30 days)
gemmily 1 mg-20 mcg (24)/75 mg (4) capsule ^{MM}	1	
GEMTESA 75 MG TABLET ^{MM}	3	QL(30 per 30 days)
GENABIO COVID-19 RAPID AT-HOME KIT	3	
GENERESS FE 0.8 MG-25 MCG (24)/75 MG (4) CHEWABLE TABLET ^{MM}	3	
generlac 10 gram/15 ml oral solution ^{MM}	1	
gengraf 100 mg capsule ^{MM}	1	QL(720 per 30 days)
gengraf 100 mg/ml oral solution ^{MM}	1	
gengraf 25 mg capsule ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
GENOTROPIN 12 MG/ML (36 UNIT/ML) SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN 5 MG/ML (15 UNIT/ML) SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 0.2 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 0.4 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 0.6 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 0.8 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 1 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 1.2 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 1.4 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 1.6 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 1.8 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENOTROPIN MINIQUICK 2 MG/0.25 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
GENSTRIP TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
gentak 0.3 % (3 mg/gram) eye ointment	1	
gentamicin 0.1 % topical cream	1	
gentamicin 0.1 % topical ointment	1	
gentamicin 0.3 % eye drops	1	
GENTEEL VACUUM LANCING DEVICE COMBO PACK ^{MM}	3	
GENULTIMATE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
GEODON 20 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
GEODON 20 MG/ML (FINAL CONCENTRATION) INTRAMUSCULAR SOLUTION	3	
GEODON 40 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
GEODON 60 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
GEODON 80 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
GILENYA 0.25 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
GILENYA 0.5 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
GILOTRIF 20 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
GILOTRIF 30 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
GILOTRIF 40 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
GIMOTI 15 MG/SPRAY NASAL SPRAY WITH PUMP ^{DL,SP}	*	PA,QL(9.8 per 28 days)
glatiramer 20 mg/ml subcutaneous syringe ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
glatiramer 40 mg/ml subcutaneous syringe ^{DL,MM,SP}	*	PA,QL(12 per 28 days)
glatopa 20 mg/ml subcutaneous syringe ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
glatopa 40 mg/ml subcutaneous syringe ^{DL,MM,SP}	*	PA,QL(12 per 28 days)
GLEEVEC 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
GLEEVEC 400 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
GLEOSTINE 10 MG CAPSULE ^{DL,SP}	*	PA,QL(35 per 30 days)
GLEOSTINE 100 MG CAPSULE ^{DL,SP}	*	PA,QL(3 per 30 days)
GLEOSTINE 40 MG CAPSULE ^{DL,SP}	*	PA,QL(9 per 30 days)
glimepiride 1 mg tablet ^{MM}	1	
glimepiride 2 mg tablet ^{MM}	1	
glimepiride 4 mg tablet ^{MM}	1	
glipizide 10 mg tablet ^{MM}	1	
glipizide 2.5 mg-metformin 250 mg tablet ^{MM}	1	
glipizide 2.5 mg-metformin 500 mg tablet ^{MM}	1	
glipizide 5 mg tablet ^{MM}	1	
glipizide 5 mg-metformin 500 mg tablet ^{MM}	1	
glipizide er 10 mg tablet, extended release 24 hr ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
glipizide er 2.5 mg tablet, extended release 24 hr ^{MM}	1	
glipizide er 5 mg tablet, extended release 24 hr ^{MM}	1	
GLOPERBA 0.6 MG/5 ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
GLUCAGEN DIAGNOSTIC KIT 1 MG/ML INJECTION	2	
GLUCAGEN HYPOKIT 1 MG INJECTION	2	
GLUCAGON (HCL) EMERGENCY KIT 1 MG SOLUTION FOR INJECTION	3	
glucagon emergency kit 1 mg solution for injection	1	ST
GLUCO NAVII GLUCOSE MONITOR KIT ^{MM}	3	ST
GLUCO NAVII TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
GLUCOCARD 01 HIGH-NORMAL CONTROL SOLUTION ^{MM}	3	
GLUCOCARD 01 METER KIT ^{MM}	3	ST
GLUCOCARD 01 NORMAL CONTROL SOLUTION ^{MM}	3	
GLUCOCARD 01 SENSOR PLUS STRIPS ^{MM}	3	ST,QL(150 per 30 days)
GLUCOCARD EXPRESSION ^{MM}	3	ST
GLUCOCARD EXPRESSION KIT ^{MM}	3	ST
GLUCOCARD EXPRESSION SOLUTION ^{MM}	3	
GLUCOCARD EXPRESSION STRIPS ^{MM}	3	ST,QL(150 per 30 days)
GLUCOCARD SHINE CONNEX METER ^{MM}	3	ST
GLUCOCARD SHINE EXPRESS METER ^{MM}	3	ST
GLUCOCARD SHINE METER ^{MM}	3	ST
GLUCOCARD SHINE METER KIT ^{MM}	3	ST
GLUCOCARD SHINE SOLUTION ^{MM}	3	
GLUCOCARD SHINE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
GLUCOCARD SHINE XL METER ^{MM}	3	ST
GLUCOCARD VITAL KIT ^{MM}	3	ST
GLUCOCARD VITAL SENSOR STRIPS ^{MM}	3	ST,QL(150 per 30 days)
GLUCOCARD VITAL TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
GLUCOCOM BLOOD GLUCOSE KIT ^{MM}	3	ST
GLUCOCOM CONTROL HIGH SOLUTION ^{MM}	3	
GLUCOCOM CONTROL NORMAL SOLUTION ^{MM}	3	
GLUCOCOM GLUCOSE STRIPS ^{MM}	3	ST,QL(150 per 30 days)
GLUCOCOM LANCETS 28 GAUGE ^{MM}	2	
GLUCOCOM LANCETS 30 GAUGE ^{MM}	2	
GLUCOCOM LANCETS 33 GAUGE ^{MM}	2	
glucose 4 gram chewable tablet	1	
GLUCOSE CONTROL SOLUTION ^{MM}	3	
GLUCOSE KETONE CONTROL SOLN SOLUTION ^{MM}	3	
GLUCOTROL 10 MG TABLET ^{MM}	3	
GLUCOTROL XL 10 MG TABLET,EXTENDED RELEASE ^{MM}	3	
GLUCOTROL XL 2.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	
GLUCOTROL XL 5 MG TABLET,EXTENDED RELEASE ^{MM}	3	
GLUMETZA 1,000 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(60 per 30 days)
GLUMETZA 500 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
glyburide 1.25 mg tablet ^{MM}	1	
glyburide 1.25 mg-metformin 250 mg tablet ^{MM}	1	
glyburide 2.5 mg tablet ^{MM}	1	
glyburide 2.5 mg-metformin 500 mg tablet ^{MM}	1	
glyburide 5 mg tablet ^{MM}	1	
glyburide 5 mg-metformin 500 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
glyburide micronized 1.5 mg tablet ^{MM}	1	
glyburide micronized 3 mg tablet ^{MM}	1	
glyburide micronized 6 mg tablet ^{MM}	1	
GLYCATE 1.5 MG TABLET ^{DL,MM,SP}	*	
glycopyrrolate 1 mg tablet ^{MM}	1	
glycopyrrolate 1 mg/5 ml (0.2 mg/ml) oral solution ^{MM}	1	
glycopyrrolate 1.5 mg tablet ^{DL,MM,SP}	*	
glycopyrrolate 2 mg tablet ^{MM}	1	
glydo 2 % mucosal jelly in applicator	1	
GLYNASE 1.5 MG TABLET ^{MM}	3	
GLYNASE 3 MG TABLET ^{MM}	3	
GLYNASE 6 MG TABLET ^{MM}	3	
GLYXAMBI 10 MG-5 MG TABLET ^{MM}	2	QL(30 per 30 days)
GLYXAMBI 25 MG-5 MG TABLET ^{MM}	2	QL(30 per 30 days)
GM100 KIT ^{MM}	3	ST
GM100 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
GOCOVRI 137 MG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
GOCOVRI 68.5 MG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
GOJJI BLOOD GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
GOJJI GLUCOSE CONTROL SOLUTION-NORMAL ^{MM}	3	
GOJJI KETONE CONTROL SOLUTION-L1 ^{MM}	3	
GOJJI LANCETS 30 GAUGE ^{MM}	2	
GOJJI LANCETS 30 GAUGE-GLUCOSE TEST STRIPS COMBO PACK ^{MM}	3	ST
GOJJI LANCING DEVICE	2	
GOJJI MULTI-FUNCTIONAL METER ^{MM}	3	ST
GOJJI MULTI-FUNCTIONAL METER KIT ^{MM}	3	ST
GOLYTELY 236 GRAM-22.74 GRAM-6.74 GRAM-5.86 GRAM ORAL SOLUTION	3	
GONITRO 400 MCG SUBLINGUAL POWDER IN A PACKET ^{MM}	3	
GOODLIFE AC-302 GLUCOSE METER ^{MM}	3	ST
GOODLIFE AC-302 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
GRALISE 300 MG (9)-600 MG (24) TABLET, ER 24 HR DOSE PACK ^{DL,SP}	*	ST,QL(33 per 15 days)
GRALISE 300 MG TABLET,EXTENDED RELEASE ^{DL,SP}	*	ST,QL(30 per 30 days)
GRALISE 600 MG TABLET,EXTENDED RELEASE ^{DL,SP}	*	ST,QL(90 per 30 days)
granisetron hcl 1 mg tablet	1	QL(28 per 28 days)
GRANIX 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(7 per 28 days)
GRANIX 300 MCG/ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	PA,QL(14 per 28 days)
GRANIX 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(11.2 per 28 days)
GRANIX 480 MCG/1.6 ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	PA,QL(22.4 per 28 days)
GRASTEK 2,800 BAU SUBLINGUAL TABLET ^{MM}	3	ST,QL(30 per 30 days)
griseofulvin microsize 125 mg/5 ml oral suspension	1	
griseofulvin microsize 500 mg tablet	1	
griseofulvin ultramicrosize 125 mg tablet	1	
griseofulvin ultramicrosize 250 mg tablet	1	
guanfacine 1 mg tablet ^{MM}	1	
guanfacine 2 mg tablet ^{MM}	1	
guanfacine er 1 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
guanfacine er 2 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
guanfacine er 3 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
guanfacine er 4 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
GUARDIAN CONNECT TRANSMITTER DEVICE ^{MM}	3	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
GUARDIAN LINK 3 TRANSMITTER DEVICE ^{MM}	3	PA
GUARDIAN REAL-TIME GLUCOSE MONITOR ^{MM}	3	PA
GUARDIAN SENSOR 3 DEVICE ^{MM}	3	PA
GVOKE 1 MG/0.2 ML SUBCUTANEOUS SOLUTION	2	
GVOKE HYPOPEN 1-PACK 0.5 MG/0.1 ML SUBCUTANEOUS AUTO-INJECTOR	2	
GVOKE HYPOPEN 1-PACK 1 MG/0.2 ML SUBCUTANEOUS AUTO-INJECTOR	2	
GVOKE HYPOPEN 2-PACK 0.5 MG/0.1 ML SUBCUTANEOUS AUTO-INJECTOR	2	
GVOKE HYPOPEN 2-PACK 1 MG/0.2 ML SUBCUTANEOUS AUTO-INJECTOR	2	
GVOKE PFS 1-PACK 0.5 MG/0.1 ML SUBCUTANEOUS SYRINGE	2	
GVOKE PFS 1-PACK 1 MG/0.2 ML SUBCUTANEOUS SYRINGE	2	
GVOKE PFS 2-PACK 0.5 MG/0.1 ML SUBCUTANEOUS SYRINGE	2	
GVOKE PFS 2-PACK 1 MG/0.2 ML SUBCUTANEOUS SYRINGE	2	
gynazole-1 2 % vaginal cream	1	
HAEGARDA 2,000 UNIT SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(20 per 28 days)
HAEGARDA 3,000 UNIT SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(20 per 28 days)
hailey 1.5 mg-30 mcg tablet ^{MM}	1	
hailey 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet ^{MM}	1	
hailey fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet ^{MM}	1	
hailey fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
halcinonide 0.1 % topical cream	1	ST
HALCION 0.25 MG TABLET ^{DL}	3	QL(30 per 30 days)
HALDOL DECANOATE 100 MG/ML INTRAMUSCULAR SOLUTION ^{MM}	3	QL(5 per 30 days)
HALDOL DECANOATE 50 MG/ML INTRAMUSCULAR SOLUTION ^{MM}	3	QL(9 per 30 days)
HALO CLOSED VIAL ADAPTOR 13 MM DEVICE	3	
HALO CLOSED VIAL ADAPTOR 20 MM DEVICE	3	
HALO CLOSED VIAL ADAPTOR 28 MM DEVICE	3	
HALO VIAL CONVERTER 13 MM DEVICE	3	
halobetasol propionate 0.05 % topical cream	1	
halobetasol propionate 0.05 % topical foam ^{DL,SP}	*	PA
halobetasol propionate 0.05 % topical ointment	1	
haloette 0.12 mg-0.015 mg/24 hr vaginal ring ^{MM}	1	QL(1 per 28 days)
HALOG 0.1 % TOPICAL CREAM	3	ST
HALOG 0.1 % TOPICAL OINTMENT ^{DL,SP}	*	ST
HALOG 0.1 % TOPICAL SOLUTION ^{DL,SP}	*	ST
haloperidol 0.5 mg tablet ^{MM}	1	
haloperidol 1 mg tablet ^{MM}	1	
haloperidol 10 mg tablet ^{MM}	1	
haloperidol 2 mg tablet ^{MM}	1	
haloperidol 20 mg tablet ^{MM}	1	
haloperidol 5 mg tablet ^{MM}	1	
haloperidol decanoate 100 mg/ml intramuscular solution ^{MM}	1	QL(5 per 30 days)
haloperidol decanoate 50 mg/ml intramuscular solution ^{MM}	1	QL(9 per 30 days)
haloperidol lactate 2 mg/ml oral concentrate ^{MM}	1	
HARMONY CONTROL L1,L3 SOLUTION ^{MM}	3	
HARMONY GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
HARVONI 33.75 MG-150 MG ORAL PELLETS IN PACKET ^{DL,SP}	*	PA,QL(28 per 28 days)
HARVONI 45 MG-200 MG ORAL PELLETS IN PACKET ^{DL,SP}	*	PA,QL(56 per 28 days)
HARVONI 45 MG-200 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
HARVONI 90 MG-400 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
HAVRIX (PF) 1,440 ELISA UNIT/ML INTRAMUSCULAR SYRINGE	3	
HAVRIX (PF) 720 ELISA UNIT/0.5 ML INTRAMUSCULAR SYRINGE	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
HEALTHPRO GLUCOSE MONITOR ^{MM}	3	ST
HEALTHPRO HIGH-LOW CONTROL SOLUTION ^{MM}	3	
HEALTHPRO TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
HEALTHWISE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
HEALTHWISE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
HEALTHWISE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
HEALTHWISE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
HEALTHWISE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
HEALTHWISE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
HEALTHWISE PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
HEALTHWISE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
HEALTHWISE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
HEALTHY ACCENTS AUTOLET IMPRESSION LANCING DEVICE	3	
HEALTHY ACCENTS UNIFINE PENTIP 29 GAUGE X 1/2" NEEDLE ^{MM}	2	
HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 1/4" NEEDLE ^{MM}	2	
HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
HEALTHY ACCENTS UNIFINE PENTIP 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
HEALTHY ACCENTS UNIFINE PENTIP 32 GAUGE X 5/32" NEEDLE ^{MM}	2	
HEALTHY ACCENTS UNILET LANCET 30 GAUGE ^{MM}	2	
heather 0.35 mg tablet ^{MM}	1	
helidac 250 mg-500 mg-262.4 mg oral pack ^{DL,SP}	*	PA,QL(224 per 30 days)
HEMADY 20 MG TABLET	3	PA,QL(24 per 28 days)
HEMANGEOL 4.28 MG/ML ORAL SOLUTION ^{DL,SP}	*	
hematinic/folic acid 324 mg (106 mg iron)-1 mg tablet	1	
hematogen fa 200 mg-250 mg-0.01 mg-1 mg capsule	1	
hematogen forte 460 mg-60 mg-0.01 mg-1 mg capsule	1	
HEMOCYTE-F 324 MG (106 MG IRON)-1 MG TABLET	3	
HEMOCYTE-PLUS 106 MG IRON-1 MG CAPSULE	3	
heparin (porcine) 1,000 unit/ml injection solution	1	
heparin (porcine) 10,000 unit/ml injection solution	1	
heparin (porcine) 20,000 unit/ml injection solution	1	
heparin (porcine) 5,000 unit/ml (1 ml) injection cartridge	1	
heparin (porcine) 5,000 unit/ml injection solution	1	
heparin (porcine) 5,000 unit/ml injection syringe	1	
heparin, porcine (pf) 1,000 unit/ml injection solution	1	
heparin, porcine (pf) 5,000 unit/0.5 ml injection solution	1	
heparin, porcine (pf) 5,000 unit/0.5 ml injection syringe	1	
heparin, porcine (pf) 5,000 unit/0.5 ml subcutaneous syringe	1	
heparin, porcine (pf) 5,000 unit/ml injection syringe	1	
HEPSERA 10 MG TABLET ^{DL,SP}	*	
her style 1.5 mg tablet	1	
HETLIOZ 20 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
HETLIOZ LQ 4 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(158 per 30 days)
hidex 1.5 mg (21 tabs) tablets in a dose pack	1	
HIPREX 1 GRAM TABLET	3	
HIZENTRA 1 GRAM/5 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA
HIZENTRA 1 GRAM/5 ML (20 %) SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA
HIZENTRA 10 GRAM/50 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA
HIZENTRA 2 GRAM/10 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA
HIZENTRA 2 GRAM/10 ML (20 %) SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA
HIZENTRA 4 GRAM/20 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
HIZENTRA 4 GRAM/20 ML (20 %) SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA
HORIZANT ER 300 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
HORIZANT ER 600 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
HUMALOG JUNIOR KWIKPEN (U-100) 100 UNIT/ML SUBCUTANEOUS HALF-UNIT PEN ^{MM}	3	ST
HUMALOG KWIKPEN (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS ^{MM}	3	ST
HUMALOG KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST
HUMALOG MIX 50-50 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION ^{MM}	3	ST
HUMALOG MIX 50-50 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN ^{MM}	3	ST
HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION ^{MM}	3	ST
HUMALOG MIX 75-25 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN ^{MM}	3	ST
HUMALOG TEMPO PEN (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS ^{MM}	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS CARTRIDGE ^{MM}	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
HUMATIN 250 MG CAPSULE	1	ST
HUMATROPE 12 MG (36 UNIT) INJECTION CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
HUMATROPE 24 MG (72 UNIT) INJECTION CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
HUMATROPE 5 MG (15 UNIT) SOLUTION FOR INJECTION ^{DL,MM,SP}	*	PA,QL(12 per 30 days)
HUMATROPE 6 MG (18 UNIT) INJECTION CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 30 days)
HUMIRA 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML SUBCUTANEOUS KIT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML SUBCUT KIT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS-ADOL HID SUP START 40 MG/0.8 ML SUBCUT KT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML SUBCUTANEOUS SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML SUBCUTANEOUS SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) 40 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) PEDI CROHN'S START 80 MG/0.8 ML-40 MG/0.4 ML SUBCUT SYR KIT ^{DL,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML SUBCUT SYRINGE KIT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML SUBCUTANEOUS KIT ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) PEN 80 MG/0.8 ML SUBCUTANEOUS KIT ^{DL,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) PEN CROHN'S-ULC COLITIS-HID SUP STRT 80 MG/0.8 ML SUBCUT KT ^{DL,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PEDIATRIC ULCER COLITIS STARTER 80 MG/0.8 ML SUBCUT KIT ^{DL,SP}	*	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PS-UV-ADOL HS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT ^{DL,SP}	*	PA,QL(6 per 28 days)
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION ^{MM}	3	ST
HUMULIN 70/30 U-100 INSULIN KWIKPEN 100 UNIT/ML SUBCUTANEOUS ^{MM}	3	ST
HUMULIN N NPH U-100 INSULIN (ISOPHANE SUSP) 100 UNIT/ML SUBCUTANEOUS ^{MM}	3	ST
HUMULIN N NPH U-100 INSULIN KWIKPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST
HUMULIN R REGULAR U-100 INSULIN 100 UNIT/ML INJECTION SOLUTION ^{MM}	3	ST
HUMULIN R U-500 (CONC) INSULIN KWIKPEN 500 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	
HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML SUBCUTANEOUS SOLN ^{MM}	3	
HYCAMTIN 0.25 MG CAPSULE ^{DL,SP}	*	QL(100 per 25 days)
HYCAMTIN 1 MG CAPSULE ^{DL,SP}	*	QL(25 per 25 days)
HYCODAN (WITH HOMATROPINE) 5 MG-1.5 MG TABLET	3	
HYCODAN (WITH HOMATROPINE) 5 MG-1.5 MG/5 ML ORAL SYRUP	3	
HYCODAN 5 MG-1.5 MG/5 ML (5 ML) ORAL SYRUP	3	
hydralazine 10 mg tablet ^{MM}	1	
hydralazine 100 mg tablet ^{MM}	1	
hydralazine 25 mg tablet ^{MM}	1	
hydralazine 50 mg tablet ^{MM}	1	
HYDREA 500 MG CAPSULE ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
hydrochlorothiazide 12.5 mg capsule ^{MM}	1	
hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
hydrochlorothiazide 25 mg tablet ^{MM}	1	
hydrochlorothiazide 50 mg tablet ^{MM}	1	
hydrocodone 10 mg-acetaminophen 300 mg tablet ^{DL}	1	QL(180 per 30 days)
hydrocodone 10 mg-acetaminophen 325 mg tablet ^{DL}	1	QL(360 per 30 days)
hydrocodone 10 mg-acetaminophen 325 mg/15 ml (15 ml) oral solution ^{DL}	1	QL(2700 per 30 days)
hydrocodone 10 mg-chlorpheniramine 8 mg/5 ml oral susp extend.rel 12hr	1	
hydrocodone 10 mg-ibuprofen 200 mg tablet ^{DL}	1	QL(150 per 30 days)
hydrocodone 2.5 mg-acetaminophen 325 mg tablet ^{DL}	1	QL(360 per 30 days)
hydrocodone 5 mg-acetaminophen 300 mg tablet ^{DL}	1	QL(240 per 30 days)
hydrocodone 5 mg-acetaminophen 325 mg tablet ^{DL}	1	QL(360 per 30 days)
hydrocodone 5 mg-ibuprofen 200 mg tablet ^{DL}	1	QL(150 per 30 days)
hydrocodone 7.5 mg-acetaminophen 300 mg tablet ^{DL}	1	QL(180 per 30 days)
hydrocodone 7.5 mg-acetaminophen 325 mg tablet ^{DL}	1	QL(360 per 30 days)
hydrocodone 7.5 mg-acetaminophen 325 mg/15 ml oral solution ^{DL}	1	QL(5520 per 30 days)
hydrocodone 7.5 mg-ibuprofen 200 mg tablet ^{DL}	1	QL(150 per 30 days)
hydrocodone bitartrate er 10 mg capsule, oral only, extended rel 12 hr ^{DL}	1	ST,QL(90 per 30 days)
hydrocodone bitartrate er 100 mg tablet, crush resist,extend.rel. 24hr ^{DL}	1	ST,QL(30 per 30 days)
hydrocodone bitartrate er 120 mg tablet, crush resist,extend.rel. 24hr ^{DL}	1	ST,QL(30 per 30 days)
hydrocodone bitartrate er 15 mg capsule, oral only, extended rel 12 hr ^{DL}	1	ST,QL(90 per 30 days)
hydrocodone bitartrate er 20 mg capsule, oral only, extended rel 12 hr ^{DL}	1	ST,QL(90 per 30 days)
hydrocodone bitartrate er 20 mg tablet,crush resist,extended rel. 24hr ^{DL}	1	ST,QL(30 per 30 days)
hydrocodone bitartrate er 30 mg capsule, oral only, extended rel 12 hr ^{DL}	1	ST,QL(90 per 30 days)
hydrocodone bitartrate er 30 mg tablet,crush resist,extended rel. 24hr ^{DL}	1	ST,QL(30 per 30 days)
hydrocodone bitartrate er 40 mg capsule, oral only, extended rel 12 hr ^{DL}	1	ST,QL(90 per 30 days)
hydrocodone bitartrate er 40 mg tablet,crush resist,extended rel. 24hr ^{DL}	1	ST,QL(30 per 30 days)
hydrocodone bitartrate er 50 mg capsule, oral only, extended rel 12 hr ^{DL}	1	ST,QL(120 per 30 days)
hydrocodone bitartrate er 60 mg tablet,crush resist,extended rel. 24hr ^{DL}	1	ST,QL(30 per 30 days)
hydrocodone bitartrate er 80 mg tablet,crush resist,extended rel. 24hr ^{DL}	1	ST,QL(30 per 30 days)
hydrocodone-homatropine 5 mg-1.5 mg tablet	1	
hydrocodone-homatropine 5 mg-1.5 mg/5 ml (5 ml) oral syrup	1	
hydrocodone-homatropine 5 mg-1.5 mg/5 ml oral syrup	1	
hydrocortisone 1 % topical cream	1	
hydrocortisone 1 % topical cream with perineal applicator	1	
hydrocortisone 1 % topical ointment	1	
hydrocortisone 10 mg tablet ^{MM}	1	
hydrocortisone 100 mg/60 ml enema	1	
hydrocortisone 2.5 % lotion	1	
hydrocortisone 2.5 % topical cream	1	
hydrocortisone 2.5 % topical cream with perineal applicator	1	
hydrocortisone 2.5 % topical ointment	1	
hydrocortisone 20 mg tablet ^{MM}	1	
hydrocortisone 5 mg tablet ^{MM}	1	
hydrocortisone butyrate 0.1 % lotion ^{DL,SP}	*	ST
hydrocortisone butyrate 0.1 % topical cream	1	
hydrocortisone butyrate 0.1 % topical ointment	1	
hydrocortisone butyrate 0.1 % topical solution	1	
hydrocortisone butyrate-emollient 0.1 % topical cream	1	ST
hydrocortisone valerate 0.2 % topical cream	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
hydrocortisone valerate 0.2 % topical ointment	1	
hydrocortisone-acetic acid 1 %-2 % ear drops	1	
hydrocortisone-pramoxine 1 %-1 % rectal cream	1	
hydromet 5 mg-1.5 mg/5 ml oral syrup	1	
hydromorphone 1 mg/ml oral liquid ^{DL}	1	QL(2400 per 30 days)
hydromorphone 2 mg tablet ^{DL}	1	QL(360 per 30 days)
hydromorphone 3 mg rectal suppository ^{DL}	1	QL(120 per 30 days)
hydromorphone 4 mg tablet ^{DL}	1	QL(360 per 30 days)
hydromorphone 8 mg tablet ^{DL}	1	QL(240 per 30 days)
hydromorphone er 12 mg tablet,extended release 24 hr ^{DL}	1	ST,QL(180 per 30 days)
hydromorphone er 16 mg tablet,extended release 24 hr ^{DL}	1	ST,QL(120 per 30 days)
hydromorphone er 32 mg tablet,extended release 24 hr ^{DL}	1	ST,QL(60 per 30 days)
hydromorphone er 8 mg tablet,extended release 24 hr ^{DL}	1	ST,QL(240 per 30 days)
hydroxocobalamin 1,000 mcg/ml intramuscular solution	1	
hydroxychloroquine 100 mg tablet ^{MM}	1	
hydroxychloroquine 200 mg tablet ^{MM}	1	
hydroxychloroquine 300 mg tablet ^{MM}	1	
hydroxychloroquine 400 mg tablet ^{MM}	1	
hydroxyurea 500 mg capsule ^{MM}	1	
hydroxyzine hcl 10 mg tablet	1	
hydroxyzine hcl 10 mg/5 ml oral solution	1	
hydroxyzine hcl 25 mg tablet	1	
hydroxyzine hcl 50 mg tablet	1	
hydroxyzine pamoate 100 mg capsule	1	
hydroxyzine pamoate 25 mg capsule	1	
hydroxyzine pamoate 50 mg capsule	1	
HYFTOR 0.2 % TOPICAL GEL ^{DL,MM,SP}	*	PA
hyoscyamine 0.125 mg disintegrating tablet ^{MM}	1	
hyoscyamine 0.125 mg sublingual tablet ^{MM}	1	
hyoscyamine 0.125 mg/5 ml oral elixir ^{MM}	1	
hyoscyamine 0.125 mg/ml oral drops ^{MM}	1	
hyoscyamine er 0.375 mg tablet,extended release,12 hr ^{MM}	1	
hyoscyamine sulfate 0.125 mg tablet ^{MM}	1	
hyosyne 0.125 mg/5 ml oral elixir ^{MM}	1	
hyosyne 0.125 mg/ml oral drops ^{MM}	1	
hyper-sal 3.5 % solution for nebulization	3	
hyper-sal 7 % solution for nebulization	3	
HYPOLANCE AST LANCING KIT ^{MM}	3	
HYQVIA 10 GRAM/100 ML (10 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
HYQVIA 2.5 GRAM/25 ML (10 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
HYQVIA 20 GRAM/200 ML (10 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
HYQVIA 30 GRAM/300 ML (10 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
HYQVIA 5 GRAM/50 ML (10 %) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA
HYQVIA HY COMPONENT 1,600 UNIT/10 ML SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA HY COMPONENT 2,400 UNIT/15 ML SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA HY COMPONENT 200 UNIT/1.25 ML SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA HY COMPONENT 400 UNIT/2.5 ML SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA HY COMPONENT 800 UNIT/5 ML SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA IG COMPONENT 10 GRAM/100 ML (10 %) SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA IG COMPONENT 2.5 GRAM/25 ML (10 %) SUBCUTANEOUS SOLUTION ^{MM}	3	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
HYQVIA IG COMPONENT 20 GRAM/200 ML (10 %) SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA IG COMPONENT 30 GRAM/300 ML (10 %) SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYQVIA IG COMPONENT 5 GRAM/50 ML (10 %) SUBCUTANEOUS SOLUTION ^{MM}	3	PA
HYSINGLA ER 100 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
HYSINGLA ER 120 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
HYSINGLA ER 20 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
HYSINGLA ER 30 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
HYSINGLA ER 40 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
HYSINGLA ER 60 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
HYSINGLA ER 80 MG TABLET, CRUSH RESISTANT, EXTENDED RELEASE ^{DL}	3	ST,QL(30 per 30 days)
HYZAAR 100 MG-12.5 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
HYZAAR 100 MG-25 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
HYZAAR 50 MG-12.5 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ibandronate 150 mg tablet ^{MM}	1	QL(1 per 28 days)
IBRANCE 100 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
IBRANCE 100 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
IBRANCE 125 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
IBRANCE 125 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
IBRANCE 75 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
IBRANCE 75 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
IBSRELA 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ibu 400 mg tablet ^{MM}	1	
ibu 600 mg tablet ^{MM}	1	
ibu 800 mg tablet ^{MM}	1	
ibuprofen 100 mg/5 ml oral suspension ^{MM}	1	
ibuprofen 400 mg tablet ^{MM}	1	
ibuprofen 600 mg tablet ^{MM}	1	
ibuprofen 800 mg tablet ^{MM}	1	
ibuprofen 800 mg-famotidine 26.6 mg tablet ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ICAR-C PLUS 100 MG-250 MG-25 MCG-1 MG TABLET	3	
icatibant 30 mg/3 ml subcutaneous syringe ^{DL,SP}	*	PA,QL(9 per 30 days)
iclevia 0.15 mg-30 mcg (91) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
ICLUSIG 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ICLUSIG 15 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ICLUSIG 30 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ICLUSIG 45 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
icosapent ethyl 0.5 gram capsule ^{MM}	1	PA,QL(240 per 30 days)
icosapent ethyl 1 gram capsule ^{MM}	1	PA,QL(120 per 30 days)
IDHIFA 100 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
IDHIFA 50 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
IGLUCE BLOOD GLUCOSE MONITOR KIT ^{MM}	3	ST
IGLUCE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
IHEALTH COVID-19 ANTIGEN RAPID HOME TEST KIT	3	
ILEVRO 0.3 % EYE DROPS,SUSPENSION	2	
imatinib 100 mg tablet ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
imatinib 400 mg tablet ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
IMBRUVICA 140 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
IMBRUVICA 140 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
IMBRUVICA 280 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
IMBRUVICA 420 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
IMBRUVICA 560 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
IMBRUVICA 70 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA
imipramine 10 mg tablet ^{MM}	1	
imipramine 25 mg tablet ^{MM}	1	
imipramine 50 mg tablet ^{MM}	1	
imipramine pamoate 100 mg capsule ^{MM}	1	
imipramine pamoate 125 mg capsule ^{MM}	1	
imipramine pamoate 150 mg capsule ^{MM}	1	
imipramine pamoate 75 mg capsule ^{MM}	1	
imiquimod 3.75 % topical cream in a pump ^{DL,SP}	*	ST,QL(15 per 30 days)
imiquimod 3.75 % topical cream packet ^{DL,SP}	*	ST,QL(28 per 28 days)
imiquimod 5 % topical cream packet	1	QL(12 per 30 days)
IMITREX 100 MG TABLET	3	ST,QL(9 per 30 days)
IMITREX 20 MG/ACTUATION NASAL SPRAY	3	ST,QL(12 per 30 days)
IMITREX 25 MG TABLET	3	ST,QL(9 per 30 days)
IMITREX 5 MG/ACTUATION NASAL SPRAY	3	ST,QL(12 per 30 days)
IMITREX 50 MG TABLET	3	ST,QL(9 per 30 days)
IMITREX 6 MG/0.5 ML SUBCUTANEOUS SOLUTION	3	QL(6 per 30 days)
IMITREX STATDOSE PEN 4 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	3	QL(6 per 30 days)
IMITREX STATDOSE PEN 6 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	3	QL(6 per 30 days)
IMITREX STATDOSE REFILL 4 MG/0.5 ML SUBCUTANEOUS CARTRIDGE	3	QL(6 per 30 days)
IMITREX STATDOSE REFILL 6 MG/0.5 ML SUBCUTANEOUS CARTRIDGE	3	QL(6 per 30 days)
IMPAVIDO 50 MG CAPSULE ^{DL,SP}	*	QL(84 per 28 days)
IMPEKLO 0.05 % TOPICAL LOTION IN PUMP ^{DL,SP}	*	ST,QL(136 per 28 days)
IMPOYZ 0.025 % TOPICAL CREAM ^{DL,SP}	*	ST,QL(120 per 30 days)
IMURAN 50 MG TABLET ^{MM}	3	
INBRIJA 42 MG CAPSULE WITH INHALATION DEVICE ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
INBRIJA 42 MG CAPSULES FOR INHALATION ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
incassia 0.35 mg tablet ^{MM}	1	
INCONTROL LANCING DEVICE	3	
INCONTROL PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
INCONTROL PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
INCONTROL PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
INCONTROL PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
INCONTROL PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
INCONTROL SUPER THIN LANCETS 30 GAUGE ^{MM}	3	
INCONTROL ULTRA THIN LANCETS 28 GAUGE ^{MM}	3	
INCRELEX 10 MG/ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	PA,QL(52 per 30 days)
INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION ^{MM}	2	QL(30 per 30 days)
indapamide 1.25 mg tablet ^{MM}	1	
indapamide 2.5 mg tablet ^{MM}	1	
INDERAL LA 120 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
INDERAL LA 160 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
INDERAL LA 60 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
INDERAL LA 80 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
INDERAL XL 120 MG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	
INDERAL XL 80 MG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	
INDICAID COVID-19 AG HOME TEST KIT	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
INDOCIN 25 MG/5 ML ORAL SUSPENSION ^{DL,SP}	*	
INDOCIN 50 MG RECTAL SUPPOSITORY	3	
indomethacin 25 mg capsule	1	
indomethacin 50 mg capsule	1	
indomethacin er 75 mg capsule,extended release	1	
indomethacin submicronized 20 mg capsule ^{DL,SP}	*	QL(90 per 30 days)
INFASURF 35 MG/ML INTRATRACHEAL SUSPENSION	3	
INFINITY CONTROL SOLUTION HIGH ^{MM}	3	
INFINITY CONTROL SOLUTION LOW ^{MM}	3	
INFINITY CONTROL SOLUTION NORMAL ^{MM}	3	
INFINITY METER KIT ^{MM}	3	ST
INFINITY STARTER KIT ^{MM}	3	ST
INFINITY TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
INFINITY VOICE CONTROL SOLUTION-LEVEL 2 ^{MM}	3	
INFINITY VOICE GLUCOSE MONITOR ^{MM}	3	ST
INFINITY VOICE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
INGREZZA 40 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
INGREZZA 60 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
INGREZZA 80 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
INGREZZA INITIATION PACK 40 MG (7)-80 MG (21) CAPSULES IN A DOSE PACK ^{DL,SP}	*	PA,QL(28 per 28 days)
INJECT EASE LANCETS 28 GAUGE ^{MM}	2	
INJECT EASE LANCETS 30 GAUGE ^{MM}	2	
INLYTA 1 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
INLYTA 5 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
INNOPRAN XL 120 MG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	
INNOPRAN XL 80 MG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	
INQOVI 35 MG-100 MG TABLET ^{DL,MM,SP}	*	PA,QL(5 per 28 days)
INREBIC 100 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
INSPIRACHAMBER SPACER	3	
INSPIRACHAMBER WITH MASK-LARGE	3	
INSPIRACHAMBER WITH MASK-MED	3	
INSPIRACHAMBER WITH MASK-SMALL	3	
INSPIRA 25 MG TABLET ^{MM}	3	
INSPIRA 50 MG TABLET ^{MM}	3	
INSULIN ASPAR PROT-INSULIN ASPART 100 UNIT/ML (70-30) SUBCUTANEOUS PEN ^{MM}	2	PA
INSULIN ASPAR PRT-INSULIN ASPART 100 UNIT/ML (70-30) SUBCUTANEOUS SOLN ^{MM}	2	PA
INSULIN ASPART (U-100) 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	2	PA
INSULIN ASPART U-100 100 UNIT/ML SUBCUTANEOUS CARTRIDGE ^{MM}	2	PA
INSULIN ASPART U-100 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	PA
INSULIN DEGLUDEC (U-100) 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	3	ST
INSULIN DEGLUDEC (U-100) 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
INSULIN DEGLUDEC (U-200) 200 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	3	ST
INSULIN GLARGINE (U-100) 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	2	ST
INSULIN GLARGINE (U-100) 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	ST
INSULIN GLARGINE-YFGN (U-100) 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	3	ST
INSULIN GLARGINE-YFGN (U-100) 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
INSULIN LISPRO (U-100) 100 UNIT/ML SUBCUTANEOUS HALF-UNIT PEN ^{MM}	3	ST
INSULIN LISPRO (U-100) 100 UNIT/ML SUBCUTANEOUS PEN ^{MM}	3	ST
INSULIN LISPRO (U-100) 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
INSULIN LISPRO PROTAMINE-LISPRO 100 UNIT/ML (75-25) SUBCUTANEOUS PEN ^{MM}	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"MM	2	
INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"MM	2	
INSULIN SYRINGE MICROFINE 1 ML 27 GAUGE X 5/8"MM	2	
INSULIN SYRINGE MICROFINE 1/2 ML 28 GAUGE X 1/2"MM	2	
INSULIN SYRINGE NEEDLELESS 1 MLMM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 29 GAUGE ^{MM}	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 29 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30 ^{MM}	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 30 GAUGE X 5/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 1/4"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 15/64"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.3 ML 31 GAUGE X 5/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 29 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 30 GAUGE X 5/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 0.5 ML 31 GAUGE X 5/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 27 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 28 GAUGE ^{MM}	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 28 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 29 GAUGE X 7/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 3/8"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 5/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 30 GAUGE X 7/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 1/4"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 15/64"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1 ML 31 GAUGE X 5/16"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 27 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE ^{MM}	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 28 GAUGE X 1/2"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 29 ^{MM}	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 30 GAUGE ^{MM}	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 1/4"MM	2	
INSULIN SYRINGE U-100 WITH NEEDLE 1/2 ML 31 GAUGE X 15/64"MM	2	
INSULIN SYRINGE-NEEDLE U-100 HALF UNIT MARKING 0.3 ML 31 GAUGE X 1/4"MM	2	
INSUPEN PEN NEEDLE 29 GAUGE X 1/2"MM	2	
INSUPEN PEN NEEDLE 30 GAUGE X 5/16"MM	2	
INSUPEN PEN NEEDLE 31 GAUGE X 1/4"MM	2	
INSUPEN PEN NEEDLE 31 GAUGE X 3/16"MM	2	
INSUPEN PEN NEEDLE 31 GAUGE X 5/16"MM	2	
INSUPEN PEN NEEDLE 32 GAUGE X 1/4"MM	2	
INSUPEN PEN NEEDLE 32 GAUGE X 5/16"MM	2	
INSUPEN PEN NEEDLE 32 GAUGE X 5/32"MM	2	
INSUPEN PEN NEEDLE 33 GAUGE X 5/32"MM	3	
INTEGRA F 125 MG-1 MG-40 MG-3 MG CAPSULE	3	
INTEGRA PLUS 125 MG IRON-1 MG CAPSULE	3	
INTEGRA SYRINGE 3 ML 21 GAUGE X 1"	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
INTELENCE 100 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
INTELENCE 200 MG TABLET ^{MM,SP}	*	QL(60 per 30 days)
INTELENCE 25 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
INTELISWAB COVID-19 RAPID HOME TEST KIT	3	
INTERLINK SYRINGE AND CANNULA 15 X 10 ML	3	
INTRON A 10 MILLION UNIT (1 ML) SOLUTION FOR INJECTION ^{DL,LD,SP}	*	PA,QL(12 per 30 days)
INTRON A 10 MILLION UNIT/ML INJECTION SOLUTION ^{DL,LD,SP}	*	PA,QL(12 per 30 days)
INTRON A 18 MILLION UNIT (1 ML) SOLUTION FOR INJECTION ^{DL,LD,SP}	*	PA,QL(12 per 30 days)
INTRON A 50 MILLION UNIT (1 ML) SOLUTION FOR INJECTION ^{DL,LD,SP}	*	PA,QL(12 per 30 days)
INTRON A 6 MILLION UNIT/ML INJECTION SOLUTION ^{DL,LD,SP}	*	PA,QL(136.8 per 30 days)
INTUNIV ER 1 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
INTUNIV ER 2 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
INTUNIV ER 3 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
INTUNIV ER 4 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
INVACARE LANCETS 30 GAUGE ^{MM}	2	
INVEGA 1.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
INVEGA 3 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
INVEGA 6 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
INVEGA 9 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
INVEGA HAFYERA 1,092 MG/3.5 ML INTRAMUSCULAR SYRINGE ^{MM,SP}	*	QL(3.5 per 180 days)
INVEGA HAFYERA 1,560 MG/5 ML INTRAMUSCULAR SYRINGE ^{MM,SP}	*	QL(5 per 180 days)
INVEGA SUSTENNA 117 MG/0.75 ML INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	QL(1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	QL(1 per 28 days)
INVEGA SUSTENNA 234 MG/1.5 ML INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	QL(1.5 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	QL(1.5 per 28 days)
INVEGA SUSTENNA 78 MG/0.5 ML INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	QL(1.5 per 28 days)
INVEGA TRINZA 273 MG/0.88 ML INTRAMUSCULAR SYRINGE ^{MM,SP}	*	QL(0.88 per 90 days)
INVEGA TRINZA 410 MG/1.32 ML INTRAMUSCULAR SYRINGE ^{MM,SP}	*	QL(1.32 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML INTRAMUSCULAR SYRINGE ^{MM,SP}	*	QL(1.75 per 90 days)
INVEGA TRINZA 819 MG/2.63 ML INTRAMUSCULAR SYRINGE ^{MM,SP}	*	QL(2.63 per 90 days)
INVELTYS 1 % EYE DROPS,SUSPENSION	3	ST
INVIRASE 500 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
INVOKAMET 150 MG-1,000 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
INVOKAMET 150 MG-500 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
INVOKAMET 50 MG-1,000 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
INVOKAMET 50 MG-500 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
INVOKANA 100 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
INVOKANA 300 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
IOPIDINE 1 % EYE DROPS IN A DROPPERETTE	3	
ipratropium 0.5 mg-albuterol 3 mg (2.5 mg base)/3 ml nebulization soln ^{MM}	1	
ipratropium bromide 0.02 % solution for inhalation ^{MM}	1	
ipratropium bromide 21 mcg (0.03 %) nasal spray ^{MM}	1	QL(30 per 30 days)
ipratropium bromide 42 mcg (0.06 %) nasal spray	1	QL(45 per 30 days)
irbesartan 150 mg tablet ^{MM}	1	QL(30 per 30 days)
irbesartan 150 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
irbesartan 300 mg tablet ^{MM}	1	QL(30 per 30 days)
irbesartan 300 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(30 per 30 days)
irbesartan 75 mg tablet ^{MM}	1	QL(30 per 30 days)
IRESSA 250 MG TABLET ^{DL,SP}	*	PA,QL(30 per 30 days)
IROSPAN 24/6 65 MG-65 MG-1,000 MCG (24) TABLET	3	
ISENTRESS 100 MG CHEWABLE TABLET ^{MM,SP}	*	QL(180 per 30 days)
ISENTRESS 100 MG ORAL POWDER PACKET ^{MM,SP}	*	QL(300 per 30 days)
ISENTRESS 25 MG CHEWABLE TABLET ^{MM,SP}	*	QL(180 per 30 days)
ISENTRESS 400 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
ISENTRESS HD 600 MG TABLET ^{MM,SP}	*	QL(60 per 30 days)
isibloom 0.15 mg-0.03 mg tablet ^{MM}	1	
isoniazid 100 mg tablet	1	
isoniazid 300 mg tablet	1	
isoniazid 50 mg/5 ml oral solution	1	
ISOPTO CARPINE 1 % EYE DROPS ^{MM}	2	
ISOPTO CARPINE 2 % EYE DROPS ^{MM}	2	
ISOPTO CARPINE 4 % EYE DROPS ^{MM}	2	
ISORDIL 40 MG TABLET ^{MM}	3	
ISORDIL TITRADOSE 5 MG TABLET ^{MM}	3	
isosorbide 20 mg-hydralazine 37.5 mg tablet ^{MM}	1	QL(180 per 30 days)
isosorbide dinitrate 10 mg tablet ^{MM}	1	
isosorbide dinitrate 20 mg tablet ^{MM}	1	
isosorbide dinitrate 30 mg tablet ^{MM}	1	
isosorbide dinitrate 40 mg tablet ^{MM}	1	
isosorbide dinitrate 5 mg tablet ^{MM}	1	
isosorbide mononitrate 10 mg tablet ^{MM}	1	
isosorbide mononitrate 20 mg tablet ^{MM}	1	
isosorbide mononitrate er 120 mg tablet,extended release 24 hr ^{MM}	1	
isosorbide mononitrate er 30 mg tablet,extended release 24 hr ^{MM}	1	
isosorbide mononitrate er 60 mg tablet,extended release 24 hr ^{MM}	1	
isotretinoin 10 mg capsule	1	QL(60 per 30 days)
isotretinoin 20 mg capsule	1	QL(60 per 30 days)
isotretinoin 25 mg capsule ^{DL,SP}	*	ST,QL(60 per 30 days)
isotretinoin 30 mg capsule	1	QL(60 per 30 days)
isotretinoin 35 mg capsule ^{DL,SP}	*	ST,QL(60 per 30 days)
isotretinoin 40 mg capsule	1	QL(120 per 30 days)
isradipine 2.5 mg capsule ^{MM}	1	
isradipine 5 mg capsule ^{MM}	1	
ISTALOL 0.5 % EYE DROPS ^{MM}	3	
ISTURISA 1 MG TABLET ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
ISTURISA 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
ISTURISA 5 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
itraconazole 10 mg/ml oral solution	1	QL(150 per 30 days)
itraconazole 100 mg capsule	1	QL(120 per 30 days)
ivermectin 1 % topical cream	1	ST
ivermectin 3 mg tablet	1	
JADENU 180 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(600 per 30 days)
JADENU 360 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(300 per 30 days)
JADENU 90 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(1200 per 30 days)
JADENU SPRINKLE 180 MG ORAL GRANULES IN PACKET ^{DL,LD,MM,SP}	*	PA,QL(600 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
JADENU SPRINKLE 360 MG ORAL GRANULES IN PACKET ^{DL,LD,MM,SP}	*	PA,QL(300 per 30 days)
JADENU SPRINKLE 90 MG ORAL GRANULES IN PACKET ^{DL,LD,MM,SP}	*	PA,QL(1200 per 30 days)
jaimiess 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
JAKAFI 10 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
JAKAFI 15 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
JAKAFI 20 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
JAKAFI 25 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
JAKAFI 5 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
JALYN 0.5 MG-0.4 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
JANSSEN COVID-19 VACCINE (PF) 0.5 ML INTRAMUSCULAR SUSPENSION (EUA)	3	
jantoven 1 mg tablet ^{MM}	1	
jantoven 10 mg tablet ^{MM}	1	
jantoven 2 mg tablet ^{MM}	1	
jantoven 2.5 mg tablet ^{MM}	1	
jantoven 3 mg tablet ^{MM}	1	
jantoven 4 mg tablet ^{MM}	1	
jantoven 5 mg tablet ^{MM}	1	
jantoven 6 mg tablet ^{MM}	1	
jantoven 7.5 mg tablet ^{MM}	1	
JANUMET 50 MG-1,000 MG TABLET ^{MM}	2	QL(60 per 30 days)
JANUMET 50 MG-500 MG TABLET ^{MM}	2	QL(60 per 30 days)
JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
JANUVIA 100 MG TABLET ^{MM}	2	QL(30 per 30 days)
JANUVIA 25 MG TABLET ^{MM}	2	QL(30 per 30 days)
JANUVIA 50 MG TABLET ^{MM}	2	QL(30 per 30 days)
JARDIANCE 10 MG TABLET ^{MM}	2	QL(30 per 30 days)
JARDIANCE 25 MG TABLET ^{MM}	2	QL(30 per 30 days)
jasmiel (28) 3 mg-0.02 mg tablet ^{MM}	1	
JATENZO 158 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
JATENZO 198 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
JATENZO 237 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
javygtor 100 mg oral powder packet ^{DL,MM,SP}	*	PA
javygtor 100 mg soluble tablet ^{DL,MM,SP}	*	PA
javygtor 500 mg oral powder packet ^{DL,MM,SP}	*	PA
JAYPIRCA 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
JAYPIRCA 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
JAZZ WIRELESS 2 METER KIT ^{MM}	3	ST
jencycla 0.35 mg tablet ^{MM}	1	
JENTADUETO 2.5 MG-1,000 MG TABLET ^{MM}	2	QL(60 per 30 days)
JENTADUETO 2.5 MG-500 MG TABLET ^{MM}	2	QL(60 per 30 days)
JENTADUETO 2.5 MG-850 MG TABLET ^{MM}	2	QL(60 per 30 days)
JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
jinteli 1 mg-5 mcg tablet ^{MM}	1	
JOENJA 70 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
jolessa 0.15 mg-30 mcg (91) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
JORNAY PM 100 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
JORNAY PM 20 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
JORNAY PM 40 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
JORNAY PM 60 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
JORNAY PM 80 MG CAPSULE,DELAYED RELEASE,EXTENDED RELEASE SPRINKLE ^{MM}	3	ST,QL(30 per 30 days)
juleber 0.15 mg-0.03 mg tablet ^{MM}	1	
JULUCA 50 MG-25 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
junel 1.5/30 (21) 1.5 mg-30 mcg tablet ^{MM}	1	
junel 1/20 (21) 1 mg-20 mcg tablet ^{MM}	1	
junel fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet ^{MM}	1	
junel fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
junel fe 24 1 mg-20 mcg (24)/75 mg (4) tablet ^{MM}	1	
JUXTAPID 10 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
JUXTAPID 20 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(84 per 28 days)
JUXTAPID 30 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
JUXTAPID 5 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
JYNARQUE 15 MG (AM)/15 MG (PM) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
JYNARQUE 15 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
JYNARQUE 30 MG (AM)/15 MG (PM) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
JYNARQUE 30 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
JYNARQUE 45 MG (AM)/15 MG (PM) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
JYNARQUE 60 MG (AM)/30 MG (PM) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
JYNARQUE 90 MG (AM)/30 MG (PM) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
K-PHOS NO 2 305 MG-700 MG TABLET	3	
K-PHOS ORIGINAL 500 MG SOLUBLE TABLET	2	
K-TAB 10 MEQ TABLET,EXTENDED RELEASE ^{MM}	2	
K-TAB 20 MEQ TABLET,EXTENDED RELEASE ^{MM}	2	
K-TAB 8 MEQ TABLET,EXTENDED RELEASE ^{MM}	2	
kaitlib fe 0.8 mg-25 mcg (24)/75 mg (4) chewable tablet ^{MM}	1	
KALETRA 100 MG-25 MG TABLET ^{MM,SP}	*	QL(300 per 30 days)
KALETRA 200 MG-50 MG TABLET ^{MM,SP}	*	QL(150 per 30 days)
KALETRA 400 MG-100 MG/5 ML ORAL SOLUTION ^{MM}	3	
kalliga 0.15 mg-0.03 mg tablet ^{MM}	1	
KALYDECO 150 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
KALYDECO 25 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
KALYDECO 50 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
KALYDECO 75 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
KAPSPARGO SPRINKLE 100 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
KAPSPARGO SPRINKLE 200 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
KAPSPARGO SPRINKLE 25 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
KAPSPARGO SPRINKLE 50 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
KAPVAY 0.1 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(120 per 30 days)
KARBINAL ER 4 MG/5 ML ORAL SUSPENSION,EXTENDED RELEASE	3	
kariva (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet ^{MM}	1	
KATERZIA 1 MG/ML ORAL SUSPENSION ^{MM}	3	QL(300 per 30 days)
KAZANO 12.5 MG-1,000 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
KAZANO 12.5 MG-500 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
KEFLEX 750 MG CAPSULE	3	
kelnor 1-50 (28) 1 mg-50 mcg tablet ^{MM}	1	
kelnor 1/35 (28) 1 mg-35 mcg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
KENALOG 0.147 MG/GRAM TOPICAL AEROSOL ^{DL,SP}	*	ST
KEPPRA 1,000 MG TABLET ^{MM}	3	ST
KEPPRA 100 MG/ML ORAL SOLUTION ^{MM}	3	ST,QL(900 per 30 days)
KEPPRA 250 MG TABLET ^{MM}	3	ST
KEPPRA 500 MG TABLET ^{MM}	3	ST
KEPPRA 750 MG TABLET ^{MM}	3	ST
KEPPRA XR 500 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
KEPPRA XR 750 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
KERENDIA 10 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
KERENDIA 20 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
KESIMPTA PEN 20 MG/0.4 ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(6 per 365 days)
ketoconazole 2 % shampoo	1	
ketoconazole 2 % topical cream	1	
ketoconazole 2 % topical foam ^{DL,SP}	*	ST
ketoconazole 200 mg tablet	1	
ketodan 2 % topical foam ^{DL,SP}	*	ST
ketoprofen 25 mg capsule	1	
ketoprofen 50 mg capsule	1	
ketoprofen 75 mg capsule	1	
ketoprofen er 200 mg 24 hr capsule,extended release	1	
ketorolac 0.4 % eye drops	1	QL(10 per 30 days)
ketorolac 0.5 % eye drops	1	QL(10 per 30 days)
ketorolac 10 mg tablet	1	QL(20 per 30 days)
ketorolac 15.75 mg/spray nasal spray ^{DL,SP}	*	PA,QL(5 per 30 days)
KEVEYIS 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
KEVZARA 150 MG/1.14 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(2.28 per 28 days)
KEVZARA 150 MG/1.14 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(2.28 per 28 days)
KEVZARA 200 MG/1.14 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(2.28 per 28 days)
KEVZARA 200 MG/1.14 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(2.28 per 28 days)
KINERET 100 MG/0.67 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(20.1 per 30 days)
kionex (with sorbitol) 15 gram-19.3 gram/60 ml oral suspension	1	
KISQALI 200 MG/DAY (200 MG X 1) TABLET ^{DL,MM,SP}	*	PA,QL(21 per 28 days)
KISQALI 400 MG/DAY (200 MG X 2) TABLET ^{DL,MM,SP}	*	PA,QL(42 per 28 days)
KISQALI 600 MG/DAY (200 MG X 3) TABLET ^{DL,MM,SP}	*	PA,QL(63 per 28 days)
KISQALI FEMARA CO-PACK 200 MG/DAY(200 MG X 1)-2.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(49 per 28 days)
KISQALI FEMARA CO-PACK 400 MG/DAY(200 MG X 2)-2.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(70 per 28 days)
KISQALI FEMARA CO-PACK 600 MG/DAY(200 MG X 3)-2.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(91 per 28 days)
KITABIS PAK 300 MG/5 ML SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	PA,QL(280 per 28 days)
KLARON 10 % LOTION (SUSPENSION)	3	
KLISYRI 1 % TOPICAL OINTMENT IN PACKET ^{DL,SP}	*	PA,QL(5 per 30 days)
KLONOPIN 0.5 MG TABLET ^{DL,MM}	3	
KLONOPIN 1 MG TABLET ^{DL,MM}	3	
KLONOPIN 2 MG TABLET ^{DL,MM}	3	
KLOR-CON 10 MEQ TABLET,EXTENDED RELEASE ^{MM}	2	
klor-con 20 meq oral packet ^{MM}	1	
KLOR-CON 8 MEQ TABLET,EXTENDED RELEASE ^{MM}	2	
klor-con m10 meq tablet,extended release ^{MM}	1	
KLOR-CON M15 MEQ TABLET,EXTENDED RELEASE ^{MM}	1	
klor-con m20 meq tablet,extended release ^{MM}	1	
klor-con/ef 25 meq effervescent tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
KLOXXADO 8 MG/ACTUATION NASAL SPRAY	2	QL(2 per 30 days)
KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
KOMBIGLYZE XR 5 MG-500 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
KONVOMEF 2 MG-84 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	ST,QL(600 per 30 days)
KORLYM 300 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
KOSELUGO 10 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
KOSELUGO 25 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
KOSHER PRENATAL PLUS IRON 30 MG IRON-1 MG TABLET ^{MM}	3	
KRAZATI 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
KRINTAFEL 150 MG TABLET	2	QL(4 per 180 days)
KRISTALOSE 10 GRAM ORAL PACKET ^{MM}	1	
KRISTALOSE 20 GRAM ORAL PACKET ^{MM}	1	
kurvelo (28) 0.15 mg-0.03 mg tablet ^{MM}	1	
KUVAN 100 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	PA
KUVAN 100 MG SOLUBLE TABLET ^{DL,MM,SP}	*	PA
KUVAN 500 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	PA
KYLEENA 17.5 MCG/24 HRS (5YRS) 19.5MG INTRAUTERINE DEVICE ^{DL,LD,MM,SP}	*	
KYNMOBI 10 MG SUBLINGUAL FILM ^{DL,LD,MM}	3	PA,QL(150 per 30 days)
KYNMOBI 10 MG-15 MG-20 MG-25 MG-30 MG SUBLINGUAL FILM ^{DL}	3	PA,QL(150 per 30 days)
KYNMOBI 15 MG SUBLINGUAL FILM ^{DL,LD,MM}	3	PA,QL(150 per 30 days)
KYNMOBI 20 MG SUBLINGUAL FILM ^{DL,LD,MM}	3	PA,QL(150 per 30 days)
KYNMOBI 25 MG SUBLINGUAL FILM ^{DL,LD,MM}	3	PA,QL(150 per 30 days)
KYNMOBI 30 MG SUBLINGUAL FILM ^{DL,LD,MM}	3	PA,QL(150 per 30 days)
KYZATREX 100 MG CAPSULE ^{MM}	3	PA,QL(60 per 30 days)
KYZATREX 150 MG CAPSULE ^{MM}	3	PA,QL(120 per 30 days)
KYZATREX 200 MG CAPSULE ^{MM}	3	PA,QL(120 per 30 days)
l norgest/e estradiol-e estrad 0.1 mg-20 mcg (84)/10 mcg (7) tabs,3mos ^{MM}	1	QL(91 per 90 days)
l norgest/e estradiol-e estrad 0.15 mg-30 mcg (84)/10 mcg(7) tabs,3mos ^{MM}	1	QL(91 per 90 days)
l norgest/ee 0.15-0.02mg/0.15-0.025mg/0.15-0.03mg/ee 0.01 mg tabs,3mo ^{MM}	1	QL(91 per 90 days)
l-methylfolate 15 mg tablet	1	
l-methylfolate 7.5 mg tablet	1	
l.norgest-eth.estradiol triphasic 50-30 (6)/75-40(5)/125-30(10) tablet ^{MM}	1	
labetalol 100 mg tablet ^{MM}	1	
labetalol 200 mg tablet ^{MM}	1	
labetalol 300 mg tablet ^{MM}	1	
lacosamide 10 mg/ml oral solution ^{MM}	1	QL(1395 per 30 days)
lacosamide 100 mg tablet ^{MM}	1	
lacosamide 150 mg tablet ^{MM}	1	
lacosamide 200 mg tablet ^{MM}	1	
lacosamide 50 mg tablet ^{MM}	1	
lactulose 10 gram oral packet ^{MM}	1	
lactulose 10 gram/15 ml (15 ml) oral solution ^{MM}	1	
lactulose 10 gram/15 ml oral solution ^{MM}	1	
lactulose 20 gram/30 ml oral solution ^{MM}	1	
LAGEVRIO 200 MG CAPSULE (EUA)	3	QL(40 per 5 days)
LAMICTAL 100 MG TABLET ^{MM}	3	ST
LAMICTAL 150 MG TABLET ^{MM}	3	ST
LAMICTAL 200 MG TABLET ^{MM}	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
LAMICTAL 25 MG CHEWABLE DISPERSIBLE TABLET ^{MM}	3	QL(120 per 30 days)
LAMICTAL 25 MG TABLET ^{MM}	3	ST
LAMICTAL 5 MG CHEWABLE DISPERSIBLE TABLET ^{MM}	3	QL(150 per 30 days)
LAMICTAL ODT 100 MG DISINTEGRATING TABLET ^{MM}	3	ST
LAMICTAL ODT 200 MG DISINTEGRATING TABLET ^{MM}	3	ST
LAMICTAL ODT 25 MG DISINTEGRATING TABLET ^{MM}	3	ST
LAMICTAL ODT 50 MG DISINTEGRATING TABLET ^{MM}	3	ST
LAMICTAL ODT STARTER (BLUE) 25 MG (21)-50 MG (7) TABLET,DISINTEGRATING	3	ST
LAMICTAL ODT STARTER (GREEN) 50 MG (42)-100 MG (14) TABLET,DISINTEGRAT	3	ST
LAMICTAL ODT STARTER(ORANGE) 25 MG(14)-50 MG(14)-100 MG(7) TAB,DISINT	3	ST
LAMICTAL STARTER (BLUE) KIT 25 MG (35) TABLETS IN A DOSE PACK	3	ST
LAMICTAL STARTER (GREEN) KIT 25 MG (84)-100 MG (14) TABLETS, DOSE PACK	3	ST
LAMICTAL STARTER (ORANGE) KIT 25 MG (42)-100 MG (7) TABLETS, DOSE PACK	3	ST
LAMICTAL XR 100 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
LAMICTAL XR 200 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
LAMICTAL XR 25 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
LAMICTAL XR 250 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
LAMICTAL XR 300 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
LAMICTAL XR 50 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST
LAMICTAL XR STARTER (BLUE) 25 MG (21)-50 MG (7) TABLET,EXTEND RELEASE	3	ST
LAMICTAL XR STARTER (GREEN) 50 MG(14)-100 MG(14)-200 MG(7) TAB,EXT.REL	3	ST
LAMICTAL XR STARTER (ORANGE) 25 MG(14)-50 MG(14)-100 MG(7) TAB,EXT.REL	3	ST
lamivudine 10 mg/ml oral solution ^{MM}	1	QL(960 per 30 days)
lamivudine 100 mg tablet ^{MM}	1	QL(90 per 30 days)
lamivudine 150 mg tablet ^{MM}	1	QL(60 per 30 days)
lamivudine 150 mg-zidovudine 300 mg tablet ^{MM}	1	QL(60 per 30 days)
lamivudine 300 mg tablet ^{MM}	1	QL(30 per 30 days)
lamotrigine 100 mg disintegrating tablet ^{MM}	1	ST
lamotrigine 100 mg tablet ^{MM}	1	
lamotrigine 150 mg tablet ^{MM}	1	
lamotrigine 200 mg disintegrating tablet ^{MM}	1	ST
lamotrigine 200 mg tablet ^{MM}	1	
lamotrigine 25 mg (21)-50 mg (7) tablet,disintegrating, pack	1	ST
lamotrigine 25 mg (35) tablets in a dose pack	1	
lamotrigine 25 mg (42)-100 mg (7) tablets in a dose pack	1	
lamotrigine 25 mg (84)-100 mg (14) tablets in a dose pack	1	
lamotrigine 25 mg chewable dispersible tablet ^{MM}	1	QL(120 per 30 days)
lamotrigine 25 mg disintegrating tablet ^{MM}	1	ST
lamotrigine 25 mg tablet ^{MM}	1	
lamotrigine 25 mg(14)-50 mg(14)-100 mg(7) tablet,disintegrating, pack	1	ST
lamotrigine 5 mg chewable dispersible tablet ^{MM}	1	QL(150 per 30 days)
lamotrigine 50 mg (42)-100 mg (14) tablet,disintegrating, pack	1	ST
lamotrigine 50 mg disintegrating tablet ^{MM}	1	ST
lamotrigine er 100 mg tablet,extended release 24 hr ^{MM}	1	ST
lamotrigine er 200 mg tablet,extended release 24 hr ^{MM}	1	ST
lamotrigine er 25 mg tablet,extended release 24 hr ^{MM}	1	ST
lamotrigine er 250 mg tablet,extended release 24 hr ^{MM}	1	ST
lamotrigine er 300 mg tablet,extended release 24 hr ^{MM}	1	ST
lamotrigine er 50 mg tablet,extended release 24 hr ^{MM}	1	ST
LAMPIT 120 MG TABLET	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
LAMPIT 30 MG TABLET	3	
LANCETS ^{MM}	2	
LANCETS 21 GAUGE ^{MM}	2	
LANCETS 26 GAUGE ^{MM}	2	
LANCETS 28 GAUGE ^{MM}	2	
LANCETS 30 GAUGE ^{MM}	2	
LANCETS 33 GAUGE ^{MM}	2	
LANCETS, SUPER THIN ^{MM}	2	
LANCETS, THIN ^{MM}	2	
LANCETS, THIN 23 GAUGE ^{MM}	2	
LANCETS, THIN 28 GAUGE ^{MM}	2	
LANCETS, ULTRA THIN ^{MM}	2	
LANCETS, ULTRA THIN 26 GAUGE ^{MM}	2	
LANCING DEVICE	2	
LANCING DEVICE WITH LANCETS	2	
LANCING DEVICE WITH LANCETS KIT ^{MM}	2	
LANCING SYSTEM	3	
LANOXIN 125 MCG (0.125 MG) TABLET ^{MM}	3	QL(30 per 30 days)
LANOXIN 250 MCG (0.25 MG) TABLET ^{MM}	3	QL(30 per 30 days)
LANOXIN 62.5 MCG (0.0625 MG) TABLET ^{MM}	3	QL(30 per 30 days)
lanreotide 120 mg/0.5 ml subcutaneous syringe ^{DL,MM,SP}	*	PA,QL(0.5 per 28 days)
lansoprazole 15 mg capsule, delayed release ^{MM}	1	QL(60 per 30 days)
lansoprazole 15 mg delayed release, disintegrating tablet ^{MM}	1	ST,QL(30 per 30 days)
lansoprazole 30 mg capsule, delayed release ^{MM}	1	QL(60 per 30 days)
lansoprazole 30 mg delayed release, disintegrating tablet ^{MM}	1	ST,QL(30 per 30 days)
lanthanum 1,000 mg chewable tablet ^{DL,MM,SP}	*	ST
lanthanum 500 mg chewable tablet ^{DL,MM,SP}	*	ST
lanthanum 750 mg chewable tablet ^{DL,MM,SP}	*	ST
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	2	
LANTUS U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	
LANZO LANCING DEVICE KIT ^{MM}	3	
lapatinib 250 mg tablet ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
larin 1.5/30 (21) 1.5 mg-30 mcg tablet ^{MM}	1	
larin 1/20 (21) 1 mg-20 mcg tablet ^{MM}	1	
larin 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet ^{MM}	1	
larin fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet ^{MM}	1	
larin fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
larissia 0.1 mg-20 mcg tablet ^{MM}	1	
LASIX 20 MG TABLET ^{MM}	3	
LASIX 40 MG TABLET ^{MM}	3	
LASIX 80 MG TABLET ^{MM}	3	
LASTACFT 0.25 % EYE DROPS	3	ST
latanoprost 0.005 % eye drops ^{MM}	1	QL(5 per 25 days)
LATUDA 120 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LATUDA 20 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LATUDA 40 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LATUDA 60 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LATUDA 80 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
LAYOLIS FE 0.8 MG-25 MCG (24)/75 MG (4) CHEWABLE TABLET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
LAZANDA 100 MCG/SPRAY NASAL SPRAY ^{DL}	3	PA,QL(30 per 30 days)
LAZANDA 400 MCG/SPRAY NASAL SPRAY ^{DL}	3	PA,QL(30 per 30 days)
ledipasvir 90 mg-sofosbuvir 400 mg tablet ^{DL,SP}	*	PA,QL(28 per 28 days)
leena 28 0.5 mg/1 mg/0.5 mg-35 mcg tablet ^{MM}	3	
leflunomide 10 mg tablet ^{MM}	1	QL(30 per 30 days)
leflunomide 20 mg tablet ^{MM}	1	QL(30 per 30 days)
lenalidomide 10 mg capsule ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
lenalidomide 15 mg capsule ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
lenalidomide 2.5 mg capsule ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
lenalidomide 20 mg capsule ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
lenalidomide 25 mg capsule ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
lenalidomide 5 mg capsule ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
LENVIMA 10 MG/DAY (10 MG X 1) CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LENVIMA 12 MG/DAY (4 MG X 3) CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
LENVIMA 14 MG/DAY(10 MG X 1-4 MG X 1) CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
LENVIMA 18 MG/DAY (10 MG X 1 AND 4 MG X 2) CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
LENVIMA 20 MG/DAY (10 MG X 2) CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
LENVIMA 24 MG PER DAY (10 MG X 2 AND 4 MG X 1) CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
LENVIMA 4 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LENVIMA 8 MG/DAY (4 MG X 2) CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
LESCOL XL 80 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
lessina 0.1 mg-20 mcg tablet ^{MM}	1	
LETAIRIS 10 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
LETAIRIS 5 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
letrozole 2.5 mg tablet ^{MM}	1	QL(30 per 30 days)
leucovorin calcium 10 mg tablet	1	
leucovorin calcium 15 mg tablet	1	
leucovorin calcium 25 mg tablet	1	
leucovorin calcium 5 mg tablet	1	
LEUKERAN 2 MG TABLET	3	QL(480 per 30 days)
LEUKINE 250 MCG SOLUTION FOR INJECTION ^{DL,SP}	*	PA,QL(28 per 28 days)
leuprolide 1 mg/0.2 ml subcutaneous kit ^{DL,MM,SP}	*	PA,QL(2.8 per 14 days)
leuprolide 1 mg/0.2 ml subcutaneous solution ^{MM}	1	PA,QL(2.8 per 14 days)
levalbuterol 0.31 mg/3 ml solution for nebulization ^{MM}	1	
levalbuterol 0.63 mg/3 ml solution for nebulization ^{MM}	1	
levalbuterol 1.25 mg/3 ml solution for nebulization ^{MM}	1	
levalbuterol concentrate 1.25 mg/0.5 ml solution for nebulization ^{MM}	1	
levalbuterol hfa 45 mcg/actuation aerosol inhaler ^{MM}	1	ST,QL(30 per 30 days)
levamlodipine 2.5 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
levamlodipine 5 mg tablet ^{MM}	3	PA,QL(30 per 30 days)
LEVBID 0.375 MG TABLET,EXTENDED RELEASE ^{MM}	3	
LEVEMIR FLEXPEN 100 UNIT/ML (3 ML) SOLUTION SUBCUTANEOUS INSULIN PEN ^{MM}	2	
LEVEMIR FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	2	
LEVEMIR U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	
levetiracetam 1,000 mg tablet ^{MM}	1	
levetiracetam 100 mg/ml oral solution ^{MM}	1	QL(900 per 30 days)
levetiracetam 250 mg tablet ^{MM}	1	
levetiracetam 500 mg tablet ^{MM}	1	
levetiracetam 500 mg/5 ml (5 ml) oral solution ^{MM}	1	QL(900 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
levetiracetam 750 mg tablet ^{MM}	1	
levetiracetam er 500 mg tablet,extended release 24 hr ^{MM}	1	
levetiracetam er 750 mg tablet,extended release 24 hr ^{MM}	1	
LEVO-T 100 MCG TABLET ^{MM}	2	
LEVO-T 112 MCG TABLET ^{MM}	2	
LEVO-T 125 MCG TABLET ^{MM}	2	
LEVO-T 137 MCG TABLET ^{MM}	2	
LEVO-T 150 MCG TABLET ^{MM}	2	
LEVO-T 175 MCG TABLET ^{MM}	2	
LEVO-T 200 MCG TABLET ^{MM}	2	
LEVO-T 25 MCG TABLET ^{MM}	2	
LEVO-T 300 MCG TABLET ^{MM}	2	
LEVO-T 50 MCG TABLET ^{MM}	2	
LEVO-T 75 MCG TABLET ^{MM}	2	
LEVO-T 88 MCG TABLET ^{MM}	2	
levobunolol 0.5 % eye drops ^{MM}	1	QL(5 per 25 days)
levocarnitine (with sugar) 100 mg/ml oral solution ^{MM}	1	
levocarnitine 100 mg/ml oral solution ^{MM}	1	
levocarnitine 330 mg tablet ^{MM}	1	
levocetirizine 2.5 mg/5 ml oral solution ^{MM}	1	QL(300 per 30 days)
levocetirizine 5 mg tablet ^{MM}	1	QL(30 per 30 days)
levofloxacin 0.5 % eye drops	1	
levofloxacin 1.5 % eye drops	1	
levofloxacin 250 mg tablet	1	
levofloxacin 250 mg/10 ml oral solution	1	
levofloxacin 500 mg tablet	1	
levofloxacin 750 mg tablet	1	
levomefolate 15 mg-algal oil 90.314 mg capsule	1	
levomefolate calcium 15 mg tablet	1	
levomefolate calcium 7.5 mg tablet	1	
levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet ^{MM}	1	
levonorgestrel 0.15 mg-ethinyl estradiol 0.03 mg tablet ^{MM}	1	
levonorgestrel 0.15 mg-ethinyl estradiol 30 mcg tablets,3 mos pack(91) ^{MM}	1	QL(91 per 90 days)
levonorgestrel 1.5 mg tablet	1	
levonorgestrel-ethinyl estradiol 0.1 mg-20 mcg tablet ^{MM}	1	
levonorgestrel-ethinyl estradiol 90 mcg-20 mcg (28) tablet ^{MM}	1	
levora-28 0.15 mg-0.03 mg tablet ^{MM}	1	
levorphanol tartrate 2 mg tablet ^{DL,SP}	*	ST,QL(240 per 30 days)
levorphanol tartrate 3 mg tablet ^{DL,SP}	*	ST,QL(150 per 30 days)
levothyroxine 100 mcg capsule ^{MM}	3	ST
levothyroxine 100 mcg tablet ^{MM}	1	
levothyroxine 112 mcg capsule ^{MM}	3	ST
levothyroxine 112 mcg tablet ^{MM}	1	
levothyroxine 125 mcg capsule ^{MM}	3	ST
levothyroxine 125 mcg tablet ^{MM}	1	
levothyroxine 13 mcg capsule ^{MM}	3	ST
levothyroxine 137 mcg capsule ^{MM}	3	ST
levothyroxine 137 mcg tablet ^{MM}	1	
levothyroxine 150 mcg capsule ^{MM}	3	ST
levothyroxine 150 mcg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
levothyroxine 175 mcg capsule ^{MM}	3	ST
levothyroxine 175 mcg tablet ^{MM}	1	
levothyroxine 200 mcg capsule ^{MM}	3	ST
levothyroxine 200 mcg tablet ^{MM}	1	
levothyroxine 25 mcg capsule ^{MM}	3	ST
levothyroxine 25 mcg tablet ^{MM}	1	
levothyroxine 300 mcg tablet ^{MM}	1	
levothyroxine 50 mcg capsule ^{MM}	3	ST
levothyroxine 50 mcg tablet ^{MM}	1	
levothyroxine 75 mcg capsule ^{MM}	3	ST
levothyroxine 75 mcg tablet ^{MM}	1	
levothyroxine 88 mcg capsule ^{MM}	3	ST
levothyroxine 88 mcg tablet ^{MM}	1	
LEVOXYL 100 MCG TABLET ^{MM}	2	
LEVOXYL 112 MCG TABLET ^{MM}	2	
LEVOXYL 125 MCG TABLET ^{MM}	2	
LEVOXYL 137 MCG TABLET ^{MM}	2	
LEVOXYL 150 MCG TABLET ^{MM}	2	
LEVOXYL 175 MCG TABLET ^{MM}	2	
LEVOXYL 200 MCG TABLET ^{MM}	2	
LEVOXYL 25 MCG TABLET ^{MM}	2	
LEVOXYL 50 MCG TABLET ^{MM}	2	
LEVOXYL 75 MCG TABLET ^{MM}	2	
LEVOXYL 88 MCG TABLET ^{MM}	2	
LEVSIN 0.125 MG TABLET ^{MM}	3	
LEVSIN/SL 0.125 MG SUBLINGUAL TABLET ^{MM}	3	
LEVULAN 20 % TOPICAL SOLUTION	3	
LEXAPRO 10 MG TABLET ^{MM}	3	ST,QL(45 per 30 days)
LEXAPRO 20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
LEXAPRO 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
LEXETTE 0.05 % TOPICAL FOAM ^{DL,SP}	*	PA
LEXIVA 50 MG/ML ORAL SUSPENSION ^{MM,SP}	*	QL(1575 per 28 days)
LEXIVA 700 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
LIALDA 1.2 GRAM TABLET,DELAYED RELEASE ^{MM}	3	ST,QL(120 per 30 days)
LIBRAX (WITH CLIDINIUM) 5 MG-2.5 MG CAPSULE	3	
LICART 1.3 % TRANSDERMAL 24 HOUR PATCH ^{DL,SP}	*	PA,QL(30 per 30 days)
lidocaine 2 % mucosal jelly in applicator	1	
lidocaine 5 % topical ointment	1	PA
lidocaine 5 % topical patch	1	PA,QL(90 per 30 days)
lidocaine hcl 2 % mucosal jelly	1	
lidocaine hcl 2 % mucosal solution	1	
lidocaine hcl 4 % (40 mg/ml) mucosal solution	1	
lidocaine hcl 4 % laryngotracheal solution	1	
lidocaine viscous 2 % mucosal solution	1	
lidocaine-prilocaine 2.5 %-2.5 % topical cream	1	
lidocaine-prilocaine 2.5 %-2.5 % topical kit	1	
LIDODERM 5 % TOPICAL PATCH	3	PA,QL(90 per 30 days)
LILETTA 20.4 MCG/24 HRS (8 YRS) 52 MG INTRAUTERINE DEVICE ^{DL,MM,SP}	*	
lillow (28) 0.15 mg-0.03 mg tablet ^{MM}	1	
lindane 1 % shampoo	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
linezolid 100 mg/5 ml oral suspension	1	QL(1800 per 30 days)
linezolid 600 mg tablet	1	QL(30 per 30 days)
LINZESS 145 MCG CAPSULE ^{MM}	2	QL(30 per 30 days)
LINZESS 290 MCG CAPSULE ^{MM}	2	QL(30 per 30 days)
LINZESS 72 MCG CAPSULE ^{MM}	2	QL(30 per 30 days)
liothyronine 25 mcg tablet ^{MM}	1	
liothyronine 5 mcg tablet ^{MM}	1	
liothyronine 50 mcg tablet ^{MM}	1	
LIPITOR 10 MG TABLET ^{MM}	3	ST
LIPITOR 20 MG TABLET ^{MM}	3	ST
LIPITOR 40 MG TABLET ^{MM}	3	ST
LIPITOR 80 MG TABLET ^{MM}	3	ST
LIPOFEN 150 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
LIPOFEN 50 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
lisinopril 10 mg tablet ^{MM}	1	
lisinopril 10 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
lisinopril 2.5 mg tablet ^{MM}	1	
lisinopril 20 mg tablet ^{MM}	1	
lisinopril 20 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
lisinopril 20 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
lisinopril 30 mg tablet ^{MM}	1	
lisinopril 40 mg tablet ^{MM}	1	
lisinopril 5 mg tablet ^{MM}	1	
LITE TOUCH INSULIN PEN NEEDLES 29 GAUGE X 1/2" ^{MM}	2	
LITE TOUCH INSULIN PEN NEEDLES 31 GAUGE X 1/4" ^{MM}	2	
LITE TOUCH INSULIN PEN NEEDLES 31 GAUGE X 3/16" ^{MM}	2	
LITE TOUCH INSULIN PEN NEEDLES 31 GAUGE X 5/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1 ML 28 GAUGE ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1 ML 29 GAUGE ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1 ML 30 GAUGE X 7/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1/2 ML 28 GAUGE ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1/2 ML 29 ^{MM}	2	
LITE TOUCH INSULIN SYRINGE 1/2 ML 30 GAUGE ^{MM}	2	
LITE TOUCH LANCETS 28 GAUGE ^{MM}	2	
LITE TOUCH LANCETS 30 GAUGE ^{MM}	2	
LITE TOUCH LANCETS 33 GAUGE ^{MM}	2	
LITE TOUCH LANCING DEVICE	3	
LITE TOUCH-MEDIUM MASK	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
LITEAIRE MDI CHAMBER	3	
LITETOUCH-LARGE MASK	3	
LITETOUCH-SMALL MASK	3	
lithium carbonate 150 mg capsule ^{MM}	1	
lithium carbonate 300 mg capsule ^{MM}	1	
lithium carbonate 300 mg tablet ^{MM}	1	
lithium carbonate 600 mg capsule ^{MM}	1	
lithium carbonate er 300 mg tablet,extended release ^{MM}	1	
lithium carbonate er 450 mg tablet,extended release ^{MM}	1	
LITHOBID 300 MG TABLET,EXTENDED RELEASE ^{MM}	3	
LITHOSTAT 250 MG TABLET	3	
LIVALO 1 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
LIVALO 2 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
LIVALO 4 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
LIVMARLI 9.5 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
LIVTENCITY 200 MG TABLET ^{DL,SP}	*	PA,QL(120 per 30 days)
LO LOESTRIN FE 1 MG-10 MCG (24)/10 MCG (2) TABLET ^{MM}	2	
lo-zumandimine (28) 3 mg-0.02 mg tablet ^{MM}	1	
LOCOID 0.1 % LOTION ^{DL,SP}	*	ST
LOCOID LIPOCREAM 0.1 % TOPICAL	3	ST
LODINE 400 MG TABLET ^{MM}	3	ST
LODOSYN 25 MG TABLET ^{MM}	3	
LOESTRIN 1.5/30 (21) 1.5 MG-30 MCG TABLET ^{MM}	3	
LOESTRIN 1/20 (21) 1 MG-20 MCG TABLET ^{MM}	3	
LOESTRIN FE 1.5/30 (28-DAY) 1.5 MG-30 MCG (21)/75 MG (7) TABLET ^{MM}	3	
LOESTRIN FE 1/20 (28-DAY) 1 MG-20 MCG (21)/75 MG (7) TABLET ^{MM}	3	
lofena 25 mg tablet ^{DL,SP}	*	
lojaimiess 0.1 mg-20 mcg (84)/10 mcg (7) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
LOKELMA 10 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LOKELMA 5 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LOMOTIL 2.5 MG-0.025 MG TABLET	3	
LONHALA MAGNAIR REFILL 25 MCG/ML SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
LONHALA MAGNAIR STARTER 25 MCG/ML SOLUTION FOR NEBULIZATION ^{DL,SP}	*	PA,QL(60 per 365 days)
LONSURF 15 MG-6.14 MG TABLET ^{DL,SP}	*	PA,QL(100 per 30 days)
LONSURF 20 MG-8.19 MG TABLET ^{DL,SP}	*	PA,QL(80 per 30 days)
loperamide 2 mg capsule ^{MM}	1	
LOPID 600 MG TABLET ^{MM}	3	QL(60 per 30 days)
lopinavir-ritonavir 100 mg-25 mg tablet ^{MM,SP}	*	QL(300 per 30 days)
lopinavir-ritonavir 200 mg-50 mg tablet ^{MM,SP}	*	QL(150 per 30 days)
lopinavir-ritonavir 400 mg-100 mg/5 ml oral solution ^{MM}	1	
LOPRESSOR 100 MG TABLET ^{MM}	3	
LOPRESSOR 50 MG TABLET ^{MM}	3	
LOPROX (AS OLAMINE) 0.77 % TOPICAL CREAM	3	
LOPROX (AS OLAMINE) 0.77 % TOPICAL SUSPENSION	3	
LOPROX 1 % SHAMPOO	3	
lorazepam 0.5 mg tablet ^{DL}	1	QL(90 per 30 days)
lorazepam 1 mg tablet ^{DL}	1	QL(90 per 30 days)
lorazepam 2 mg tablet ^{DL}	1	QL(150 per 30 days)
lorazepam 2 mg/ml oral concentrate ^{DL}	1	QL(150 per 30 days)
lorazepam intensol 2 mg/ml oral concentrate ^{DL}	1	QL(150 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
LORBRENA 100 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
LORBRENA 25 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(90 per 30 days)
LOREEV XR 1 MG CAPSULE,EXTENDED RELEASE ^{DL,SP}	*	PA,QL(210 per 30 days)
LOREEV XR 1.5 MG CAPSULE,EXTENDED RELEASE ^{DL,SP}	*	PA,QL(150 per 30 days)
LOREEV XR 2 MG CAPSULE,EXTENDED RELEASE ^{DL,SP}	*	PA,QL(150 per 30 days)
LOREEV XR 3 MG CAPSULE,EXTENDED RELEASE ^{DL,SP}	*	PA,QL(90 per 30 days)
lorTAB elixir 10 mg-300 mg/15 ml oral solution ^{DL}	1	QL(6000 per 30 days)
loryna (28) 3 mg-0.02 mg tablet ^{MM}	1	
LORZONE 375 MG TABLET	3	ST,QL(120 per 30 days)
LORZONE 750 MG TABLET	3	ST,QL(120 per 30 days)
losartan 100 mg tablet ^{MM}	1	QL(60 per 30 days)
losartan 100 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(60 per 30 days)
losartan 100 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	QL(60 per 30 days)
losartan 25 mg tablet ^{MM}	1	QL(60 per 30 days)
losartan 50 mg tablet ^{MM}	1	QL(60 per 30 days)
losartan 50 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(60 per 30 days)
LOSEASONIQUE 0.1 MG-20 MCG (84)/10 MCG (7) TABLETS,3 MONTH DOSE PACK ^{MM}	3	QL(91 per 90 days)
LOTEMAX 0.5 % EYE DROPS,SUSPENSION	3	ST
LOTEMAX 0.5 % EYE GEL DROPS	3	ST
LOTEMAX 0.5 % EYE OINTMENT	3	ST
LOTEMAX SM 0.38 % EYE GEL DROPS	3	ST
LOTENSIN 10 MG TABLET ^{MM}	3	
LOTENSIN 20 MG TABLET ^{MM}	3	
LOTENSIN 40 MG TABLET ^{MM}	3	
LOTENSIN HCT 10 MG-12.5 MG TABLET ^{MM}	3	
LOTENSIN HCT 20 MG-12.5 MG TABLET ^{MM}	3	
LOTENSIN HCT 20 MG-25 MG TABLET ^{MM}	3	
loteprednol etabonate 0.5 % eye drops,suspension	1	ST
loteprednol etabonate 0.5 % eye gel drops	1	ST
LOTREL 10 MG-20 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
LOTREL 10 MG-40 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
LOTREL 5 MG-10 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
LOTREL 5 MG-20 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
LOTRONEX 0.5 MG TABLET ^{DL,SP}	*	PA,QL(60 per 30 days)
LOTRONEX 1 MG TABLET ^{DL,SP}	*	PA,QL(60 per 30 days)
lovastatin 10 mg tablet ^{MM}	1	
lovastatin 20 mg tablet ^{MM}	1	
lovastatin 40 mg tablet ^{MM}	1	
LOVAZA 1 GRAM CAPSULE ^{MM}	3	PA,QL(120 per 30 days)
LOVENOX 100 MG/ML SUBCUTANEOUS SYRINGE	3	QL(28 per 28 days)
LOVENOX 120 MG/0.8 ML SUBCUTANEOUS SYRINGE	3	QL(22.4 per 28 days)
LOVENOX 150 MG/ML SUBCUTANEOUS SYRINGE	3	QL(28 per 28 days)
LOVENOX 30 MG/0.3 ML SUBCUTANEOUS SYRINGE	3	QL(16.8 per 28 days)
LOVENOX 300 MG/3 ML SUBCUTANEOUS SOLUTION	3	QL(84 per 28 days)
LOVENOX 40 MG/0.4 ML SUBCUTANEOUS SYRINGE	3	QL(11.2 per 28 days)
LOVENOX 60 MG/0.6 ML SUBCUTANEOUS SYRINGE	3	QL(16.8 per 28 days)
LOVENOX 80 MG/0.8 ML SUBCUTANEOUS SYRINGE	3	QL(22.4 per 28 days)
low-ogestrel (28) 0.3 mg-30 mcg tablet ^{MM}	1	
loxapine succinate 10 mg capsule ^{MM}	1	
loxapine succinate 25 mg capsule ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
loxapine succinate 5 mg capsule ^{MM}	1	
loxapine succinate 50 mg capsule ^{MM}	1	
lubiprostone 24 mcg capsule ^{MM}	3	PA,QL(60 per 30 days)
lubiprostone 8 mcg capsule ^{MM}	3	PA,QL(60 per 30 days)
LUCEMYRA 0.18 MG TABLET ^{SP}	*	PA,QL(224 per 365 days)
LUCIRA CHECK-IT COVID-19 HOME TEST KIT	3	
lugols 5 % oral solution	1	
lugols 5 %-10 % topical solution	3	
luliconazole 1 % topical cream	1	ST,QL(60 per 28 days)
LUMAKRAS 120 MG TABLET ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
LUMAKRAS 320 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
LUMIGAN 0.01 % EYE DROPS ^{MM}	2	QL(2.5 per 25 days)
LUNESTA 1 MG TABLET	3	ST,QL(30 per 30 days)
LUNESTA 2 MG TABLET	3	ST,QL(30 per 30 days)
LUNESTA 3 MG TABLET	3	ST,QL(30 per 30 days)
LUPANETA PACK (1 MONTH) 3.75 MG IM SYRINGE AND 5 MG (30) TABLETS,KIT ^{DL,SP}	*	PA,QL(1 per 30 days)
LUPANETA PACK (3 MONTH) 11.25 MG IM SYRINGE AND 5 MG (90) TABLETS,KIT ^{SP}	*	PA,QL(1 per 90 days)
LUPKYNIS 7.9 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
lurasidone 120 mg tablet ^{MM}	1	QL(30 per 30 days)
lurasidone 20 mg tablet ^{MM}	1	QL(30 per 30 days)
lurasidone 40 mg tablet ^{MM}	1	QL(30 per 30 days)
lurasidone 60 mg tablet ^{MM}	1	QL(30 per 30 days)
lurasidone 80 mg tablet ^{MM}	1	QL(60 per 30 days)
lutera (28) 0.1 mg-20 mcg tablet ^{MM}	1	
LUXIQ 0.12 % TOPICAL FOAM	3	ST
LUZU 1 % TOPICAL CREAM	3	ST,QL(60 per 28 days)
LYBALVI 10 MG-10 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LYBALVI 15 MG-10 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LYBALVI 20 MG-10 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
LYBALVI 5 MG-10 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
lyleq 0.35 mg tablet ^{MM}	1	
lyllana 0.025 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
lyllana 0.0375 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
lyllana 0.05 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
lyllana 0.075 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
lyllana 0.1 mg/24 hr transdermal patch ^{MM}	1	QL(8 per 28 days)
LYMEPAK 100 MG TABLET	3	
LYNPARZA 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
LYNPARZA 150 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
LYRICA 100 MG CAPSULE ^{MM}	3	ST,QL(90 per 30 days)
LYRICA 150 MG CAPSULE ^{MM}	3	ST,QL(90 per 30 days)
LYRICA 20 MG/ML ORAL SOLUTION ^{MM}	3	ST,QL(900 per 30 days)
LYRICA 200 MG CAPSULE ^{MM}	3	ST,QL(90 per 30 days)
LYRICA 225 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
LYRICA 25 MG CAPSULE ^{MM}	3	ST,QL(90 per 30 days)
LYRICA 300 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
LYRICA 50 MG CAPSULE ^{MM}	3	ST,QL(90 per 30 days)
LYRICA 75 MG CAPSULE ^{MM}	3	ST,QL(90 per 30 days)
LYRICA CR 165 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
LYRICA CR 330 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
LYRICA CR 82.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
LYSODREN 500 MG TABLET ^{DL,MM,SP}	*	
LYSTEDA 650 MG TABLET ^{MM}	3	QL(30 per 5 days)
LYTGOBI 4 MG TABLET ^{DL,MM,SP}	*	PA,QL(140 per 28 days)
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS ^{MM}	3	ST
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST
LYUMJEV TEMPO PEN (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS ^{MM}	3	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
LYVISPAH 10 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
LYVISPAH 20 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
LYVISPAH 5 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(270 per 30 days)
lyza 0.35 mg tablet ^{MM}	1	
M-M-R II (PF) 1,000-12,500 TCID50/0.5 ML SUBCUTANEOUS SOLUTION	3	
m-natal plus 27 mg iron-1 mg tablet ^{MM}	1	
MACROBID 100 MG CAPSULE	3	
MACRODANTIN 100 MG CAPSULE	3	
MACRODANTIN 25 MG CAPSULE	3	
MACRODANTIN 50 MG CAPSULE	3	
mafenide 50 gram topical packet	1	
MAGELLAN INSULIN SAFETY SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
MAGELLAN INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
MAGELLAN INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
MAGELLAN INSULIN SAFETY SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
MAGELLAN SAFETY SYRINGE 1 ML 23 GAUGE X 1"	3	
MAGELLAN SYRINGE 0.3 ML 30 X 5/16" ^{MM}	2	
MAGELLAN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
MAGELLAN SYRINGE 1 ML 27 GAUGE X 1/2"	2	
MAGELLAN TUBERCULIN SAFETY SYRINGE 1 ML 28 GAUGE X 1/2"	3	
MAKENA (PF) 275 MG/1.1 ML SUBCUTANEOUS AUTO-INJECTOR ^{DL,LD,SP}	*	PA
MAKENA 250 MG/ML (1 ML) INTRAMUSCULAR OIL ^{DL,LD,SP}	*	PA
MAKENA 250 MG/ML INTRAMUSCULAR OIL ^{DL,LD,SP}	*	PA
MALARONE 250 MG-100 MG TABLET	3	QL(30 per 30 days)
MALARONE PEDIATRIC 62.5 MG-25 MG TABLET	3	QL(30 per 30 days)
malathion 0.5 % lotion	1	
maraviroc 150 mg tablet ^{MM,SP}	*	QL(240 per 30 days)
maraviroc 300 mg tablet ^{MM,SP}	*	QL(120 per 30 days)
MARINOL 10 MG CAPSULE	3	PA,QL(120 per 30 days)
MARINOL 2.5 MG CAPSULE	3	PA,QL(120 per 30 days)
MARINOL 5 MG CAPSULE	3	PA,QL(120 per 30 days)
marlissa (28) 0.15 mg-0.03 mg tablet ^{MM}	1	
MARNATAL-F 60 MG IRON-1 MG CAPSULE ^{MM}	3	
MARPLAN 10 MG TABLET ^{MM}	3	
MATULANE 50 MG CAPSULE ^{DL,SP}	*	
matzim la 180 mg tablet,extended release ^{MM}	1	QL(60 per 30 days)
matzim la 240 mg tablet,extended release ^{MM}	1	QL(60 per 30 days)
matzim la 300 mg tablet,extended release ^{MM}	1	QL(30 per 30 days)
matzim la 360 mg tablet,extended release ^{MM}	1	QL(30 per 30 days)
matzim la 420 mg tablet,extended release ^{MM}	1	QL(30 per 30 days)
MAVENCLAD (10 TABLET PACK) 10 MG TABLET ^{DL,LD,MM,SP}	*	PA
MAVENCLAD (4 TABLET PACK) 10 MG TABLET ^{DL,LD,MM,SP}	*	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
MAVENCLAD (5 TABLET PACK) 10 MG TABLET ^{DL,LD,MM,SP}	*	PA
MAVENCLAD (6 TABLET PACK) 10 MG TABLET ^{DL,LD,MM,SP}	*	PA
MAVENCLAD (7 TABLET PACK) 10 MG TABLET ^{DL,LD,MM,SP}	*	PA
MAVENCLAD (8 TABLET PACK) 10 MG TABLET ^{DL,LD,MM,SP}	*	PA
MAVENCLAD (9 TABLET PACK) 10 MG TABLET ^{DL,LD,MM,SP}	*	PA
MAVYRET 100 MG-40 MG TABLET ^{DL,SP}	*	PA,QL(84 per 28 days)
MAVYRET 50 MG-20 MG ORAL PELLETS IN PACKET ^{DL,SP}	*	PA,QL(150 per 30 days)
MAXALT 10 MG TABLET	3	ST,QL(12 per 30 days)
MAXALT-MLT 10 MG DISINTEGRATING TABLET	3	ST,QL(12 per 30 days)
MAXI-COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	3	
MAXI-COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	3	
MAXICOMFORT II PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
MAXICOMFORT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2" ^{MM}	2	
MAXICOMFORT INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2" ^{MM}	2	
MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 3/16" ^{MM}	2	
MAXICOMFORT SAFETY PEN NEEDLE 29 GAUGE X 5/16" ^{MM}	2	
MAXIDEX 0.1 % EYE DROPS,SUSPENSION	3	ST
MAXITROL 3.5 MG/G-10,000 UNIT/G-0.1 % EYE OINTMENT	3	
MAXITROL 3.5 MG/ML-10,000 UNIT/ML-0.1% EYE DROPS,SUSPENSION	3	
MAXZIDE 75 MG-50 MG TABLET ^{MM}	3	
MAXZIDE-25MG 37.5 MG-25 MG TABLET ^{MM}	3	
MAYZENT 0.25 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
MAYZENT 1 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
MAYZENT 2 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
MAYZENT STARTER PACK (FOR 1 MG MAINT DOSE) 0.25 MG (7 TABS) TABLETS ^{DL,SP}	*	PA,QL(7 per 30 days)
MAYZENT STARTER PACK (FOR 2 MG MAINT DOSE) 0.25 MG (12 TABS) TABLETS ^{DL,LD,SP}	*	PA,QL(12 per 30 days)
meclizine 12.5 mg tablet	1	
meclizine 25 mg tablet	1	
meclofenamate 100 mg capsule	1	
meclofenamate 50 mg capsule	1	
mecobalamin (vitamin b12) 10,000 mcg solution for injection	1	
MEDISENSE COMBO PACK ^{MM}	3	
MEDISENSE CONTROLS 1-HI 1-LO COMBO PACK ^{MM}	3	
MEDISENSE GLUCOSE KETONE COMBO PACK ^{MM}	3	
MEDISENSE MID CONTROL SOLUTION ^{MM}	3	
MEDISENSE THIN LANCETS 28 GAUGE ^{MM}	2	
MEDLANCE PLUS LANCETS 21 GAUGE ^{MM}	2	
MEDLANCE PLUS LANCETS 25 GAUGE ^{MM}	2	
MEDLANCE PLUS LANCETS 30 GAUGE ^{MM}	2	
MEDPOINT NORMAL CONTROL SOLUTION ^{MM}	3	
MEDROL (PAK) 4 MG TABLETS IN A DOSE PACK	3	
MEDROL 16 MG TABLET	3	
MEDROL 2 MG TABLET	3	
MEDROL 32 MG TABLET	3	
MEDROL 4 MG TABLET	3	
MEDROL 8 MG TABLET	3	
medroxyprogesterone 10 mg tablet ^{MM}	1	
medroxyprogesterone 150 mg/ml intramuscular suspension ^{MM}	1	QL(1 per 90 days)
medroxyprogesterone 150 mg/ml intramuscular syringe ^{MM}	1	QL(1 per 90 days)
medroxyprogesterone 2.5 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
medroxyprogesterone 5 mg tablet ^{MM}	1	
mefenamic acid 250 mg capsule	1	
mefloquine 250 mg tablet	1	
megestrol 20 mg tablet	1	
megestrol 40 mg tablet	1	
megestrol 400 mg/10 ml (10 ml) oral suspension ^{MM}	1	
megestrol 400 mg/10 ml (40 mg/ml) oral suspension ^{MM}	1	
megestrol 625 mg/5 ml (125 mg/ml) oral suspension ^{MM}	1	ST
MEKINIST 0.5 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
MEKINIST 2 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
MEKTOVI 15 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
meloxicam 15 mg tablet ^{MM}	1	QL(30 per 30 days)
meloxicam 7.5 mg tablet ^{MM}	1	QL(60 per 30 days)
meloxicam 7.5 mg/5 ml oral suspension ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
meloxicam submicronized 10 mg capsule ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
meloxicam submicronized 5 mg capsule ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
melphalan 2 mg tablet ^{DL,SP}	*	QL(80 per 30 days)
memantine 10 mg tablet ^{MM}	1	QL(60 per 30 days)
memantine 14 mg capsule sprinkle,extended release 24hr ^{MM}	1	QL(30 per 30 days)
memantine 2 mg/ml oral solution ^{MM}	1	QL(360 per 30 days)
memantine 21 mg capsule sprinkle,extended release 24hr ^{MM}	1	QL(30 per 30 days)
memantine 28 mg capsule sprinkle,extended release 24hr ^{MM}	1	QL(30 per 30 days)
memantine 5 mg tablet ^{MM}	1	QL(60 per 30 days)
memantine 5 mg-10 mg tablets in a dose pack	1	QL(98 per 30 days)
memantine 7 mg capsule sprinkle,extended release 24hr ^{MM}	1	QL(30 per 30 days)
MENEST 0.3 MG TABLET ^{MM}	3	
MENEST 0.625 MG TABLET ^{MM}	3	
MENEST 1.25 MG TABLET ^{MM}	3	
MENEST 2.5 MG TABLET ^{MM}	3	
MENOSTAR 14 MCG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
MENTAX 1 % TOPICAL CREAM	3	
meperidine 50 mg tablet ^{DL}	1	QL(480 per 30 days)
meperidine 50 mg/5 ml oral solution ^{DL}	1	QL(720 per 30 days)
MEPHYTON 5 MG TABLET	3	
meprobamate 200 mg tablet	1	
meprobamate 400 mg tablet	1	
MEPRON 750 MG/5 ML ORAL SUSPENSION ^{DL,SP}	*	QL(600 per 30 days)
mercaptopurine 50 mg tablet ^{MM}	1	QL(480 per 30 days)
merzee 1 mg-20 mcg (24)/75 mg (4) capsule ^{MM}	1	
mesalamine 1,000 mg rectal suppository ^{MM}	1	ST,QL(30 per 30 days)
mesalamine 1.2 gram tablet,delayed release ^{MM}	1	ST,QL(120 per 30 days)
mesalamine 4 gram/60 ml enema ^{MM}	1	QL(1800 per 30 days)
mesalamine 400 mg capsule (with delayed release tablets inside) ^{MM}	1	ST,QL(180 per 30 days)
mesalamine 800 mg tablet,delayed release ^{DL,MM,SP}	*	ST,QL(180 per 30 days)
mesalamine er 0.375 gram capsule,extended release 24 hr ^{MM}	1	QL(120 per 30 days)
mesalamine er 500 mg capsule,extended release ^{DL,MM,SP}	*	ST,QL(300 per 30 days)
mesalamine rectal susp enema with cleansing wipes 4 gram/60 ml kit ^{MM}	1	QL(30 per 30 days)
MESNEX 400 MG TABLET	3	
MESTINON 60 MG TABLET ^{MM}	3	
MESTINON 60 MG/5 ML ORAL SYRUP ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
MESTINON TIMESPAN 180 MG TABLET,EXTENDED RELEASE ^{MM}	3	
metadate er 20 mg tablet,extended release ^{MM}	1	QL(90 per 30 days)
metaxalone 400 mg tablet	1	ST,QL(120 per 30 days)
metaxalone 800 mg tablet	1	ST,QL(120 per 30 days)
METER-CHECK SOLUTION ^{MM}	3	
metformin 1,000 mg tablet ^{MM}	1	
metformin 500 mg tablet ^{MM}	1	
metformin 500 mg/5 ml oral solution ^{DL,MM,SP}	*	QL(750 per 30 days)
metformin 625 mg tablet ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
metformin 850 mg tablet ^{MM}	1	
metformin er 1,000 mg 24 hr tablet,extended release ^{DL,MM,SP}	*	ST,QL(60 per 30 days)
metformin er 1,000 mg tablet,extended release 24hr ^{MM}	1	ST,QL(60 per 30 days)
metformin er 500 mg 24 hr tablet,extended release ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
metformin er 500 mg tablet,extended release 24 hr ^{MM}	1	QL(120 per 30 days)
metformin er 500 mg tablet,extended release 24hr ^{MM}	1	ST,QL(150 per 30 days)
metformin er 750 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
methadone 10 mg tablet ^{DL}	1	QL(240 per 30 days)
methadone 10 mg/5 ml oral solution ^{DL}	1	QL(1800 per 30 days)
methadone 10 mg/ml oral concentrate ^{DL}	1	QL(360 per 30 days)
methadone 40 mg soluble tablet ^{DL}	1	QL(90 per 30 days)
methadone 5 mg tablet ^{DL}	1	QL(480 per 30 days)
methadone 5 mg/5 ml oral solution ^{DL}	1	QL(3600 per 30 days)
methadone intensol 10 mg/ml oral concentrate ^{DL}	1	QL(360 per 30 days)
METHADOSE 10 MG/ML ORAL CONCENTRATE ^{DL}	3	QL(360 per 30 days)
methadose 40 mg soluble tablet ^{DL}	1	QL(90 per 30 days)
methamphetamine 5 mg tablet ^{MM}	1	QL(150 per 30 days)
methazolamide 25 mg tablet ^{MM}	1	
methazolamide 50 mg tablet ^{MM}	1	
methenamine hippurate 1 gram tablet	1	
methergine 0.2 mg tablet	1	
methimazole 10 mg tablet ^{MM}	1	
methimazole 5 mg tablet ^{MM}	1	
METHITEST 10 MG TABLET ^{DL,MM,SP}	*	
methocarbamol 1,000 mg tablet ^{DL,SP}	*	PA
methocarbamol 500 mg tablet	1	
methocarbamol 750 mg tablet	1	
methotrexate sodium (pf) 25 mg/ml injection solution	1	
methotrexate sodium 2.5 mg tablet ^{MM}	1	
methotrexate sodium 25 mg/ml injection solution	1	
methoxsalen 10 mg liquid-filled,rapid release capsule ^{DL,SP}	*	
methscopolamine 2.5 mg tablet	1	
methscopolamine 5 mg tablet	1	
methyl dopa 250 mg tablet ^{MM}	1	
methyl dopa 250 mg-hydrochlorothiazide 15 mg tablet ^{MM}	1	
methyl dopa 250 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
methyl dopa 500 mg tablet ^{MM}	1	
methylergonovine 0.2 mg tablet	1	
METHYLIN 10 MG/5 ML ORAL SOLUTION ^{MM}	3	QL(900 per 30 days)
METHYLIN 5 MG/5 ML ORAL SOLUTION ^{MM}	3	QL(1800 per 30 days)
methylphenidate 10 mg chewable tablet ^{MM}	1	ST,QL(180 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
methylphenidate 10 mg tablet ^{MM}	1	QL(90 per 30 days)
methylphenidate 10 mg/5 ml oral solution ^{MM}	1	QL(900 per 30 days)
methylphenidate 10 mg/9 hr daily transdermal patch ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate 15 mg/9 hr daily transdermal patch ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate 2.5 mg chewable tablet ^{MM}	1	ST,QL(150 per 30 days)
methylphenidate 20 mg tablet ^{MM}	1	QL(90 per 30 days)
methylphenidate 20 mg/9 hr daily transdermal patch ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate 30 mg/9 hr daily transdermal patch ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate 5 mg chewable tablet ^{MM}	1	ST,QL(150 per 30 days)
methylphenidate 5 mg tablet ^{MM}	1	QL(90 per 30 days)
methylphenidate 5 mg/5 ml oral solution ^{MM}	1	QL(1800 per 30 days)
methylphenidate cd 10 mg biphasic 30-70 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylphenidate cd 20 mg biphasic 30-70 capsule,extended release ^{MM}	1	QL(60 per 30 days)
methylphenidate cd 30 mg biphasic 30-70 capsule,extended release ^{MM}	1	QL(60 per 30 days)
methylphenidate cd 40 mg biphasic 30-70 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylphenidate cd 50 mg biphasic 30-70 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylphenidate cd 60 mg biphasic 30-70 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylphenidate er 10 mg capsule,extended release (40-60) sprinkle ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 10 mg tablet,extended release ^{MM}	1	QL(180 per 30 days)
methylphenidate er 15 mg capsule,extended release (40-60) sprinkle ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 18 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 20 mg capsule,extended release (40-60) sprinkle ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 20 mg tablet,extended release ^{MM}	1	QL(90 per 30 days)
methylphenidate er 27 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 30 mg capsule,extended release (40-60) sprinkle ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 36 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(60 per 30 days)
methylphenidate er 40 mg capsule,extended release (40-60) sprinkle ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 45 mg tablet,extended release 24 hr ^{MM}	3	ST,QL(30 per 30 days)
methylphenidate er 50 mg capsule,extended release (40-60) sprinkle ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 54 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 60 mg capsule,extended release (40-60) sprinkle ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate er 63 mg tablet,extended release 24 hr ^{MM}	3	ST,QL(30 per 30 days)
methylphenidate er 72 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
methylphenidate la 10 mg biphasic 50-50 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylphenidate la 20 mg biphasic 50-50 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylphenidate la 30 mg biphasic 50-50 capsule,extended release ^{MM}	1	QL(60 per 30 days)
methylphenidate la 40 mg biphasic 50-50 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylphenidate la 60 mg biphasic 50-50 capsule,extended release ^{MM}	1	QL(30 per 30 days)
methylprednisolone 16 mg tablet	1	
methylprednisolone 32 mg tablet	1	
methylprednisolone 4 mg tablet	1	
methylprednisolone 4 mg tablets in a dose pack	1	
methylprednisolone 8 mg tablet	1	
methyltestosterone 10 mg capsule ^{DL,MM,SP}	*	
metipranolol 0.3 % eye drops ^{MM}	1	
metoclopramide 10 mg disintegrating tablet	1	QL(180 per 30 days)
metoclopramide 10 mg tablet	1	
metoclopramide 5 mg disintegrating tablet	1	QL(360 per 30 days)
metoclopramide 5 mg tablet	1	
metoclopramide 5 mg/5 ml oral solution	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
metolazone 10 mg tablet ^{MM}	1	
metolazone 2.5 mg tablet ^{MM}	1	
metolazone 5 mg tablet ^{MM}	1	
METOPIRONE 250 MG CAPSULE	3	
metoprolol succinate er 100 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
metoprolol succinate er 200 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
metoprolol succinate er 25 mg tablet,extended release 24 hr ^{MM}	1	QL(90 per 30 days)
metoprolol succinate er 50 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
metoprolol tartrate 100 mg tablet ^{MM}	1	
metoprolol tartrate 100 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
metoprolol tartrate 100 mg-hydrochlorothiazide 50 mg tablet ^{MM}	1	
metoprolol tartrate 25 mg tablet ^{MM}	1	
metoprolol tartrate 37.5 mg tablet ^{MM}	1	
metoprolol tartrate 50 mg tablet ^{MM}	1	
metoprolol tartrate 50 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
metoprolol tartrate 75 mg tablet ^{MM}	1	
METROCREAM 0.75 % TOPICAL	3	ST
METROGEL 1 % TOPICAL	3	ST
METROGEL VAGINAL 0.75 % (37.5 MG/5 GRAM)	3	
METROLOTION 0.75 % TOPICAL	3	ST
metronidazole 0.75 % (37.5 mg/5 gram) vaginal gel	1	
metronidazole 0.75 % lotion	1	
metronidazole 0.75 % topical cream	1	
metronidazole 0.75 % topical gel	1	
metronidazole 1 % topical gel	1	
metronidazole 1 % topical gel with pump	1	
metronidazole 250 mg tablet	1	
metronidazole 375 mg capsule	1	
metronidazole 500 mg tablet	1	
metyrosine 250 mg capsule	1	
mexiletine 150 mg capsule ^{MM}	1	
mexiletine 200 mg capsule ^{MM}	1	
mexiletine 250 mg capsule ^{MM}	1	
MIACALCIN 200 UNIT/ML INJECTION SOLUTION	3	ST,QL(4 per 28 days)
mibelas 24 fe 1 mg-20 mcg (24)/75 mg (4) chewable tablet ^{MM}	1	
MICARDIS 20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
MICARDIS 40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
MICARDIS 80 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
MICARDIS HCT 40 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
MICARDIS HCT 80 MG-12.5 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
MICARDIS HCT 80 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
miconazole nit 0.25 %-zinc ox 15 %-petrolatum 81.35 % topical ointment	1	
miconazole-3 200 mg vaginal suppository	1	
MICRO BLOOD GLUCOSE STRIPS ^{MM}	3	ST,QL(150 per 30 days)
MICRO THIN LANCETS 33 GAUGE ^{MM}	2	
MICROCHAMBER SPACER	3	
MICRODOT BLOOD GLUCOSE MONITORING SYSTEM ^{MM}	3	ST
MICRODOT BLOOD GLUCOSE MONITORING SYSTEM KIT ^{MM}	3	ST
MICRODOT BLOOD GLUCOSE MONITORING SYSTEM STRIPS ^{MM}	3	ST,QL(150 per 30 days)
MICRODOT HIGH-LOW CONTROL SOLUTION ^{MM}	3	
MICRODOT INSULIN PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
MICRODOT INSULIN PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
MICRODOT INSULIN PEN NEEDLE 33 GAUGE X 5/32" ^{MM}	2	
MICRODOT NORMAL CONTROL SOLUTION ^{MM}	3	
MICRODOT XTRA BLOOD GLUCOSE STRIPS ^{MM}	3	ST,QL(150 per 30 days)
microgestin 1.5/30 (21) 1.5 mg-30 mcg tablet ^{MM}	1	
microgestin 1/20 (21) 1 mg-20 mcg tablet ^{MM}	1	
microgestin 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet ^{MM}	1	
microgestin fe 1.5/30 (28) 1.5 mg-30 mcg (21)/75 mg (7) tablet ^{MM}	1	
microgestin fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
MICROLET 2 LANCING DEVICE KIT ^{MM}	3	
MICROLET LANCET ^{MM}	2	
MICROLET NEXT LANCING DEVICE KIT ^{MM}	3	
MICROSPACER	2	
midazolam 10 mg/5 ml (2 mg/ml) oral syrup ^{DL}	1	
midazolam 2 mg/ml oral syrup ^{DL}	1	
midodrine 10 mg tablet	1	
midodrine 2.5 mg tablet	1	
midodrine 5 mg tablet	1	
migergot 2 mg-100 mg rectal suppository ^{DL,SP}	*	
miglitol 100 mg tablet ^{MM}	1	
miglitol 25 mg tablet ^{MM}	1	
miglitol 50 mg tablet ^{MM}	1	
miglustat 100 mg capsule ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
MIGRANAL 0.5 MG/PUMP ACT. (4 MG/ML) NASAL SPRAY ^{DL,SP}	*	PA,QL(8 per 30 days)
mili 0.25 mg-35 mcg tablet ^{MM}	1	
millipred 5 mg tablet	1	
millipred dp 5 mg (21 tabs) tablets in a dose pack	1	
millipred dp 5 mg (48 tabs) tablets in a dose pack	1	
mimvey 1 mg-0.5 mg tablet ^{MM}	1	
MINASTRIN 24 FE 1 MG-20 MCG (24)/75 MG (4) CHEWABLE TABLET ^{MM}	3	
MINI LANCING DEVICE	3	
MINI ULTRA-THIN II 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
MINI WRIGHT PEAK FLOW METER	2	
MINILINK REAL-TIME TRANSMITTER DEVICE ^{MM}	3	PA
MINIMED SYRINGE RESERVOIR 1.8 ML ^{MM}	2	
MINIMED SYRINGE RESERVOIR 3 ML ^{MM}	2	
MINIPRESS 1 MG CAPSULE ^{MM}	3	
MINIPRESS 2 MG CAPSULE ^{MM}	3	
MINIPRESS 5 MG CAPSULE ^{MM}	3	
minitran 0.1 mg/hr transdermal 24 hour patch ^{MM}	1	QL(30 per 30 days)
minitran 0.2 mg/hr transdermal 24 hour patch ^{MM}	1	QL(30 per 30 days)
minitran 0.4 mg/hr transdermal 24 hour patch ^{MM}	1	QL(60 per 30 days)
minitran 0.6 mg/hr transdermal 24 hour patch ^{MM}	1	QL(30 per 30 days)
MINIVELLE 0.025 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
MINIVELLE 0.0375 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
MINIVELLE 0.05 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
MINIVELLE 0.075 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
MINIVELLE 0.1 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
minocycline 100 mg capsule	1	
minocycline 100 mg tablet	1	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
minocycline 105 mg tablet, immediate and extended release 24hr	3	ST,QL(30 per 30 days)
minocycline 135 mg tablet, immediate and extended release 24hr	3	ST,QL(30 per 30 days)
minocycline 50 mg capsule	1	
minocycline 50 mg tablet	1	ST
minocycline 75 mg capsule	1	
minocycline 75 mg tablet	1	ST
minocycline er 105 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
minocycline er 115 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
minocycline er 135 mg capsule, extended release 24 hr	3	ST,QL(30 per 30 days)
minocycline er 135 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
minocycline er 45 mg capsule, extended release 24 hr	3	ST,QL(30 per 30 days)
minocycline er 45 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
minocycline er 55 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
minocycline er 65 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
minocycline er 80 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
minocycline er 90 mg capsule, extended release 24 hr	3	ST,QL(30 per 30 days)
minocycline er 90 mg tablet,extended release 24 hr	1	ST,QL(30 per 30 days)
MINOLIRA ER 105 MG TABLET, EXTENDED RELEASE ^{DL,SP}	*	ST,QL(30 per 30 days)
MINOLIRA ER 135 MG TABLET, EXTENDED RELEASE ^{DL,SP}	*	ST,QL(30 per 30 days)
minoxidil 10 mg tablet ^{MM}	1	
minoxidil 2.5 mg tablet ^{MM}	1	
MIRAPEX 0.125 MG TABLET ^{MM}	3	ST
MIRAPEX 0.25 MG TABLET ^{MM}	3	ST
MIRAPEX 0.5 MG TABLET ^{MM}	3	ST
MIRAPEX 0.75 MG TABLET ^{MM}	3	ST
MIRAPEX 1 MG TABLET ^{MM}	3	ST
MIRAPEX 1.5 MG TABLET ^{MM}	3	ST
MIRAPEX ER 0.375 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
MIRAPEX ER 0.75 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
MIRAPEX ER 1.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
MIRAPEX ER 2.25 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
MIRAPEX ER 3 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
MIRAPEX ER 3.75 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
MIRAPEX ER 4.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
MIRCERA 100 MCG/0.3 ML INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(1.2 per 28 days)
MIRCERA 120 MCG/0.3 ML INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(0.9 per 28 days)
MIRCERA 150 MCG/0.3 ML INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(0.6 per 28 days)
MIRCERA 200 MCG/0.3 ML INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(0.6 per 28 days)
MIRCERA 30 MCG/0.3 ML INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(0.6 per 28 days)
MIRCERA 50 MCG/0.3 ML INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(0.9 per 28 days)
MIRCERA 75 MCG/0.3 ML INJECTION SYRINGE ^{DL,MM,SP}	*	PA,QL(0.9 per 28 days)
MIRCETTE (28) 0.15 MG-0.02 MG (21)/0.01 MG (5) TABLET ^{MM}	3	
MIRENA 21 MCG/24 HOURS (8 YRS) 52 MG INTRAUTERINE DEVICE ^{DL,LD,MM,SP}	*	
mirtazapine 15 mg disintegrating tablet ^{MM}	1	QL(30 per 30 days)
mirtazapine 15 mg tablet ^{MM}	1	QL(30 per 30 days)
mirtazapine 30 mg disintegrating tablet ^{MM}	1	QL(30 per 30 days)
mirtazapine 30 mg tablet ^{MM}	1	QL(30 per 30 days)
mirtazapine 45 mg disintegrating tablet ^{MM}	1	QL(30 per 30 days)
mirtazapine 45 mg tablet ^{MM}	1	QL(30 per 30 days)
mirtazapine 7.5 mg tablet ^{MM}	1	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
MIRVASO 0.33 % TOPICAL GEL WITH PUMP	3	ST
misoprostol 100 mcg tablet ^{MM}	1	
misoprostol 200 mcg tablet ^{MM}	1	
MISTASSIST DEVICE	3	
MITIGARE 0.6 MG CAPSULE ^{MM}	2	QL(60 per 30 days)
MOBIC 15 MG TABLET ^{MM}	3	QL(30 per 30 days)
MOBIC 7.5 MG TABLET ^{MM}	3	QL(60 per 30 days)
MOBILE LANCETS 30 GAUGE ^{MM}	2	
modafinil 100 mg tablet ^{MM}	1	PA,QL(60 per 30 days)
modafinil 200 mg tablet ^{MM}	1	PA,QL(60 per 30 days)
MODERNA COVID-19 (12 YR UP) VACCINE (PF) 100 MCG/0.5 ML IM SUSP (EUA)	3	
MODERNA COVID-19 BIVALENT BOOST(6MO-5Y)(PF) 10 MCG/0.2 ML IM SUSP(EUA)	3	
MODERNA COVID-19 BIVALENT BOOST(6YR UP)(PF) 50 MCG/0.5 ML IM SUSP(EUA)	3	
MODERNA COVID-19 VACC (6-11YR PRIMARY)(PF) 50 MCG/0.5 ML IM SUSP (EUA)	3	
MODERNA COVID-19 VACCINE(6MO-5YR)(PF) 25 MCG/0.25 ML IM SUSP (EUA)	3	
moexipril 15 mg tablet ^{MM}	1	
moexipril 7.5 mg tablet ^{MM}	1	
molindone 10 mg tablet ^{MM}	1	PA,QL(240 per 30 days)
molindone 25 mg tablet ^{MM}	1	PA,QL(270 per 30 days)
molindone 5 mg tablet ^{MM}	1	PA,QL(360 per 30 days)
mometasone 0.1 % topical cream	1	
mometasone 0.1 % topical ointment	1	
mometasone 0.1 % topical solution	1	
mometasone 50 mcg/actuation nasal spray ^{MM}	1	ST,QL(34 per 30 days)
mondoxyne nl 100 mg capsule	1	QL(90 per 30 days)
mondoxyne nl 75 mg capsule	1	ST,QL(60 per 30 days)
mono-linyah 0.25 mg-35 mcg tablet ^{MM}	1	
MONODOX 100 MG CAPSULE	3	ST,QL(90 per 30 days)
MONODOX 50 MG CAPSULE	3	ST,QL(60 per 30 days)
MONODOX 75 MG CAPSULE	3	ST,QL(60 per 30 days)
MONOJECT BLOOD COLLECTION 20 GAUGE X 1" NEEDLE	3	
MONOJECT BLOOD COLLECTION 20 X 1 1/2" NEEDLE	3	
MONOJECT BLOOD COLLECTION 21 GAUGE X 1" NEEDLE	3	
MONOJECT BLOOD COLLECTION 22 GAUGE X 1" NEEDLE	3	
MONOJECT CONTROL SYRINGE LUER LOCK 12 ML	3	
MONOJECT ENFIT STERILE SYRINGE 1 ML	3	
MONOJECT ENFIT STERILE SYRINGE 3 ML	3	
MONOJECT ENFIT STERILE SYRINGE 35 ML	3	
MONOJECT ENFIT STERILE SYRINGE 6 ML	3	
MONOJECT ENFIT STERILE SYRINGE 60 ML	3	
MONOJECT ENFIT SYRINGE 12 ML	3	
MONOJECT ENFIT SYRINGE CAP	3	
MONOJECT HYPODERMIC NEEDLES 22 GAUGE X 1 1/2"	3	
MONOJECT HYPODERMIC NEEDLES 22 GAUGE X 1"	3	
MONOJECT HYPODERMIC NEEDLES 23 GAUGE X 1"	3	
MONOJECT HYPODERMIC NEEDLES 25 GAUGE X 1 1/2"	3	
MONOJECT HYPODERMIC NEEDLES 25 GAUGE X 1"	3	
MONOJECT HYPODERMIC NEEDLES 25 GAUGE X 5/8"	3	
MONOJECT HYPODERMIC NEEDLES 26 GAUGE X 1 1/2"	3	
MONOJECT HYPODERMIC NEEDLES 27 GAUGE X 1/2"	3	
MONOJECT HYPODERMIC NEEDLES 30 GAUGE X 3/4"	3	
MONOJECT INSULIN SAFETY SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
MONOJECT INSULIN SAFETY SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
MONOJECT INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SAFETY SYRINGE 29 GAUGE X 1/2" ^{MM}	2	
MONOJECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
MONOJECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
MONOJECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SYRINGE 1 ML ^{MM}	2	
MONOJECT INSULIN SYRINGE 1 ML 25 GAUGE X 5/8" ^{MM}	2	
MONOJECT INSULIN SYRINGE 1 ML 27 GAUGE X 1/2" ^{MM}	2	
MONOJECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
MONOJECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
MONOJECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
MONOJECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
MONOJECT LUER-LOCK TIP 12 ML SYRINGE	3	
MONOJECT MAGELLAN SYRINGE 1 ML 25 GAUGE X 1"	3	
MONOJECT MAGELLAN SYRINGE 1 ML 25 GAUGE X 5/8"	3	
MONOJECT MAGELLAN SYRINGE 3 ML 20 GAUGE X 1"	3	
MONOJECT PHARMACY TRAY REGULAR TIP 1 ML SYRINGE	3	
MONOJECT REGULAR LUER 12 ML SYRINGE	3	
MONOJECT SAFETY SYRINGES	3	
MONOJECT SAFETY SYRINGES 12 ML 21 X 1 1/2"	3	
MONOJECT SAFETY SYRINGES 3 ML 21 GAUGE X 1"	3	
MONOJECT SAFETY SYRINGES 3 ML 22 GAUGE X 1 1/2"	3	
MONOJECT SAFETY SYRINGES 6 ML	3	
MONOJECT SMARTIP CANNULA 12 ML SYRINGE	3	
MONOJECT SMARTIP CANNULA 3 ML SYRINGE	3	
MONOJECT SMARTIP CANNULA 6 ML SYRINGE	3	
MONOJECT SYRINGE 1/2 ML 28 GAUGE ^{MM}	2	
MONOJECT SYRINGE 3 ML	2	
MONOJECT SYRINGE 6 ML	2	
MONOJECT SYRINGE 6 ML 20 X 1 1/2"	2	
MONOJECT SYRINGE 6 ML 21 X 1 1/2"	2	
MONOJECT SYRINGE 6 ML 21 X 1"	2	
MONOJECT SYRINGE 6 ML 22 X 1 1/2"	2	
MONOJECT TB LUER LOK 1 ML SYRINGE	3	
MONOJECT TUBERCULIN SYRINGE 1 ML	3	
MONOJECT ULTRA COMFORT INSULIN 1/2 ML 28 GAUGE SYRINGE ^{MM}	2	
MONOLET LANCETS 21 GAUGE ^{MM}	2	
MONOLET THIN LANCETS 28 GAUGE ^{MM}	2	
montelukast 10 mg tablet ^{MM}	1	QL(30 per 30 days)
montelukast 4 mg chewable tablet ^{MM}	1	QL(30 per 30 days)
montelukast 4 mg oral granules in packet ^{MM}	1	QL(30 per 30 days)
montelukast 5 mg chewable tablet ^{MM}	1	QL(30 per 30 days)
MONUROL 3 GRAM ORAL PACKET	3	
morgidox 100 mg capsule	1	QL(90 per 30 days)
morgidox 50 mg capsule	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
morphine 10 mg rectal suppository ^{DL}	1	QL(180 per 30 days)
morphine 10 mg/5 ml oral solution ^{DL}	1	QL(2700 per 30 days)
morphine 15 mg immediate release tablet ^{DL}	1	QL(180 per 30 days)
morphine 20 mg rectal suppository ^{DL}	1	QL(180 per 30 days)
morphine 20 mg/5 ml (4 mg/ml) oral solution ^{DL}	1	QL(1350 per 30 days)
morphine 30 mg immediate release tablet ^{DL}	1	QL(180 per 30 days)
morphine 30 mg rectal suppository ^{DL}	1	QL(180 per 30 days)
morphine 5 mg rectal suppository ^{DL}	1	QL(180 per 30 days)
morphine concentrate 100 mg/5 ml (20 mg/ml) oral solution ^{DL}	1	QL(540 per 30 days)
morphine er 10 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 100 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 100 mg tablet,extended release ^{DL}	1	QL(180 per 30 days)
morphine er 120 mg capsule,extended release 24 hr multiphase ^{DL}	1	ST,QL(60 per 30 days)
morphine er 15 mg tablet,extended release ^{DL}	1	QL(120 per 30 days)
morphine er 20 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 200 mg tablet,extended release ^{DL}	1	QL(90 per 30 days)
morphine er 30 mg capsule,extended release 24 hr multiphase ^{DL}	1	ST,QL(30 per 30 days)
morphine er 30 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 30 mg tablet,extended release ^{DL}	1	QL(120 per 30 days)
morphine er 40 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 45 mg capsule,extended release 24 hr multiphase ^{DL}	1	ST,QL(30 per 30 days)
morphine er 50 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 60 mg capsule,extended release 24 hr multiphase ^{DL}	1	ST,QL(60 per 30 days)
morphine er 60 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 60 mg tablet,extended release ^{DL}	1	QL(120 per 30 days)
morphine er 75 mg capsule,extended release 24 hr multiphase ^{DL}	1	ST,QL(60 per 30 days)
morphine er 80 mg capsule,extended release pellets ^{DL}	1	ST,QL(60 per 30 days)
morphine er 90 mg capsule,extended release 24 hr multiphase ^{DL}	1	ST,QL(60 per 30 days)
MOTEGRITY 1 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
MOTEGRITY 2 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
MOTOFEN 1 MG-0.025 MG TABLET	3	
MOUNJARO 10 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
MOUNJARO 12.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
MOUNJARO 15 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
MOUNJARO 2.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	2	QL(2 per 28 days)
MOUNJARO 5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
MOUNJARO 7.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
MOVANTIK 12.5 MG TABLET	2	QL(30 per 30 days)
MOVANTIK 25 MG TABLET	2	QL(30 per 30 days)
MOVIPREP 100 GRAM-7.5 GRAM-2.691 GRAM ORAL POWDER PACKET	3	ST
MOXATAG 775 MG TABLET,EXTENDED RELEASE	3	
MOXEZA 0.5 % EYE DROPS	3	ST
moxifloxacin 0.5 % eye drops	1	
moxifloxacin 0.5 % viscous eye drops	1	ST
moxifloxacin 400 mg tablet	1	
MS CONTIN 100 MG TABLET,EXTENDED RELEASE ^{DL}	3	ST,QL(180 per 30 days)
MS CONTIN 15 MG TABLET,EXTENDED RELEASE ^{DL}	3	ST,QL(120 per 30 days)
MS CONTIN 200 MG TABLET,EXTENDED RELEASE ^{DL}	3	ST,QL(90 per 30 days)
MS CONTIN 30 MG TABLET,EXTENDED RELEASE ^{DL}	3	ST,QL(120 per 30 days)
MS CONTIN 60 MG TABLET,EXTENDED RELEASE ^{DL}	3	ST,QL(120 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
MULPLETA 3 MG TABLET ^{DL,SP}	*	PA,QL(7 per 30 days)
MULTAQ 400 MG TABLET ^{MM}	3	QL(60 per 30 days)
MULTI-LANCET DEVICE 2 KIT ^{MM}	2	
multigen 70 mg-150 mg-10 mcg-2 mg-75mg tablet	1	
multigen plus 151 mg-60 mg-10 mcg-1 mg tablet	1	
mupirocin 2 % topical ointment	1	
mupirocin calcium 2 % topical cream	1	ST
my choice 1.5 mg tablet	1	
my way 1.5 mg tablet	1	
MYALEPT 5 MG/ML (FINAL CONCENTRATION) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
MYAMBUTOL 400 MG TABLET	3	
MYCAPSSA 20 MG CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	PA,QL(112 per 28 days)
MYCOBUTIN 150 MG CAPSULE	3	
mycophenolate mofetil 200 mg/ml oral suspension ^{MM}	1	
mycophenolate mofetil 250 mg capsule ^{MM}	1	QL(360 per 30 days)
mycophenolate mofetil 500 mg tablet ^{MM}	1	QL(180 per 30 days)
mycophenolate sodium 180 mg tablet,delayed release ^{MM}	1	
mycophenolate sodium 360 mg tablet,delayed release ^{MM}	1	
MYDAYIS 12.5 MG CAPSULE EXTENDED RELEASE 24 HR ^{MM}	2	QL(30 per 30 days)
MYDAYIS 25 MG CAPSULE EXTENDED RELEASE 24 HR ^{MM}	2	QL(30 per 30 days)
MYDAYIS 37.5 MG CAPSULE EXTENDED RELEASE 24 HR ^{MM}	2	QL(30 per 30 days)
MYDAYIS 50 MG CAPSULE EXTENDED RELEASE 24 HR ^{MM}	2	QL(30 per 30 days)
MYDRIACYL 1 % EYE DROPS	3	
MYFEMBREE 40 MG-1 MG-0.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
MYFORTIC 180 MG TABLET,DELAYED RELEASE ^{MM}	3	
MYFORTIC 360 MG TABLET,DELAYED RELEASE ^{MM}	3	
MYGLUCOHEALTH CONTROL SOLUTION ^{MM}	3	
MYGLUCOHEALTH KIT ^{MM}	3	ST
MYGLUCOHEALTH LANCETS 30 GAUGE ^{MM}	2	
MYGLUCOHEALTH STRIPS ^{MM}	3	ST,QL(150 per 30 days)
MYLERAN 2 MG TABLET ^{DL,SP}	*	QL(150 per 30 days)
MYNATAL 65 MG IRON-1 MG CAPSULE ^{MM}	2	
mynatal plus 65 mg iron-1 mg tablet ^{MM}	1	
mynatal-z 65 mg iron-1 mg tablet ^{MM}	1	
mynephrocaps 1 mg capsule	1	
myorisan 10 mg capsule	1	QL(60 per 30 days)
myorisan 20 mg capsule	1	QL(60 per 30 days)
myorisan 30 mg capsule	1	QL(60 per 30 days)
myorisan 40 mg capsule	1	QL(120 per 30 days)
MYRBETRIQ 25 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
MYRBETRIQ 50 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
MYRBETRIQ 8 MG/ML ORAL SUSPENSION,EXTENDED RELEASE ^{MM}	3	PA,QL(300 per 30 days)
MYSOLINE 250 MG TABLET ^{MM}	3	ST
MYSOLINE 50 MG TABLET ^{MM}	3	ST
MYTESI 125 MG TABLET,DELAYED RELEASE ^{DL,SP}	*	PA,QL(60 per 30 days)
nabumetone 500 mg tablet	1	
nabumetone 750 mg tablet	1	
nadolol 20 mg tablet ^{MM}	1	
nadolol 40 mg tablet ^{MM}	1	
nadolol 80 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
naftifine 1 % topical cream	1	
naftifine 1 % topical gel	1	ST
naftifine 2 % topical cream	1	
naftifine 2 % topical gel	1	ST
NAFTIN 1 % TOPICAL GEL	3	ST
NAFTIN 2 % TOPICAL GEL	3	ST
NALFON 400 MG CAPSULE	3	PA,QL(240 per 30 days)
NALFON 600 MG TABLET	1	PA
nalmefene 1 mg/ml injection solution	1	
nalocet 2.5 mg-300 mg tablet ^{DL,SP}	*	PA,QL(360 per 30 days)
naloxone 0.4 mg/ml injection solution	1	
naloxone 0.4 mg/ml injection syringe	1	
naloxone 1 mg/ml injection syringe	1	
NALOXONE 10 MG/0.4 ML INJECTION,AUTO-INJECTOR	3	
naloxone 4 mg/actuation nasal spray	1	QL(2 per 30 days)
naltrexone 50 mg tablet ^{MM}	1	
NAMENDA 10 MG TABLET ^{MM}	3	QL(60 per 30 days)
NAMENDA 5 MG TABLET ^{MM}	3	QL(60 per 30 days)
NAMENDA TITRATION PAK 5 MG-10 MG TABLETS IN A DOSE PACK	3	QL(98 per 30 days)
NAMENDA XR 14 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMENDA XR 21 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMENDA XR 28 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMENDA XR 7 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMENDA XR 7 MG-14 MG-21 MG-28 MG CAPSULE,SPRINKLE,EXT REL, DOSE PACK	3	PA,QL(28 per 28 days)
NAMZARIC 14 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMZARIC 21 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMZARIC 28 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMZARIC 7 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG CAPSULE,SPRINKLE,EXTEND RELEASE,DOSE PACK	3	PA,QL(28 per 28 days)
NAPRELAN CR 375 MG TAB,EXTENDED RELEASE 24 HR MPHASE ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
NAPRELAN CR 500 MG TAB,EXTENDED RELEASE 24 HR MPHASE ^{MM}	3	ST,QL(90 per 30 days)
NAPRELAN CR 750 MG TAB,EXTENDED RELEASE 24 HR MPHASE ^{MM}	3	ST,QL(60 per 30 days)
NAPROSYN 125 MG/5 ML ORAL SUSPENSION ^{MM}	3	ST
NAPROSYN 500 MG TABLET ^{MM}	3	
naproxen 125 mg/5 ml oral suspension ^{MM}	1	ST
naproxen 250 mg tablet ^{MM}	1	
naproxen 375 mg tablet ^{MM}	1	
naproxen 375 mg tablet,delayed release ^{MM}	1	
naproxen 375 mg-esomeprazole 20 mg tablet,immediate and delay release ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
naproxen 500 mg tablet ^{MM}	1	
naproxen 500 mg tablet,delayed release ^{MM}	1	
naproxen 500 mg-esomeprazole 20 mg tablet,immediate and delay release ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
naproxen sodium 275 mg tablet ^{MM}	1	
naproxen sodium 550 mg tablet ^{MM}	1	
naproxen sodium er (cr) 375 mg tablet,extended release 24 hr mphase ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
naproxen sodium er (cr) 500 mg tablet,extended release 24 hr mphase ^{MM}	1	ST,QL(90 per 30 days)
naproxen sodium er (cr) 750 mg tablet,extended release 24 hr mphase ^{MM}	3	ST,QL(60 per 30 days)
naratriptan 1 mg tablet	1	QL(9 per 30 days)
naratriptan 2.5 mg tablet	1	QL(9 per 30 days)
NARCAN 4 MG/ACTUATION NASAL SPRAY	2	QL(2 per 30 days)
NARDIL 15 MG TABLET ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
NASCOBAL 500 MCG/SPRAY NASAL SPRAY ^{DL,MM,SP}	*	PA
NASONEX 50 MCG/ACTUATION SPRAY ^{MM}	3	ST,QL(34 per 30 days)
NATACHEW (FE BIS-GLYCINATE) 28 MG IRON-1 MG TABLET ^{MM}	3	
NATACYN 5 % EYE DROPS,SUSPENSION	3	
NATAZIA 3 MG/2 MG-2 MG/2 MG-3 MG/1 MG TABLET ^{MM}	2	
nateglinide 120 mg tablet ^{MM}	1	
nateglinide 60 mg tablet ^{MM}	1	
NATESTO 5.5 MG/0.122 GRAM PER ACTUATION NASAL GEL PUMP ^{MM}	3	PA,QL(21.96 per 30 days)
NATPARA 100 MCG/DOSE SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
NATPARA 25 MCG/DOSE SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
NATPARA 50 MCG/DOSE SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
NATPARA 75 MCG/DOSE SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
NATROBA 0.9 % TOPICAL SUSPENSION	3	QL(240 per 30 days)
NAYZILAM 5 MG/SPRAY (0.1 ML) NASAL SPRAY ^{DL}	3	QL(10 per 30 days)
neбиволol 10 mg tablet ^{MM}	1	PA,QL(120 per 30 days)
neбиволol 2.5 mg tablet ^{MM}	1	PA,QL(30 per 30 days)
neбиволol 20 mg tablet ^{MM}	1	PA,QL(60 per 30 days)
neбиволol 5 mg tablet ^{MM}	1	PA,QL(30 per 30 days)
NEBUPENT 300 MG SOLUTION FOR INHALATION ^{MM}	3	
nebusal 3 % solution for nebulization	1	
nebusal 6 % solution for nebulization	3	
necon 0.5/35 (28) 0.5 mg-35 mcg tablet ^{MM}	1	
nefazodone 100 mg tablet ^{MM}	1	
nefazodone 150 mg tablet ^{MM}	1	
nefazodone 200 mg tablet ^{MM}	1	
nefazodone 250 mg tablet ^{MM}	1	
nefazodone 50 mg tablet ^{MM}	1	
neo-polycin 3.5 mg-400 unit-10,000 unit/g eye ointment	1	
neo-polycin hc 3.5 mg-400-10,000 unit/g-1 % eye ointment	1	
NEO-SYNALAR 0.5 % (0.35 % BASE)-0.025 % TOPICAL CREAM ^{DL,SP}	*	ST
neomycin 1.75 mg-polymyxin 10,000 unit-gramicidin 0.025mg/ml eye drops	1	
neomycin 3.5 mg-polymyxin 10,000 unit-hydrocort 10 mg/ml eye drop,susp	1	
neomycin 3.5 mg/g-polymyxin b 10,000 unit/g-dexameth 0.1 % eye oint	1	
neomycin 40 mg-polymyxin b 200,000 unit/ml gu irrigation solution	1	
neomycin 500 mg tablet	1	
neomycin-bacitracin-poly-hc 3.5 mg-400-10,000 unit/g-1 % eye ointment	1	
neomycin-bacitracin-polymyxn 3.5 mg-400 unit-10,000 unit/gram eye oint	1	
neomycin-polymyxin-dexameth 3.5 mg/ml-10,000 unit/ml-0.1% eye drops	1	
neomycin-polymyxin-hydrocort 3.5 mg-10,000 unit/ml-1 % ear drops,susp	1	
neomycin-polymyxin-hydrocort 3.5 mg/ml-10,000 unit/ml-1 % ear solution	1	
NEORAL 100 MG CAPSULE ^{MM}	3	QL(720 per 30 days)
NEORAL 100 MG/ML ORAL SOLUTION ^{MM}	3	
NEORAL 25 MG CAPSULE ^{MM}	3	
NERLYNX 40 MG TABLET ^{DL,SP}	*	PA,QL(180 per 30 days)
NESINA 12.5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
NESINA 25 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
NESINA 6.25 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
NESTABS 32 MG-1,000 MCG TABLET ^{MM}	2	
NESTABS ABC 32 MG IRON-1 MG-120 MG-180 MG ORAL PACK ^{MM}	3	
NESTABS DHA 32 MG IRON-1,000 MCG-230 MG ORAL PACK ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
neuac 1.2 % (1 % base)-5 % topical gel	1	
NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.2 per 28 days)
NEULASTA ONPRO 6 MG/0.6 ML WITH WEARABLE SUBCUTANEOUS INJECTOR ^{DL,SP}	*	PA,QL(1.2 per 28 days)
NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE ^{DL,SP}	*	PA,QL(7 per 30 days)
NEUPOGEN 300 MCG/ML INJECTION SOLUTION ^{DL,SP}	*	PA,QL(14 per 30 days)
NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE ^{DL,SP}	*	PA,QL(11.2 per 30 days)
NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION ^{DL,SP}	*	PA,QL(22.4 per 30 days)
NEUPRO 1 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{DL,MM}	3	PA,QL(30 per 30 days)
NEUPRO 2 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	PA,QL(30 per 30 days)
NEUPRO 3 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{DL,MM}	3	PA,QL(30 per 30 days)
NEUPRO 4 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	PA,QL(30 per 30 days)
NEUPRO 6 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	PA,QL(30 per 30 days)
NEUPRO 8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{DL,MM}	3	PA,QL(30 per 30 days)
NEURONTIN 100 MG CAPSULE ^{MM}	3	ST,QL(270 per 30 days)
NEURONTIN 250 MG/5 ML ORAL SOLUTION ^{MM}	3	ST,QL(2250 per 30 days)
NEURONTIN 300 MG CAPSULE ^{MM}	3	ST,QL(270 per 30 days)
NEURONTIN 400 MG CAPSULE ^{MM}	3	ST,QL(270 per 30 days)
NEURONTIN 600 MG TABLET ^{MM}	3	ST,QL(180 per 30 days)
NEURONTIN 800 MG TABLET ^{MM}	3	ST,QL(180 per 30 days)
NEUTEK 2TEK TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
NEVANAC 0.1 % EYE DROPS,SUSPENSION	3	ST
nevirapine 200 mg tablet ^{MM}	1	QL(60 per 30 days)
nevirapine 50 mg/5 ml oral suspension ^{MM}	1	QL(1200 per 30 days)
nevirapine er 100 mg tablet,extended release 24 hr ^{MM}	1	QL(120 per 30 days)
nevirapine er 400 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
new day 1.5 mg tablet	1	
newgen 32 mg-1,000 mcg tablet ^{MM}	1	
NEXAVAR 200 MG TABLET ^{DL,LD,SP}	*	PA,QL(120 per 30 days)
NEXICLON XR 0.17 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
NEXIUM 20 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
NEXIUM 40 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
NEXIUM PACKET 10 MG GRANULES DELAYED RELEASE FOR SUSP ^{MM}	3	ST,QL(30 per 30 days)
NEXIUM PACKET 2.5 MG GRANULES DELAYED RELEASE FOR SUSP ^{MM}	3	QL(30 per 30 days)
NEXIUM PACKET 20 MG GRANULES DELAYED RELEASE FOR SUSP ^{MM}	3	ST,QL(30 per 30 days)
NEXIUM PACKET 40 MG GRANULES DELAYED RELEASE FOR SUSP ^{MM}	3	ST,QL(30 per 30 days)
NEXIUM PACKET 5 MG GRANULES DELAYED RELEASE FOR SUSP ^{MM}	3	QL(30 per 30 days)
NEXLETOL 180 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
NEXLIZET 180 MG-10 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
NEXPLANON 68 MG SUBDERMAL IMPLANT ^{DL,LD,SP}	*	
NEXTSTELLIS 3 MG-14.2 MG (28) TABLET ^{MM}	3	
niacin 500 mg tablet ^{MM}	1	
niacin er 1,000 mg tablet,extended release 24 hr ^{MM}	1	PA
niacin er 500 mg tablet,extended release 24 hr ^{MM}	1	PA
niacin er 750 mg tablet,extended release 24 hr ^{MM}	1	PA
niacor 500 mg tablet ^{MM}	1	
NIASPAN 1,000 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA
NIASPAN 500 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA
NIASPAN 750 MG TABLET,EXTENDED RELEASE ^{MM}	3	PA
nicardipine 20 mg capsule ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
nicardipine 30 mg capsule ^{MM}	1	
nifedipine 10 mg capsule ^{MM}	1	
nifedipine 20 mg capsule ^{MM}	1	
nifedipine er 30 mg tablet,extended release ^{MM}	1	QL(60 per 30 days)
nifedipine er 30 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
nifedipine er 60 mg tablet,extended release ^{MM}	1	QL(60 per 30 days)
nifedipine er 60 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
nifedipine er 90 mg tablet,extended release ^{MM}	1	QL(60 per 30 days)
nifedipine er 90 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
nikki (28) 3 mg-0.02 mg tablet ^{MM}	1	
NILANDRON 150 MG TABLET ^{DL,MM,SP}	*	QL(60 per 30 days)
nilutamide 150 mg tablet ^{DL,MM,SP}	*	QL(60 per 30 days)
nimodipine 30 mg capsule ^{DL,SP}	*	
NINLARO 2.3 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(3 per 28 days)
NINLARO 3 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(3 per 28 days)
NINLARO 4 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(3 per 28 days)
nisoldipine er 17 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
nisoldipine er 20 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
nisoldipine er 25.5 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
nisoldipine er 30 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
nisoldipine er 34 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
nisoldipine er 40 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
nisoldipine er 8.5 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
nitazoxanide 500 mg tablet ^{DL,SP}	*	QL(40 per 30 days)
nitisinone 10 mg capsule ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
nitisinone 2 mg capsule ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
nitisinone 20 mg capsule ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
nitisinone 5 mg capsule ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
NITRO-BID 2 % TRANSDERMAL OINTMENT ^{MM}	2	
NITRO-DUR 0.1 MG/HR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	QL(30 per 30 days)
NITRO-DUR 0.2 MG/HR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	QL(30 per 30 days)
NITRO-DUR 0.3 MG/HR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	QL(30 per 30 days)
NITRO-DUR 0.4 MG/HR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	QL(60 per 30 days)
NITRO-DUR 0.6 MG/HR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	QL(30 per 30 days)
NITRO-DUR 0.8 MG/HR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	QL(30 per 30 days)
nitro-time 2.5 mg capsule,extended release ^{MM}	1	
nitro-time 6.5 mg capsule,extended release ^{MM}	1	
nitro-time 9 mg capsule,extended release ^{MM}	1	
nitrofurantoin 25 mg/5 ml oral suspension	1	QL(2400 per 30 days)
nitrofurantoin macrocrystal 100 mg capsule	1	
nitrofurantoin macrocrystal 25 mg capsule	1	
nitrofurantoin macrocrystal 50 mg capsule	1	
nitrofurantoin monohydrate/macrocrystals 100 mg capsule	1	
nitroglycerin 0.1 mg/hr transdermal 24 hour patch ^{MM}	1	QL(30 per 30 days)
nitroglycerin 0.2 mg/hr transdermal 24 hour patch ^{MM}	1	QL(30 per 30 days)
nitroglycerin 0.3 mg sublingual tablet ^{MM}	1	
nitroglycerin 0.4 mg sublingual tablet ^{MM}	1	
nitroglycerin 0.4 mg/hr transdermal 24 hour patch ^{MM}	1	QL(60 per 30 days)
nitroglycerin 0.6 mg sublingual tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
nitroglycerin 0.6 mg/hr transdermal 24 hour patch ^{MM}	1	QL(30 per 30 days)
nitroglycerin 400 mcg/spray translingual ^{MM}	1	
NITROLINGUAL 400 MCG/SPRAY ^{MM}	3	
NITROMIST 400 MCG/SPRAY TRANSLINGUAL AEROSOL ^{MM}	3	
NITROSTAT 0.3 MG SUBLINGUAL TABLET ^{MM}	3	
NITROSTAT 0.4 MG SUBLINGUAL TABLET ^{MM}	3	
NITROSTAT 0.6 MG SUBLINGUAL TABLET ^{MM}	3	
NITYR 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
NITYR 2 MG TABLET ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
NITYR 5 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
NIVESTYM 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(7 per 30 days)
NIVESTYM 300 MCG/ML INJECTION SOLUTION ^{DL,SP}	*	PA,QL(14 per 30 days)
NIVESTYM 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(11.2 per 30 days)
NIVESTYM 480 MCG/1.6 ML INJECTION SOLUTION ^{DL,SP}	*	PA,QL(22.4 per 30 days)
nizatidine 150 mg capsule ^{MM}	1	
nizatidine 150 mg/10 ml oral solution ^{MM}	1	
nizatidine 300 mg capsule ^{MM}	1	
NOCDURNA (MEN) 55.3 MCG DISINTEGRATING TABLET,SUBLINGUAL ^{MM}	3	PA,QL(30 per 30 days)
NOCDURNA (WOMEN) 27.7 MCG DISINTEGRATING TABLET,SUBLINGUAL ^{MM}	3	PA,QL(30 per 30 days)
NOCTIVA 0.83 MCG/SPRAY (0.1 ML) NASAL SPRAY ^{MM}	3	PA,QL(3.8 per 30 days)
NOCTIVA 1.66 MCG/SPRAY (0.1 ML) NASAL SPRAY ^{MM}	3	PA,QL(3.8 per 30 days)
nolix 0.05 % lotion ^{DL,SP}	*	ST
nolix 0.05 % topical cream	1	ST
nora-be 0.35 mg tablet ^{MM}	1	
NORDITROPIN FLEXPRO 10 MG/1.5 ML (6.7 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(10 per 30 days)
NORDITROPIN FLEXPRO 15 MG/1.5 ML (10 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(10 per 30 days)
NORDITROPIN FLEXPRO 30 MG/3 ML (10 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(10 per 30 days)
NORDITROPIN FLEXPRO 5 MG/1.5 ML (3.3 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(10 per 30 days)
norethin-ethinyl estradiol-iron 0.4 mg-35 mcg(21)/75 mg(7) chew tablet ^{MM}	1	
norethin-ethinyl estradiol-iron 0.8 mg-25 mcg(24)/75 mg(4) chew tablet ^{MM}	1	
norethindrone (contraceptive) 0.35 mg tablet ^{MM}	1	
norethindrone 1 mg-e. estradiol 20 mcg (24)-iron 75 mg (4) chew tablet ^{MM}	1	
norethindrone 1 mg-ethin. estradiol 20 mcg (24)-iron 75 mg (4) capsule ^{MM}	1	
norethindrone 1 mg-ethinyl estradiol 20 mcg (21)-iron 75 mg (7) tablet ^{MM}	1	
norethindrone 1.5 mg-ethinyl estradiol 30 mcg(21)/iron 75 mg(7) tablet ^{MM}	1	
norethindrone acetate 0.5 mg-ethinyl estradiol 2.5 mcg tablet ^{MM}	1	
norethindrone acetate 1 mg-ethinyl estradiol 20 mcg tablet ^{MM}	1	
norethindrone acetate 1 mg-ethinyl estradiol 5 mcg tablet ^{MM}	1	
norethindrone acetate 1.5 mg-ethinyl estradiol 30 mcg tablet ^{MM}	1	
norethindrone acetate 5 mg tablet ^{MM}	1	
norethindrone-eth. estradiol-iron 1-20 (5)/1-30(7)/1mg-35mcg(9) tablet ^{MM}	1	
norgesic 25 mg-385 mg-30 mg tablet ^{DL,SP}	*	PA,QL(240 per 30 days)
NORGESIC FORTE 50 MG-770 MG-60 MG TABLET ^{DL,SP}	*	PA,QL(120 per 30 days)
norgestimate 0.18 mg/0.215 mg/0.25 mg-ethinyl estradiol 25 mcg tablet ^{MM}	1	
norgestimate 0.25 mg-ethinyl estradiol 35 mcg tablet ^{MM}	1	
norgestimate-ethinyl estradiol 0.18 mg/0.215mg/0.25mg-35 mcg(28)tablet ^{MM}	1	
NORITATE 1 % TOPICAL CREAM ^{DL,SP}	*	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
NORLIQVA 1 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	ST,QL(300 per 30 days)
norlyda 0.35 mg tablet ^{MM}	1	
NORM-JECT 10 ML SYRINGE	3	
NORM-JECT 20 ML SYRINGE	3	
NORM-JECT TUBERKULIN 1 ML SYRINGE	3	
NORPACE 100 MG CAPSULE ^{MM}	3	
NORPACE 150 MG CAPSULE ^{MM}	3	
NORPACE CR 100 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
NORPACE CR 150 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
NORPRAMIN 10 MG TABLET ^{MM}	3	
NORPRAMIN 25 MG TABLET ^{MM}	3	
NORTHERA 100 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
NORTHERA 200 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
NORTHERA 300 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
nortrel 0.5/35 (28) 0.5 mg-35 mcg tablet ^{MM}	1	
nortrel 1/35 (21) 1 mg-35 mcg tablet ^{MM}	1	
nortrel 1/35 (28) 1 mg-35 mcg tablet ^{MM}	1	
nortrel 7/7/7 (28) 0.5 mg/0.75 mg/1 mg-35 mcg tablet ^{MM}	1	
nortriptyline 10 mg capsule ^{MM}	1	
nortriptyline 10 mg/5 ml oral solution ^{MM}	1	
nortriptyline 25 mg capsule ^{MM}	1	
nortriptyline 50 mg capsule ^{MM}	1	
nortriptyline 75 mg capsule ^{MM}	1	
NORVASC 10 MG TABLET ^{MM}	3	QL(30 per 30 days)
NORVASC 2.5 MG TABLET ^{MM}	3	QL(30 per 30 days)
NORVASC 5 MG TABLET ^{MM}	3	QL(30 per 30 days)
NORVIR 100 MG ORAL POWDER PACKET ^{MM,SP}	*	QL(360 per 30 days)
NORVIR 100 MG TABLET ^{MM}	3	QL(360 per 30 days)
NORVIR 80 MG/ML ORAL SOLUTION ^{MM}	3	QL(480 per 30 days)
NOURIANZ 20 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
NOURIANZ 40 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
NOVA MAX GLUCOSE CONTROL SOLUTION ^{MM}	3	
NOVA MAX GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
NOVA MAX PLUS GLUCOSE-KETONE METER ^{MM}	3	ST
NOVA MAX PLUS GLUCOSE-KETONE METER KIT ^{MM}	3	ST
NOVA SAFETY LANCETS 23 GAUGE ^{MM}	3	
NOVA SAFETY LANCETS 28 GAUGE ^{MM}	3	
NOVA SUREFLEX LANCETS ^{MM}	2	
NOVAMAX PLUS GLU-KET SOLUTION ^{MM}	3	
NOVAVAX COVID-19 VACCINE,ADJUVANTED (PF) 5 MCG/0.5 ML IM SUSPEN (EUA)	3	
NOVOFINE 32 32 GAUGE X 1/4" NEEDLE ^{MM}	2	
NOVOFINE AUTOCOVER 30 GAUGE X 1/3" NEEDLE ^{MM}	2	
NOVOFINE PLUS 32 GAUGE X 1/6" NEEDLE ^{MM}	2	
NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30) SUBCUTANEOUS ^{MM}	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION ^{MM}	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN ^{MM}	2	
NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML SUBCUTANEOUS SUSP ^{MM}	2	
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN ^{MM}	2	
NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML INJECTION SOLUTION ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	2	
NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN ^{MM}	2	
NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	
NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS CARTRIDGE ^{MM}	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	
NOVOPEN ECHO SUBCUTANEOUS ^{MM}	3	
NOVOTWIST 32 GAUGE X 1/5" NEEDLE ^{MM}	2	
NOXAFIL 100 MG TABLET, DELAYED RELEASE ^{DL,SP}	*	PA, QL(93 per 30 days)
NOXAFIL 200 MG/5 ML (40 MG/ML) ORAL SUSPENSION ^{DL,SP}	*	PA, QL(840 per 28 days)
NOXAFIL 300 MG ORAL SUSPENSION, DELAYED RELEASE IN A PACKET ^{DL,SP}	*	PA, QL(32 per 30 days)
np thyroid 120 mg tablet ^{MM}	1	
np thyroid 15 mg tablet ^{MM}	1	
np thyroid 30 mg tablet ^{MM}	1	
np thyroid 60 mg tablet ^{MM}	1	
np thyroid 90 mg tablet ^{MM}	1	
NUBEQA 300 MG TABLET ^{DL,LD,MM,SP}	*	PA, QL(120 per 30 days)
NUCALA 100 MG/ML SUBCUTANEOUS AUTO-INJECTOR ^{DL,LD,MM,SP}	*	PA, QL(3 per 28 days)
NUCALA 100 MG/ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA, QL(3 per 28 days)
NUCALA 40 MG/0.4 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA, QL(0.4 per 28 days)
NUCYNTA 100 MG TABLET ^{DL,SP}	*	ST, QL(180 per 30 days)
NUCYNTA 50 MG TABLET ^{DL,SP}	*	ST, QL(180 per 30 days)
NUCYNTA 75 MG TABLET ^{DL,SP}	*	ST, QL(180 per 30 days)
NUCYNTA ER 100 MG TABLET, EXTENDED RELEASE ^{DL}	3	ST, QL(60 per 30 days)
NUCYNTA ER 150 MG TABLET, EXTENDED RELEASE ^{DL}	3	ST, QL(60 per 30 days)
NUCYNTA ER 200 MG TABLET, EXTENDED RELEASE ^{DL}	3	ST, QL(60 per 30 days)
NUCYNTA ER 250 MG TABLET, EXTENDED RELEASE ^{DL}	3	ST, QL(60 per 30 days)
NUCYNTA ER 50 MG TABLET, EXTENDED RELEASE ^{DL}	3	ST, QL(60 per 30 days)
NUEDEXTA 20 MG-10 MG CAPSULE ^{DL,SP}	*	PA, QL(60 per 30 days)
nulev 0.125 mg disintegrating tablet ^{MM}	1	
NULYTELY LEMON-LIME 420 GRAM ORAL SOLUTION	3	
NUPLAZID 10 MG TABLET ^{LD,MM,SP}	*	PA, QL(30 per 30 days)
NUPLAZID 34 MG CAPSULE ^{LD,MM,SP}	*	PA, QL(30 per 30 days)
NURTEC ODT 75 MG DISINTEGRATING TABLET	2	PA, QL(18 per 30 days)
NUTROPIN AQ NUSPIN 10 MG/2 ML (5 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA, QL(56 per 30 days)
NUTROPIN AQ NUSPIN 20 MG/2 ML (10 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA, QL(28 per 30 days)
NUTROPIN AQ NUSPIN 5 MG/2 ML (2.5 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA, QL(28 per 30 days)
NUVARING 0.12 MG-0.015 MG/24 HR VAGINAL ^{MM}	3	ST, QL(1 per 28 days)
NUVESSA 1.3 % (65 MG/5 GRAM) VAGINAL GEL	3	
NUVIGIL 150 MG TABLET ^{MM}	3	PA, QL(30 per 30 days)
NUVIGIL 200 MG TABLET ^{MM}	3	PA, QL(30 per 30 days)
NUVIGIL 250 MG TABLET ^{MM}	3	PA, QL(30 per 30 days)
NUVIGIL 50 MG TABLET ^{MM}	3	PA, QL(60 per 30 days)
NUZYRA 150 MG TABLET	3	QL(30 per 14 days)
nyamyc 100,000 unit/gram topical powder	1	PA
nylia 1/35 (28) 1 mg-35 mcg tablet ^{MM}	1	
nylia 7/7/7 (28) 0.5/0.75/1 mg-35 mcg tablet ^{MM}	1	
NYMALIZE 30 MG/5 ML ORAL SYRINGE (FOR ORAL USE ONLY) ^{DL,SP}	*	QL(630 per 28 days)
NYMALIZE 60 MG/10 ML ORAL SOLUTION ^{DL,SP}	*	QL(1260 per 28 days)
NYMALIZE 60 MG/10 ML ORAL SYRINGE (FOR ORAL USE ONLY) ^{DL,SP}	*	QL(1260 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
nymyo 0.25 mg-35 mcg tablet ^{MM}	1	
nystatin 100,000 unit/gram topical cream	1	
nystatin 100,000 unit/gram topical ointment	1	
nystatin 100,000 unit/gram topical powder	1	PA
nystatin 100,000 unit/ml oral suspension	1	
nystatin 500,000 unit tablet	1	
nystatin-triamcinolone 100,000 unit/g-0.1 % topical cream	1	
nystatin-triamcinolone 100,000 unit/gram-0.1 % topical ointment	1	
nystop 100,000 unit/gram topical powder	1	PA
NYVEPRIA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.2 per 28 days)
O-CAL PRENATAL 15 MG IRON-1,000 MCG TABLET ^{MM}	2	
OB COMPLETE ONE 40 MG-10 MG-1 MG-300 MG CAPSULE ^{MM}	3	
OB COMPLETE PETITE 35 MG IRON-5 MG IRON-1 MG CAPSULE ^{MM}	3	
OB COMPLETE PREMIER 30 MG-20 MG-1 MG TABLET ^{MM}	3	
OB COMPLETE WITH DHA 30 MG IRON-10 MG IRON-1 MG CAPSULE ^{MM}	3	
OBREDON 2.5 MG-200 MG/5 ML ORAL SOLUTION	3	
OCALIVA 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
OCALIVA 5 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ocella 3 mg-0.03 mg tablet ^{MM}	1	
octreotide acetate 1,000 mcg/ml injection solution ^{MM}	1	PA
octreotide acetate 100 mcg/ml (1 ml) injection syringe ^{MM}	1	PA
octreotide acetate 100 mcg/ml injection solution ^{MM}	1	PA
octreotide acetate 200 mcg/ml injection solution ^{MM}	1	PA
octreotide acetate 50 mcg/ml (1 ml) injection syringe ^{MM}	1	PA
octreotide acetate 50 mcg/ml injection solution ^{MM}	1	PA
octreotide acetate 500 mcg/ml (1 ml) injection syringe ^{MM}	1	PA
octreotide acetate 500 mcg/ml injection solution ^{MM}	1	PA
OCUFLOX 0.3 % EYE DROPS	3	
ODACTRA 12 SQ-HDM SUBLINGUAL TABLET ^{MM}	3	ST,QL(30 per 30 days)
ODEFSEY 200 MG-25 MG-25 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
ODOMZO 200 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
OFEV 100 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
OFEV 150 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
ofloxacin 0.3 % ear drops	1	
ofloxacin 0.3 % eye drops	1	
ofloxacin 300 mg tablet	1	
ofloxacin 400 mg tablet	1	
OHC COVID-19 ANTIGEN HOME TEST KIT	3	
olanzapine 10 mg disintegrating tablet ^{MM}	1	QL(30 per 30 days)
olanzapine 10 mg intramuscular solution	1	QL(60 per 30 days)
olanzapine 10 mg tablet ^{MM}	1	QL(30 per 30 days)
olanzapine 15 mg disintegrating tablet ^{MM}	1	QL(60 per 30 days)
olanzapine 15 mg tablet ^{MM}	1	QL(60 per 30 days)
olanzapine 2.5 mg tablet ^{MM}	1	QL(30 per 30 days)
olanzapine 20 mg disintegrating tablet ^{MM}	1	QL(60 per 30 days)
olanzapine 20 mg tablet ^{MM}	1	QL(60 per 30 days)
olanzapine 5 mg disintegrating tablet ^{MM}	1	QL(30 per 30 days)
olanzapine 5 mg tablet ^{MM}	1	QL(30 per 30 days)
olanzapine 7.5 mg tablet ^{MM}	1	QL(30 per 30 days)
olanzapine-fluoxetine 12 mg-25 mg capsule ^{MM}	1	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
olanzapine-fluoxetine 12 mg-50 mg capsule ^{MM}	1	QL(30 per 30 days)
olanzapine-fluoxetine 3 mg-25 mg capsule ^{MM}	1	QL(30 per 30 days)
olanzapine-fluoxetine 6 mg-25 mg capsule ^{MM}	1	QL(30 per 30 days)
olanzapine-fluoxetine 6 mg-50 mg capsule ^{MM}	1	QL(30 per 30 days)
olmesartan 20 mg tablet ^{MM}	1	QL(30 per 30 days)
olmesartan 20 mg-amlodipine 5 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
olmesartan 20 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(30 per 30 days)
olmesartan 40 mg tablet ^{MM}	1	QL(30 per 30 days)
olmesartan 40 mg-amlodipine 10 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
olmesartan 40 mg-amlodipine 10 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
olmesartan 40 mg-amlodipine 5 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
olmesartan 40 mg-amlodipine 5 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
olmesartan 40 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(30 per 30 days)
olmesartan 40 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	QL(30 per 30 days)
olmesartan 5 mg tablet ^{MM}	1	QL(60 per 30 days)
olopatadine 0.1 % eye drops	1	
olopatadine 0.2 % eye drops	1	
olopatadine 0.6 % nasal spray	1	ST,QL(30.5 per 30 days)
OLUMIANT 1 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
OLUMIANT 2 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
OLUMIANT 4 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
OLUX 0.05 % TOPICAL FOAM	3	ST
OLUX-E 0.05 % TOPICAL FOAM	3	ST
OMECLAMOX-PAK 20 MG-500 MG-500 MG (40) ORAL PACK ^{DL,SP}	*	ST
omega-3 acid ethyl esters 1 gram capsule ^{MM}	1	QL(120 per 30 days)
omeprazole 10 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
omeprazole 20 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
omeprazole 20 mg-sodium bicarbonate 1,680 mg oral packet ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
omeprazole 20 mg-sodium bicarbonate 1.1 gram capsule ^{MM}	1	ST,QL(30 per 30 days)
omeprazole 40 mg capsule,delayed release ^{MM}	1	QL(60 per 30 days)
omeprazole 40 mg-sodium bicarbonate 1,680 mg oral packet ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
omeprazole 40 mg-sodium bicarbonate 1.1 gram capsule ^{MM}	1	ST,QL(30 per 30 days)
OMNARIS 50 MCG NASAL SPRAY ^{MM}	3	ST,QL(12.5 per 30 days)
OMNIFLEX DIAPHRAGM 65 MM VAGINAL	3	
OMNIPOD 5 G6 INTRO KIT (GEN 5) SUBCUTANEOUS CARTRIDGE WITH CONTROLLER	2	
OMNIPOD 5 G6 PODS (GEN 5) SUBCUTANEOUS CARTRIDGE ^{MM}	2	
OMNIPOD CLASSIC PDM KIT(GEN 3) ^{MM}	2	
OMNIPOD CLASSIC PODS (GEN 3) SUBCUTANEOUS CARTRIDGE ^{MM}	2	
OMNIPOD DASH INTRO KIT (GEN 4) SUBCUTANEOUS CARTRIDGE WITH CONTROLLER	2	
OMNIPOD DASH PDM KIT (GEN 4) ^{MM}	2	
OMNIPOD DASH PODS (GEN 4) SUBCUTANEOUS CARTRIDGE ^{MM}	2	
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML) SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(12 per 28 days)
OMNITROPE 5 MG/1.5 ML (3.3 MG/ML) SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(24 per 28 days)
OMNITROPE 5.8 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
ON CALL EXPRESS CONTROL SOLUTION ^{MM}	3	
ON CALL EXPRESS METER ^{MM}	3	ST
ON CALL EXPRESS METER KIT ^{MM}	3	ST
ON CALL EXPRESS TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
ON CALL LANCET 30 GAUGE ^{MM}	3	
ON CALL LANCING DEVICE	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ON CALL PLUS CONTROL SOLUTION ^{MM}	3	
ON CALL PLUS LANCET 30 GAUGE ^{MM}	3	
ON CALL PLUS LANCING DEVICE	3	
ON CALL PLUS METER ^{MM}	3	ST
ON CALL PLUS METER KIT ^{MM}	3	ST
ON CALL PLUS TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
ON CALL VIVID CONTROL SOLUTION ^{MM}	3	
ON CALL VIVID METER ^{MM}	3	ST
ON CALL VIVID METER KIT ^{MM}	3	ST
ON CALL VIVID PAL BLOOD GLUCOSE METER ^{MM}	3	ST
ON CALL VIVID PAL BLOOD GLUCOSE METER KIT ^{MM}	3	ST
ON CALL VIVID TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
ON-GO COVID-19 AG AT HOME TEST KIT	3	
ON-THE-GO LANCETS 30 GAUGE ^{MM}	2	
ondansetron 4 mg disintegrating tablet	1	QL(90 per 30 days)
ondansetron 8 mg disintegrating tablet	1	QL(90 per 30 days)
ondansetron hcl 4 mg tablet	1	QL(90 per 30 days)
ondansetron hcl 4 mg/5 ml oral solution	1	QL(450 per 30 days)
ondansetron hcl 8 mg tablet	1	QL(90 per 30 days)
ONETOUCH DELICA LANCETS 33 GAUGE ^{MM}	3	
ONETOUCH DELICA PLUS LANCET 30 GAUGE ^{MM}	2	
ONETOUCH DELICA PLUS LANCET 33 GAUGE ^{MM}	2	
ONETOUCH DELICA PLUS LANCING DEVICE KIT ^{MM}	3	
ONETOUCH DELICA SAFETY LANCET 30 GAUGE ^{MM}	2	
ONETOUCH SOLUTIONS STARTER KIT ^{MM}	3	ST
ONETOUCH SURESOFT LANCING DEVICES 18 GAUGE ^{MM}	3	
ONETOUCH SURESOFT LANCING DEVICES 21 GAUGE ^{MM}	3	
ONETOUCH SURESOFT LANCING DEVICES 28 GAUGE ^{MM}	3	
ONETOUCH ULTRA CONTROL SOLUTION ^{MM}	3	
ONETOUCH ULTRA TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ONETOUCH ULTRA2 METER ^{MM}	3	ST
ONETOUCH ULTRA2 METER KIT ^{MM}	3	ST
ONETOUCH ULTRASOFT 2 LANCET 30 GAUGE ^{MM}	2	
ONETOUCH ULTRASOFT LANCETS ^{MM}	2	
ONETOUCH VERIO FLEX METER ^{MM}	3	ST
ONETOUCH VERIO FLEX START KIT ^{MM}	3	ST
ONETOUCH VERIO HIGH CONTROL SOLUTION ^{MM}	3	
ONETOUCH VERIO MID CONTROL SOLUTION ^{MM}	3	
ONETOUCH VERIO REFLECT METER ^{MM}	3	ST
ONETOUCH VERIO REFLECT START KIT ^{MM}	3	ST
ONETOUCH VERIO TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ONEXTON 1.2 % (1 % BASE)-3.75 % TOPICAL GEL ^{DL,SP}	*	ST
ONEXTON 1.2 % (1 % BASE)-3.75 % TOPICAL GEL WITH PUMP ^{DL,SP}	*	ST
ONFI 10 MG TABLET ^{DL,MM}	3	PA,QL(60 per 30 days)
ONFI 2.5 MG/ML ORAL SUSPENSION ^{DL,MM}	3	PA,QL(480 per 30 days)
ONFI 20 MG TABLET ^{DL,MM}	3	PA,QL(60 per 30 days)
ONGENTYS 25 MG CAPSULE ^{MM}	3	PA,QL(30 per 30 days)
ONGENTYS 50 MG CAPSULE ^{MM}	3	PA,QL(30 per 30 days)
ONGLYZA 2.5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ONGLYZA 5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
ONUREG 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(14 per 28 days)
ONUREG 300 MG TABLET ^{DL,MM,SP}	*	PA,QL(14 per 28 days)
ONZETRA XSAIL 11 MG POWDER FOR NASAL INHALATION ^{DL,SP}	*	ST,QL(16 per 30 days)
opium tincture 10 mg/ml (morphine) oral	1	QL(180 per 30 days)
OPSUMIT 10 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
OPTICHAMBER ADULT MASK-LARGE	3	
OPTICHAMBER DIAMOND VHC SPACER	3	
OPTICHAMBER DIAMOND VHC WITH LARGE MASK	2	
OPTICHAMBER DIAMOND VHC WITH MEDIUM MASK	2	
OPTICHAMBER DIAMOND VHC WITH SMALL MASK	2	
option-2 1.5 mg tablet	1	
OPTIUM EZ STRIPS ^{MM}	3	ST,QL(150 per 30 days)
OPTIUM TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
OPTUMRX KIT ^{MM}	3	ST
OPTUMRX METER ^{MM}	3	ST
OPTUMRX SOLUTION ^{MM}	3	
OPTUMRX STRIPS ^{MM}	3	ST,QL(150 per 30 days)
OPZELURA 1.5 % TOPICAL CREAM ^{DL,SP}	*	PA,QL(240 per 28 days)
ORACEA 40 MG CAPSULE,IMMEDIATE - DELAY RELEASE ^{DL,SP}	*	ST,QL(30 per 30 days)
oralone 0.1 % dental paste	1	
ORAPRED ODT 10 MG DISINTEGRATING TABLET	3	
ORAPRED ODT 15 MG DISINTEGRATING TABLET	3	
ORAPRED ODT 30 MG DISINTEGRATING TABLET	3	
ORAVIG 50 MG BUCCAL TABLET ^{DL,SP}	*	QL(14 per 30 days)
ORENCIA 125 MG/ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
ORENCIA 50 MG/0.4 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(1.6 per 28 days)
ORENCIA 87.5 MG/0.7 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(2.8 per 28 days)
ORENCIA CLICKJECT 125 MG/ML SUBCUTANEOUS AUTO-INJECTOR ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
ORENITRAM 0.125 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(1000 per 30 days)
ORENITRAM 0.25 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(500 per 30 days)
ORENITRAM 1 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(720 per 30 days)
ORENITRAM 2.5 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
ORENITRAM 5 MG TABLET, EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
ORENITRAM MONTH 1 TITRATION 0.125 MG (126)-0.25 MG (42) TABLET,ER DSPK ^{DL,SP}	*	PA,QL(168 per 28 days)
ORENITRAM MONTH 2 TITRATION 0.125 MG (126)-0.25 MG(210) TABLET,ER DSPK ^{DL,SP}	*	PA,QL(336 per 28 days)
ORENITRAM MONTH 3 TITRATION 0.125MG(126)-0.25MG(42)-1MG TABLET,ER DSPK ^{DL,SP}	*	PA,QL(252 per 28 days)
ORFADIN 10 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ORFADIN 2 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
ORFADIN 20 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ORFADIN 4 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
ORFADIN 5 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
ORGOVYX 120 MG TABLET ^{DL,MM,SP}	*	PA,QL(32 per 30 days)
ORIAHNN 300-1-0.5 MG(AM)/300 MG(PM) CAPSULES ^{MM}	2	ST,QL(56 per 28 days)
ORILISSA 150 MG TABLET ^{MM}	2	ST,QL(28 per 28 days)
ORILISSA 200 MG TABLET	2	ST,QL(56 per 28 days)
ORKAMBI 100 MG-125 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
ORKAMBI 100 MG-125 MG TABLET ^{DL,MM,SP}	*	PA,QL(112 per 28 days)
ORKAMBI 150 MG-188 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
ORKAMBI 200 MG-125 MG TABLET ^{DL,MM,SP}	*	PA,QL(112 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ORKAMBI 75 MG-94 MG ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
ORLADEYO 110 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
ORLADEYO 150 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
orphenadrine citrate er 100 mg tablet,extended release	1	
orphenadrine-asa-caffeine 25 mg-385 mg-30 mg tablet ^{DL,SP}	*	PA,QL(240 per 30 days)
orphenadrine-asa-caffeine 50 mg-770 mg-60 mg tablet ^{DL,SP}	*	PA,QL(120 per 30 days)
orphengesic forte 50 mg-770 mg-60 mg tablet ^{DL,SP}	*	PA,QL(120 per 30 days)
ORSERDU 345 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
ORSERDU 86 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
orsythia 0.1 mg-20 mcg tablet ^{MM}	1	
ORTHO MICRONOR 0.35 MG TABLET ^{MM}	3	
ORTHO TRI-CYCLEN (28) 0.18 MG(7)/0.215 MG(7)/0.25 MG(7)-35 MCG TABLET ^{MM}	3	
ORTHO-NOVUM 7/7/7 (28) 0.5 MG/0.75 MG/1 MG-35 MCG TABLET ^{MM}	3	
ORTIKOS 6 MG CAPSULE,EXTENDED RELEASE ^{DL,SP}	*	PA,QL(30 per 30 days)
ORTIKOS 9 MG CAPSULE,EXTENDED RELEASE ^{DL,SP}	*	PA,QL(30 per 30 days)
oscimin 0.125 mg tablet ^{MM}	1	
oscimin sl 0.125 mg sublingual tablet ^{MM}	1	
oscimin sr 0.375 mg tablet,extended release ^{MM}	1	
oseltamivir 30 mg capsule	1	QL(224 per 365 days)
oseltamivir 45 mg capsule	1	QL(112 per 365 days)
oseltamivir 6 mg/ml oral suspension	1	QL(1440 per 365 days)
oseltamivir 75 mg capsule	1	QL(112 per 365 days)
OSENI 12.5 MG-15 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
OSENI 12.5 MG-30 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
OSENI 12.5 MG-45 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
OSENI 25 MG-15 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
OSENI 25 MG-30 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
OSENI 25 MG-45 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
OSMOLEX ER 129 MG TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
OSMOLEX ER 193 MG TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
OSMOLEX ER 258 MG TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
OSMOLEX ER 322 MG/DAY (129 MG AND 193 MG) TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
OSMOPREP 1.5 GRAM (1.102-0.398) TABLET	3	ST
OTEZLA 30 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
OTEZLA STARTER 10 MG (4)-20 MG (4)-30 MG(19) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(27 per 30 days)
OTEZLA STARTER 10 MG (4)-20 MG (4)-30 MG(47) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(55 per 28 days)
OTIPRIO 6 % (6 MG/0.1 ML) INTRATYMPANIC SUSPENSION	3	
OTOVEL 0.3 %-0.025 % (0.25 ML) EAR SOLUTION	3	ST
OTREXUP (PF) 10 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
OTREXUP (PF) 12.5 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
OTREXUP (PF) 15 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
OTREXUP (PF) 17.5 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
OTREXUP (PF) 20 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
OTREXUP (PF) 22.5 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
OTREXUP (PF) 25 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
OVIDE 0.5 % LOTION	3	
OXANDRIN 10 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
OXANDRIN 2.5 MG TABLET ^{MM}	3	PA,QL(120 per 30 days)
oxandrolone 10 mg tablet ^{MM}	1	PA,QL(60 per 30 days)
oxandrolone 2.5 mg tablet ^{MM}	1	PA,QL(120 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
oxaprozin 600 mg tablet	1	
OXAYDO 5 MG TABLET,ORAL ONLY (NOT FEEDING TUBES) ^{DL,SP}	*	PA,QL(360 per 30 days)
OXAYDO 7.5 MG TABLET,ORAL ONLY (NOT FOR FEEDING TUBES) ^{DL,SP}	*	PA,QL(360 per 30 days)
oxazepam 10 mg capsule ^{DL}	1	
oxazepam 15 mg capsule ^{DL}	1	
oxazepam 30 mg capsule ^{DL}	1	
OXBRYTA 300 MG TABLET ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
OXBRYTA 300 MG TABLET FOR ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
OXBRYTA 500 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
oxcarbazepine 150 mg tablet ^{MM}	1	
oxcarbazepine 300 mg tablet ^{MM}	1	
oxcarbazepine 300 mg/5 ml (60 mg/ml) oral suspension ^{MM}	1	
oxcarbazepine 600 mg tablet ^{MM}	1	
OXERVATE 0.002 % EYE DROPS ^{DL,SP}	*	PA,QL(112 per 365 days)
oxiconazole 1 % topical cream	1	PA,QL(60 per 30 days)
OXISTAT 1 % LOTION	3	PA
OXISTAT 1 % TOPICAL CREAM	3	PA,QL(60 per 30 days)
OXSORALEN ULTRA 10 MG LIQUID-FILLED,RAPID RELEASE CAPSULE ^{DL,SP}	*	
OXTELLAR XR 150 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(60 per 30 days)
OXTELLAR XR 300 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(90 per 30 days)
OXTELLAR XR 600 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
oxybutynin chloride 2.5 mg tablet ^{MM}	1	QL(90 per 30 days)
oxybutynin chloride 5 mg tablet ^{MM}	1	
oxybutynin chloride 5 mg/5 ml oral syrup ^{MM}	1	
oxybutynin chloride er 10 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
oxybutynin chloride er 15 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
oxybutynin chloride er 5 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
oxycodone 10 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone 10 mg-acetaminophen 300 mg/5 ml oral solution ^{DL,SP}	*	QL(900 per 30 days)
oxycodone 15 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone 20 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone 20 mg/ml oral concentrate ^{DL}	1	QL(270 per 30 days)
oxycodone 30 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone 5 mg capsule ^{DL}	1	QL(360 per 30 days)
oxycodone 5 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone 5 mg/5 ml oral solution ^{DL}	1	QL(5400 per 30 days)
oxycodone er 10 mg tablet,crush resistant,extended release 12 hr ^{DL}	1	PA,QL(90 per 30 days)
oxycodone er 15 mg tablet,crush resistant,extended release 12 hr ^{DL}	1	PA,QL(90 per 30 days)
oxycodone er 20 mg tablet,crush resistant,extended release 12 hr ^{DL}	1	PA,QL(90 per 30 days)
oxycodone er 30 mg tablet,crush resistant,extended release 12 hr ^{DL}	1	PA,QL(90 per 30 days)
oxycodone er 40 mg tablet,crush resistant,extended release 12 hr ^{DL}	1	PA,QL(90 per 30 days)
oxycodone er 60 mg tablet,crush resistant,extended release 12 hr ^{DL}	1	PA,QL(90 per 30 days)
oxycodone er 80 mg tablet,crush resistant,extended release 12 hr ^{DL}	1	PA,QL(120 per 30 days)
oxycodone-acetaminophen 10 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
oxycodone-acetaminophen 10 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone-acetaminophen 2.5 mg-300 mg tablet ^{DL,SP}	*	PA,QL(360 per 30 days)
oxycodone-acetaminophen 2.5 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone-acetaminophen 5 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
oxycodone-acetaminophen 5 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
oxycodone-acetaminophen 5 mg-325 mg/5 ml oral solution ^{DL}	1	QL(1800 per 30 days)
oxycodone-acetaminophen 7.5 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
oxycodone-acetaminophen 7.5 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)
oxycodone-aspirin 4.8355 mg-325 mg tablet ^{DL}	1	QL(360 per 30 days)
OXYCONTIN 10 MG TABLET,CRUSH RESISTANT,EXTENDED RELEASE ^{DL}	3	PA,QL(90 per 30 days)
OXYCONTIN 15 MG TABLET,CRUSH RESISTANT,EXTENDED RELEASE ^{DL}	3	PA,QL(90 per 30 days)
OXYCONTIN 20 MG TABLET,CRUSH RESISTANT,EXTENDED RELEASE ^{DL}	3	PA,QL(90 per 30 days)
OXYCONTIN 30 MG TABLET,CRUSH RESISTANT,EXTENDED RELEASE ^{DL}	3	PA,QL(90 per 30 days)
OXYCONTIN 40 MG TABLET,CRUSH RESISTANT,EXTENDED RELEASE ^{DL}	3	PA,QL(90 per 30 days)
OXYCONTIN 60 MG TABLET,CRUSH RESISTANT,EXTENDED RELEASE ^{DL}	3	PA,QL(90 per 30 days)
OXYCONTIN 80 MG TABLET,CRUSH RESISTANT,EXTENDED RELEASE ^{DL}	3	PA,QL(120 per 30 days)
oxymorphone 10 mg tablet ^{DL}	1	QL(360 per 30 days)
oxymorphone 5 mg tablet ^{DL}	1	QL(360 per 30 days)
oxymorphone er 10 mg tablet,extended release,12 hr ^{DL}	1	ST,QL(60 per 30 days)
oxymorphone er 15 mg tablet,extended release,12 hr ^{DL}	1	ST,QL(60 per 30 days)
oxymorphone er 20 mg tablet,extended release,12 hr ^{DL}	1	ST,QL(60 per 30 days)
oxymorphone er 30 mg tablet,extended release,12 hr ^{DL}	1	ST,QL(60 per 30 days)
oxymorphone er 40 mg tablet,extended release,12 hr ^{DL}	1	ST,QL(60 per 30 days)
oxymorphone er 5 mg tablet,extended release,12 hr ^{DL}	1	ST,QL(60 per 30 days)
oxymorphone er 7.5 mg tablet,extended release,12 hr ^{DL}	1	ST,QL(60 per 30 days)
OXYTROL 3.9 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	ST,QL(8 per 28 days)
OZEMPIC 0.25 MG OR 0.5 MG (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(1.5 per 28 days)
OZEMPIC 0.25 MG OR 0.5 MG (2 MG/3 ML) SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(3 per 28 days)
OZEMPIC 1 MG/DOSE (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(3 per 28 days)
OZEMPIC 1 MG/DOSE (4 MG/3 ML) SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(3 per 28 days)
OZEMPIC 2 MG/DOSE (8 MG/3 ML) SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(3 per 28 days)
OZOBAX 5 MG/5 ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(2400 per 30 days)
PACERONE 100 MG TABLET ^{MM}	3	
pacerone 200 mg tablet ^{MM}	1	
PACERONE 400 MG TABLET ^{MM}	3	
PALFORZIA (LEVEL 1) 3 MG (1 MG X 3) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
PALFORZIA (LEVEL 2) 6 MG (1 MG X 6) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
PALFORZIA (LEVEL 3) 12 MG (1 MG X 2, 10 MG X 1) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
PALFORZIA (LEVEL 4) 20 MG SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
PALFORZIA (LEVEL 5) 40 MG (20 MG X 2) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
PALFORZIA (LEVEL 6) 80 MG (20 MG X 4) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PALFORZIA (LEVEL 7) 120 MG (20 MG X 1, 100 MG X1) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
PALFORZIA (LEVEL 8) 160 MG (20 MG X 3, 100 MG X1) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PALFORZIA (LEVEL 9) 200 MG (100 MG X 2) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
PALFORZIA (LEVEL 10) 240 MG(20 MG X 2, 100 MG X 2) SPRINKLE CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PALFORZIA (LEVEL 11 MAINTENANCE) 300 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
PALFORZIA (LEVEL 11 UP-DOSE) 300 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
PALFORZIA INITIAL DOSE 0.5 MG/1 MG/1.5 MG/3 MG/6 MG SPRINKLE CAPSULE ^{DL,SP}	*	PA,QL(13 per 5 days)
paliperidone er 1.5 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
paliperidone er 3 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
paliperidone er 6 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
paliperidone er 9 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
PALYNZIQ 10 MG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(15 per 30 days)
PALYNZIQ 2.5 MG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(4 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PALYNZIQ 20 MG/ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
PAMELOR 10 MG CAPSULE ^{MM}	3	
PAMELOR 25 MG CAPSULE ^{MM}	3	
PAMELOR 50 MG CAPSULE ^{MM}	3	
PAMELOR 75 MG CAPSULE ^{MM}	3	
PANCREAZE 10,500 UNIT-35,500 UNIT-61,500 UNIT CAPSULE,DELAYED RELEASE ^{MM}	3	ST
PANCREAZE 16,800 UNIT-56,800 UNIT-98,400 UNIT CAPSULE,DELAYED RELEASE ^{MM}	3	ST
PANCREAZE 2,600 UNIT-8,800 UNIT-15,200 UNIT CAPSULE,DELAYED RELEASE ^{MM}	3	ST
PANCREAZE 21,000 UNIT-54,700 UNIT-83,900 UNIT CAPSULE,DELAYED RELEASE ^{MM}	3	ST
PANCREAZE 37,000-97,300-149,900 UNIT CAPSULE,DELAYED RELEASE ^{MM}	3	ST
PANCREAZE 4,200 UNIT-14,200 UNIT-24,600 UNIT CAPSULE,DELAYED RELEASE ^{MM}	3	ST
PANDEL 0.1 % TOPICAL CREAM ^{DL,SP}	*	
PANRETIN 0.1 % TOPICAL GEL ^{DL,SP}	*	PA
pantoprazole 20 mg tablet,delayed release ^{MM}	1	QL(60 per 30 days)
pantoprazole 40 mg tablet,delayed release ^{MM}	1	QL(60 per 30 days)
pantoprazole dr 40 mg granules delayed-release for susp in packet ^{MM}	1	ST,QL(30 per 30 days)
PARADIGM RESERVOIR 1.8 ML ^{MM}	3	
PARADIGM RESERVOIR 3 ML ^{MM}	3	
PARAGARD T 380A 380 SQUARE MM INTRAUTERINE DEVICE ^{DL,MM,SP}	*	
PAREMYD 1 %-0.25 % EYE DROPS	3	
paricalcitol 1 mcg capsule ^{MM}	1	QL(30 per 30 days)
paricalcitol 2 mcg capsule ^{MM}	1	QL(30 per 30 days)
paricalcitol 4 mcg capsule ^{MM}	1	QL(12 per 30 days)
PARLODEL 2.5 MG TABLET ^{MM}	3	
PARLODEL 5 MG CAPSULE ^{MM}	3	
PARNATE 10 MG TABLET ^{MM}	3	QL(270 per 30 days)
paroex oral rinse 0.12 % mouthwash	1	
paromomycin 250 mg capsule	1	
paroxetine 10 mg tablet ^{MM}	1	QL(30 per 30 days)
paroxetine 10 mg/5 ml oral suspension ^{MM}	1	ST
paroxetine 20 mg tablet ^{MM}	1	QL(30 per 30 days)
paroxetine 30 mg tablet ^{MM}	1	QL(60 per 30 days)
paroxetine 40 mg tablet ^{MM}	1	QL(60 per 30 days)
paroxetine er 12.5 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(60 per 30 days)
paroxetine er 25 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(90 per 30 days)
paroxetine er 37.5 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(60 per 30 days)
paroxetine mesylate (menopausal symptoms suppressant) 7.5 mg capsule ^{MM}	1	ST,QL(30 per 30 days)
PASER 4 GRAM GRANULES DELAYED-RELEASE PACKET	3	
PATANASE 0.6 % NASAL SPRAY	3	ST,QL(30.5 per 30 days)
PAXIL 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
PAXIL 10 MG/5 ML ORAL SUSPENSION ^{MM}	3	ST
PAXIL 20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
PAXIL 30 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
PAXIL 40 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
PAXIL CR 12.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
PAXIL CR 25 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(90 per 30 days)
PAXIL CR 37.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
PAXLOVID 150 MG-100 MG TABLETS IN A DOSE PACK (RENAL DOSE)(EUA)	3	QL(40 per 10 days)
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLETS IN A DOSE PACK (EUA)	3	QL(60 per 10 days)
PEDIAPRED 5 MG BASE/5 ML (6.7 MG/5 ML) ORAL SOLUTION	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
peg 3350-electrolytes 236 gram-22.74 gram-6.74 gram-5.86 gram solution	1	
peg-electrolyte solution 420 gram oral solution	1	
peg-prep 5 mg-210 gram oral kit	1	
peg3350 100 gram-sod sulf 7.5 gram-nacl-kcl-ascorbate-c oral pwdr pack	1	ST
PEGASYS 180 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(2 per 28 days)
PEGASYS 180 MCG/ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	PA,QL(4 per 28 days)
PEGINTRON 50 MCG/0.5 ML SUBCUTANEOUS KIT ^{DL,SP}	*	PA,QL(4 per 28 days)
PEMAZYRE 13.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
PEMAZYRE 4.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
PEMAZYRE 9 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
PEN NEEDLE 29 GAUGE X 1/2"MM	2	
PEN NEEDLE 30 GAUGE X 5/16"MM	2	
PEN NEEDLE 31 GAUGE X 1/4"MM	2	
PEN NEEDLE 31 GAUGE X 3/16"MM	2	
PEN NEEDLE 31 GAUGE X 5/16"MM	2	
PEN NEEDLE 32 GAUGE X 5/32"MM	2	
PEN NEEDLE, DIABETIC 29 GAUGE X 1/2"MM	2	
PEN NEEDLE, DIABETIC 29 GAUGE X 15/32"MM	2	
PEN NEEDLE, DIABETIC 30 GAUGE X 3/16"MM	2	
PEN NEEDLE, DIABETIC 30 GAUGE X 5/16"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 1/3"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 1/4"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 1/6"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 13/64"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 15/64"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 3/16"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 5/16"MM	2	
PEN NEEDLE, DIABETIC 31 GAUGE X 5/32"MM	2	
PEN NEEDLE, DIABETIC 32 GAUGE X 1/4"MM	2	
PEN NEEDLE, DIABETIC 32 GAUGE X 3/16"MM	2	
PEN NEEDLE, DIABETIC 32 GAUGE X 5/16"MM	2	
PEN NEEDLE, DIABETIC 32 GAUGE X 5/32"MM	2	
PEN NEEDLE, DIABETIC 33 GAUGE X 1/4"MM	2	
PEN NEEDLE, DIABETIC 33 GAUGE X 3/16"MM	2	
PEN NEEDLE, DIABETIC 33 GAUGE X 5/32"MM	2	
PEN NEEDLE, DIABETIC, SAFETY 31 GAUGE X 3/16"MM	2	
PEN NEEDLE, DIABETIC, SAFETY 31 GAUGE X 5/32"MM	2	
peniclovir 1 % topical cream ^{DL,SP}	*	PA
penicillamine 250 mg capsule ^{DL,MM,SP}	*	PA
penicillamine 250 mg tablet ^{DL,MM,SP}	*	
penicillin v potassium 125 mg/5 ml oral solution	1	
penicillin v potassium 250 mg tablet	1	
penicillin v potassium 250 mg/5 ml oral solution	1	
penicillin v potassium 500 mg tablet	1	
PENNSAID 2 % TOPICAL SOLUTION IN PACKET ^{DL,SP}	*	PA
PENNSAID 20 MG/GRAM/ACTUATION (2 %) TOPICAL SOLN IN METERED-DOSE PUMP ^{DL,SP}	*	PA
PENTACEL (PF) 15 LF-48 MCG-62 DU-10 MCG/0.5 ML INTRAMUSCULAR KIT	3	
PENTACEL DTAP-IPV COMPONENT (PF) 15 LF-48 MCG-62 DU/0.5 ML IM SUSP	3	
pentamidine 300 mg solution for inhalation ^{MM}	1	
PENTASA 250 MG CAPSULE,CONTROLLED RELEASE ^{DL,MM,SP}	*	ST,QL(150 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PENTASA 500 MG CAPSULE,CONTROLLED RELEASE ^{DL,MM,SP}	*	ST,QL(300 per 30 days)
pentazocine 50 mg-naloxone 0.5 mg tablet ^{DL}	1	QL(360 per 30 days)
PENTIPS 29 GAUGE X 1/2" NEEDLE ^{MM}	2	
PENTIPS 31 GAUGE X 1/4" NEEDLE ^{MM}	2	
PENTIPS 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
PENTIPS 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
PENTIPS 32 GAUGE X 1/4" NEEDLE ^{MM}	2	
PENTIPS 32 GAUGE X 5/32" NEEDLE ^{MM}	2	
pentoxifylline er 400 mg tablet,extended release ^{MM}	1	
pepcid 20 mg tablet ^{MM}	1	
pepcid 40 mg tablet ^{MM}	1	
PERCOCET 10 MG-325 MG TABLET ^{DL}	3	QL(360 per 30 days)
PERCOCET 2.5 MG-325 MG TABLET ^{DL}	3	QL(360 per 30 days)
PERCOCET 5 MG-325 MG TABLET ^{DL}	3	QL(360 per 30 days)
PERCOCET 7.5 MG-325 MG TABLET ^{DL}	3	QL(360 per 30 days)
PERFORMIST 20 MCG/2 ML SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
PERIDEX 0.12 % MOUTHWASH	3	
perindopril erbumine 2 mg tablet ^{MM}	1	
perindopril erbumine 4 mg tablet ^{MM}	1	
perindopril erbumine 8 mg tablet ^{MM}	1	
periogard 0.12 % mouthwash	1	
permethrin 5 % topical cream	1	
perphenazine 16 mg tablet ^{MM}	1	
perphenazine 2 mg tablet ^{MM}	1	
perphenazine 4 mg tablet ^{MM}	1	
perphenazine 8 mg tablet ^{MM}	1	
perphenazine-amitriptyline 2 mg-10 mg tablet ^{MM}	1	
perphenazine-amitriptyline 2 mg-25 mg tablet ^{MM}	1	
perphenazine-amitriptyline 4 mg-10 mg tablet ^{MM}	1	
perphenazine-amitriptyline 4 mg-25 mg tablet ^{MM}	1	
perphenazine-amitriptyline 4 mg-50 mg tablet ^{MM}	1	
PERSERIS 120 MG ABDOMINAL SUBCUTANEOUS EXT. RELEASE SUSPENSION SYRINGE ^{DL,MM,SP}	*	QL(1 per 28 days)
PERSERIS 90 MG ABDOMINAL SUBCUTANEOUS EXT. RELEASE SUSPENSION SYRINGE ^{DL,MM,SP}	*	QL(1 per 28 days)
PERTZYE 16,000 UNIT-57,500 UNIT-60,500 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
PERTZYE 24,000-86,250-90,750 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
PERTZYE 4,000 UNIT-14,375 UNIT-15,125 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
PERTZYE 8,000 UNIT-28,750 UNIT-30,250 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
PEXEVA 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
PEXEVA 20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
PEXEVA 30 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
PEXEVA 40 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
PFIZER COVID-19 BIVALENT BOOST(12Y UP)(PF) 30 MCG/0.3 ML IM SUSP (EUA)	3	
PFIZER COVID-19 BIVALENT BOOST(5-11YR)(PF) 10 MCG/0.2 ML IM SUSP(EUA)	3	
PFIZER COVID-19 BIVALENT VACCINE(6MO-4Y)(PF) 3 MCG/0.2 ML IM SUSP(EUA)	3	
PFIZER-BIONT COVID19 TRIS (12Y UP) VACC(PF)30 MCG/0.3 ML IM SUSP(GRAY)	3	
PFIZER-BIONT COVID19 TRIS(5-11Y) VACC(PF)10 MCG/0.2 ML IM SUSP(ORANGE)	3	
PFIZER-BIONT COVID19 TRIS(6M-4Y) VACC(PF) 3 MCG/0.2 ML IM SUSP(MAROON)	3	
PFIZER-BIONTECH COVID-19 VACCINE (PF) 30 MCG/0.3 ML IM SUSP (PURPLE)	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PFLEX INSPIRATORY TRAINER DEVICE	3	
PHARMACIST CHOICE BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
PHARMACIST CHOICE GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PHASEAL PROTECTOR 13 MM DEVICE	3	
PHASEAL PROTECTOR 20 MM DEVICE	3	
PHASEAL PROTECTOR 28 MM DEVICE	3	
PHEBURANE 483 MG/GRAM ORAL GRANULES ^{DL,MM,SP}	*	PA
phenazopyridine 100 mg tablet	1	
phenazopyridine 200 mg tablet	1	
phenelzine 15 mg tablet ^{MM}	1	
phenobarbital 100 mg tablet ^{MM}	1	QL(90 per 30 days)
phenobarbital 15 mg tablet ^{MM}	1	QL(120 per 30 days)
phenobarbital 16.2 mg tablet ^{MM}	1	QL(90 per 30 days)
phenobarbital 20 mg/5 ml (4 mg/ml) oral elixir ^{MM}	1	QL(1500 per 30 days)
phenobarbital 30 mg tablet ^{MM}	1	QL(300 per 30 days)
phenobarbital 32.4 mg tablet ^{MM}	1	QL(90 per 30 days)
phenobarbital 60 mg tablet ^{MM}	1	QL(120 per 30 days)
phenobarbital 64.8 mg tablet ^{MM}	1	QL(90 per 30 days)
phenobarbital 97.2 mg tablet ^{MM}	1	QL(90 per 30 days)
phenoxybenzamine 10 mg capsule ^{DL,SP}	*	
phenylephrine 10 % eye drops	1	
phenylephrine 2.5 % eye drops	1	
PHENYTEK 200 MG CAPSULE ^{MM}	3	
PHENYTEK 300 MG CAPSULE ^{MM}	3	
phenytoin 100 mg/4 ml oral suspension ^{MM}	1	
phenytoin 125 mg/5 ml oral suspension ^{MM}	1	
phenytoin 50 mg chewable tablet ^{MM}	1	
phenytoin sodium extended 100 mg capsule ^{MM}	1	
phenytoin sodium extended 200 mg capsule ^{MM}	1	
phenytoin sodium extended 300 mg capsule ^{MM}	1	
PHEXXI 1.8 %-1 %-0.4 % VAGINAL GEL	3	QL(60 per 30 days)
philit 0.4 mg-35 mcg tablet ^{MM}	1	
PHOSLYRA 667 MG (169 MG CALCIUM)/5 ML ORAL SOLUTION ^{MM}	3	ST
phospha neutral 250 mg tablet	1	
PHOSPHOLINE IODIDE 0.125 % EYE DROPS ^{MM}	3	
phytonadione (vitamin k1) 1 mg/0.5 ml injection solution	1	
phytonadione (vitamin k1) 1 mg/0.5 ml injection syringe	1	
phytonadione (vitamin k1) 10 mg/ml injection solution	1	
phytonadione (vitamin k1) 5 mg tablet	1	
PIFELTRO 100 MG TABLET ^{MM,SP}	*	QL(60 per 30 days)
pilocarpine 1 % eye drops ^{MM}	1	
pilocarpine 2 % eye drops ^{MM}	1	
pilocarpine 4 % eye drops ^{MM}	1	
pilocarpine 5 mg tablet ^{MM}	1	
pilocarpine 7.5 mg tablet ^{MM}	1	
PILOT COVID-19 AT-HOME TEST KIT	3	
pimecrolimus 1 % topical cream	1	
pimozide 1 mg tablet ^{MM}	1	
pimozide 2 mg tablet ^{MM}	1	
pimtrea (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
pindolol 10 mg tablet ^{MM}	1	
pindolol 5 mg tablet ^{MM}	1	
pioglitazone 15 mg tablet ^{MM}	1	QL(30 per 30 days)
pioglitazone 15 mg-metformin 500 mg tablet ^{MM}	1	ST,QL(90 per 30 days)
pioglitazone 15 mg-metformin 850 mg tablet ^{MM}	1	ST,QL(90 per 30 days)
pioglitazone 30 mg tablet ^{MM}	1	QL(30 per 30 days)
pioglitazone 30 mg-glimepiride 2 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
pioglitazone 30 mg-glimepiride 4 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
pioglitazone 45 mg tablet ^{MM}	1	QL(30 per 30 days)
PIP BLOOD GLUCOSE MONITORING SYSTEM ^{MM}	3	ST
PIP BLOOD GLUCOSE TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
PIP GLUCOSE CONTROL SOLUTION L1-L2 ^{MM}	3	
PIP LANCET 28 GAUGE ^{MM}	2	
PIP LANCET 30 GAUGE ^{MM}	2	
PIP PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
PIP PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
PIQRAY 200 MG/DAY (200 MG X 1) TABLET ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
PIQRAY 250 MG/DAY (200 MG X 1 AND 50 MG X 1) TABLET ^{DL,LD,MM,SP}	*	PA,QL(56 per 28 days)
PIQRAY 300 MG/DAY (150 MG X 2) TABLET ^{DL,LD,MM,SP}	*	PA,QL(56 per 28 days)
pirfenidone 267 mg capsule ^{DL,MM,SP}	*	PA,QL(270 per 30 days)
pirfenidone 267 mg tablet ^{DL,MM,SP}	*	PA,QL(270 per 30 days)
pirfenidone 534 mg tablet ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
pirfenidone 801 mg tablet ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
pirmella 0.5/0.75/1 mg-35 mcg tablet ^{MM}	1	
pirmella 1 mg-35 mcg tablet ^{MM}	1	
piroxicam 10 mg capsule	1	
piroxicam 20 mg capsule	1	
PLAN B ONE-STEP 1.5 MG TABLET	3	
PLAQUENIL 200 MG TABLET ^{MM}	3	
PLAVIX 75 MG TABLET ^{MM}	3	QL(30 per 30 days)
PLEGRIDY 125 MCG/0.5 ML INTRAMUSCULAR SYRINGE ^{DL,MM,SP}	*	PA,QL(1 per 28 days)
PLEGRIDY 125 MCG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(1 per 28 days)
PLEGRIDY 125 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(1 per 28 days)
PLEGRIDY 63 MCG/0.5 ML-94 MCG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,SP}	*	PA,QL(1 per 28 days)
PLEGRIDY 63 MCG/0.5 ML-94 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,LD,SP}	*	PA,QL(1 per 28 days)
PLENVU 140 GRAM-9 GRAM-5.2 GRAM POWDER PACKS	3	ST
PNEUMOVAX-23 25 MCG/0.5 ML INJECTION SOLUTION	3	
PNEUMOVAX-23 25 MCG/0.5 ML INJECTION SYRINGE	3	
pnv-select 27 mg-1 mg tablet ^{MM}	1	
POCKET CHAMBER SPACER	3	
podofilox 0.5 % topical solution	1	
POGO AUTOMATIC BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
POGO AUTOMATIC TEST CARTRIDGE 30 GAUGE COMBO PACK ^{MM}	3	ST
poly-iron 150 forte 150 mg-25 mcg-1 mg capsule	1	
polycin 500 unit-10,000 unit/gram eye ointment	1	
polymyxin b sulfate 10,000 unit-trimethoprim 1 mg/ml eye drops	1	
POLYTRIM 10,000 UNIT-1 MG/ML EYE DROPS	3	
POMALYST 1 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
POMALYST 2 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
POMALYST 3 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
POMALYST 4 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(21 per 28 days)
PONVORY 14-DAY STARTER PACK 2-3-4-5-6-7-8-9-10 MG TABLETS ^{DL,LD,SP}	*	PA,QL(14 per 30 days)
PONVORY 20 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
portia 28 0.15 mg-0.03 mg tablet ^{MM}	1	
posaconazole 100 mg tablet,delayed release ^{DL,SP}	*	PA,QL(93 per 30 days)
posaconazole 200 mg/5 ml (40 mg/ml) oral suspension ^{DL,SP}	*	PA,QL(840 per 28 days)
potassium chloride 20 meq oral packet ^{MM}	1	
potassium chloride 20 meq/15 ml oral liquid ^{MM}	1	
potassium chloride 40 meq/15 ml oral liquid ^{MM}	1	
potassium chloride er 10 meq capsule,extended release ^{MM}	1	
potassium chloride er 10 meq tablet,extended release ^{MM}	1	
potassium chloride er 10 meq tablet,extended release(part/cryst) ^{MM}	1	
potassium chloride er 15 meq tablet,extended release(part/cryst) ^{MM}	1	
potassium chloride er 20 meq tablet,extended release ^{MM}	1	
potassium chloride er 20 meq tablet,extended release(part/cryst) ^{MM}	1	
potassium chloride er 8 meq capsule,extended release ^{MM}	1	
potassium chloride er 8 meq tablet,extended release ^{MM}	1	
potassium citrate er 10 meq (1,080 mg) tablet,extended release ^{MM}	1	
potassium citrate er 15 meq (1,620 mg) tablet,extended release ^{MM}	1	
potassium citrate er 5 meq (540 mg) tablet,extended release ^{MM}	1	
pr natal 400 29 mg-1 mg-400 mg oral pack ^{MM}	1	
pr natal 400 ec 29 mg-1 mg-400 mg tablet-capsule,delayed release ^{MM}	1	
pr natal 430 29 mg iron-1 mg-430 mg oral pack ^{MM}	1	
pr natal 430 ec 29 mg-1 mg-430 mg tablet-capsule,delayed release ^{MM}	1	
PRADAXA 110 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
PRADAXA 110 MG ORAL PELLETS IN PACKET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PRADAXA 150 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
PRADAXA 150 MG ORAL PELLETS IN PACKET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
PRADAXA 20 MG ORAL PELLETS IN PACKET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
PRADAXA 30 MG ORAL PELLETS IN PACKET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PRADAXA 40 MG ORAL PELLETS IN PACKET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PRADAXA 50 MG ORAL PELLETS IN PACKET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PRADAXA 75 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
PRALUENT PEN 150 MG/ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
PRALUENT PEN 75 MG/ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
pramipexole 0.125 mg tablet ^{MM}	1	
pramipexole 0.25 mg tablet ^{MM}	1	
pramipexole 0.5 mg tablet ^{MM}	1	
pramipexole 0.75 mg tablet ^{MM}	1	
pramipexole 1 mg tablet ^{MM}	1	
pramipexole 1.5 mg tablet ^{MM}	1	
pramipexole er 0.375 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
pramipexole er 0.75 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
pramipexole er 1.5 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
pramipexole er 2.25 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
pramipexole er 3 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
pramipexole er 3.75 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
pramipexole er 4.5 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
PRAMOSONE 1 %-1 % LOTION	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PRAMOSONE 1 %-1 % TOPICAL CREAM	3	
PRAMOSONE 2.5 %-1 % LOTION	3	
prasugrel 10 mg tablet ^{MM}	1	QL(30 per 30 days)
prasugrel 5 mg tablet ^{MM}	1	QL(30 per 30 days)
pravastatin 10 mg tablet ^{MM}	1	
pravastatin 20 mg tablet ^{MM}	1	
pravastatin 40 mg tablet ^{MM}	1	
pravastatin 80 mg tablet ^{MM}	1	
praziquantel 600 mg tablet	1	
prazosin 1 mg capsule ^{MM}	1	
prazosin 2 mg capsule ^{MM}	1	
prazosin 5 mg capsule ^{MM}	1	
PRECISION GLUCOSE CONTROL SOLN COMBO PACK ^{MM}	3	
PRECISION GLUCOSE/KETONE CONTR COMBO PACK ^{MM}	3	
PRECISION METER ^{MM}	3	ST
PRECISION PCX PLUS TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PRECISION PCX TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PRECISION POINT OF CARE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PRECISION Q-I-D TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PRECISION XTRA KETONE-GLUCOSE MONITOR KIT ^{MM}	3	ST
PRECISION XTRA MONITOR ^{MM}	3	ST
PRECISION XTRA TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PRECOSE 100 MG TABLET ^{MM}	3	
PRECOSE 25 MG TABLET ^{MM}	3	
PRECOSE 50 MG TABLET ^{MM}	3	
PRED FORTE 1 % EYE DROPS,SUSPENSION	3	ST
PRED MILD 0.12 % EYE DROPS,SUSPENSION	3	ST
PRED-G 0.3 %-1 % EYE DROPS,SUSPENSION	3	
prednicarbate 0.1 % topical cream	1	
prednicarbate 0.1 % topical ointment	1	
prednisolone 10 mg disintegrating tablet	1	
prednisolone 15 mg disintegrating tablet	1	
prednisolone 15 mg/5 ml oral solution	1	
prednisolone 30 mg disintegrating tablet	1	
prednisolone 5 mg tablet	1	
prednisolone acetate 1 % eye drops,suspension	1	
prednisolone sodium phosphate 1 % eye drops	1	
prednisolone sodium phosphate 10 mg/5 ml oral solution	1	
prednisolone sodium phosphate 15 mg/5 ml (3 mg/ml) oral solution	1	
prednisolone sodium phosphate 20 mg/5 ml (4 mg/ml) oral solution	1	
prednisolone sodium phosphate 25 mg/5 ml (5 mg/ml) oral solution	1	
prednisolone sodium phosphate 5 mg base/5 ml (6.7 mg/5 ml) oral soln	1	
prednisone 1 mg tablet	1	
prednisone 10 mg tablet	1	
prednisone 10 mg tablets in a dose pack	1	
prednisone 2.5 mg tablet	1	
prednisone 20 mg tablet	1	
prednisone 5 mg tablet	1	
prednisone 5 mg tablets in a dose pack	1	
prednisone 5 mg/5 ml oral solution	1	
prednisone 50 mg tablet	1	
prednisone intensol 5 mg/ml oral concentrate	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PREFEST 1 MG (15)/1 MG-0.09 MG (15) TABLET ^{MM}	1	
pregabalin 100 mg capsule ^{MM}	1	QL(90 per 30 days)
pregabalin 150 mg capsule ^{MM}	1	QL(90 per 30 days)
pregabalin 20 mg/ml oral solution ^{MM}	1	QL(900 per 30 days)
pregabalin 200 mg capsule ^{MM}	1	QL(90 per 30 days)
pregabalin 225 mg capsule ^{MM}	1	QL(60 per 30 days)
pregabalin 25 mg capsule ^{MM}	1	QL(90 per 30 days)
pregabalin 300 mg capsule ^{MM}	1	QL(60 per 30 days)
pregabalin 50 mg capsule ^{MM}	1	QL(90 per 30 days)
pregabalin 75 mg capsule ^{MM}	1	QL(90 per 30 days)
pregabalin er 165 mg tablet, extended release 24 hr ^{MM}	1	PA,QL(30 per 30 days)
pregabalin er 330 mg tablet, extended release 24 hr ^{MM}	1	PA,QL(60 per 30 days)
pregabalin er 82.5 mg tablet, extended release 24 hr ^{MM}	1	PA,QL(30 per 30 days)
PREHEVBRIO (PF) 10 MCG/ML INTRAMUSCULAR SUSPENSION	3	
PREMARIN 0.3 MG TABLET ^{MM}	3	
PREMARIN 0.45 MG TABLET ^{MM}	3	
PREMARIN 0.625 MG TABLET ^{MM}	3	
PREMARIN 0.625 MG/GRAM VAGINAL CREAM ^{MM}	3	
PREMARIN 0.9 MG TABLET ^{MM}	3	
PREMARIN 1.25 MG TABLET ^{MM}	3	
PREMIER BLU GLUCOSE METER ^{MM}	3	ST
PREMIER CLASSIC GLUCOSE METER ^{MM}	3	ST
PREMIER COMPACT GLUCOSE METER KIT ^{MM}	3	ST
PREMIER TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
PREMIER VOICE GLUCOSE METER ^{MM}	3	ST
PREMIUM BLOOD GLUCOSE MONITORING SYSTEM ^{MM}	3	ST
PREMIUM V10 ^{MM}	3	ST
PREMIUM V10 STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PREMPHASE 0.625 MG(14)/0.625 MG-5MG(14) TABLET ^{MM}	3	
PREMPRO 0.3 MG-1.5 MG TABLET ^{MM}	3	
PREMPRO 0.45 MG-1.5 MG TABLET ^{MM}	3	
PREMPRO 0.625 MG-2.5 MG TABLET ^{MM}	3	
PREMPRO 0.625 MG-5 MG TABLET ^{MM}	3	
PRENA1 CHEW 1.4 MG CHEW TABLET,IMMEDIATE - DELAYED RELEASE ^{MM}	3	
prena1 pearl 30 mg-1.4 mg-200 mg capsule,immediate - delay release ^{MM}	1	
prena1 true 30 mg iron-1.4 mg-300 mg oral pack ^{MM}	1	
PRENATA 29 MG IRON-1 MG CHEWABLE TABLET ^{MM}	3	
PRENATABS FA 29 MG-1 MG TABLET ^{MM}	2	
prenatal 19 29 mg iron-1 mg chewable tablet ^{MM}	1	
prenatal low iron 27 mg iron-1 mg tablet ^{MM}	1	
prenatal plus (calcium carbonate) 27 mg iron-1 mg tablet ^{MM}	1	
prenatal plus 29 mg iron-1 mg tablet ^{MM}	1	
prenatal plus dha 27 mg iron-1 mg-312 mg-250 mg oral pack ^{MM}	1	
PRENATE DHA (FERROUS ASPARTO GLYCINATE) 18 MG IRON-1 MG-300 MG CAPSULE ^{MM}	3	
PRENATE ELITE (IRON ASPARTO GLYCINATE) 20 MG IRON-1 MG TABLET ^{MM}	3	
PRENATE ELITE 26 MG IRON-1 MG TABLET ^{MM}	3	
PRENATE ENHANCE 28 MG IRON-1 MG-400 MG CAPSULE ^{MM}	3	
PRENATE MINI (FERROUS ASPARTO GLYCINATE) 18 MG-1 MG-350 MG CAPSULE ^{MM}	3	
PRENATE PIXIE 10 MG IRON-1 MG-200 MG CAPSULE ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PRENATE RESTORE 27 MG IRON-1 MG-400 MG CAPSULE ^{MM}	3	
PRENATE STAR 20 MG IRON-1 MG TABLET ^{MM}	3	
preplus 27 mg iron-1 mg tablet ^{MM}	1	
PRESSURE ACTIVATED LANCETS 21 GAUGE ^{MM}	2	
PRESSURE ACTIVATED LANCETS 28 GAUGE ^{MM}	2	
PRESTALIA 14 MG-10 MG TABLET ^{MM}	3	ST
PRESTALIA 3.5 MG-2.5 MG TABLET ^{MM}	3	ST
PRESTALIA 7 MG-5 MG TABLET ^{MM}	3	ST
PRESTO PRO BLOOD GLUCOSE METER ^{MM}	3	ST
pretab 29 mg-1 mg tablet ^{MM}	1	
PRETOMANID 200 MG TABLET	3	PA,QL(30 per 30 days)
PREVACID 15 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
PREVACID 30 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
PREVACID SOLUTAB 15 MG DELAYED RELEASE,DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
PREVACID SOLUTAB 30 MG DELAYED RELEASE,DISINTEGRATING TABLET ^{MM}	3	ST,QL(30 per 30 days)
prevalite 4 gram oral powder ^{MM}	1	
prevalite 4 gram powder for susp in a packet ^{MM}	1	
PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
PREVENT DROPSAFE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
previfem 0.25 mg-35 mcg tablet ^{MM}	1	
PREVNAR 13 (PF) 0.5 ML INTRAMUSCULAR SYRINGE	3	
PREVNAR 20 (PF) 0.5 ML INTRAMUSCULAR SYRINGE	3	
PREVYMIS 240 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
PREVYMIS 480 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
PREZCOBIX 800 MG-150 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
PREZISTA 100 MG/ML ORAL SUSPENSION ^{MM,SP}	*	QL(360 per 30 days)
PREZISTA 150 MG TABLET ^{MM,SP}	*	QL(240 per 30 days)
PREZISTA 600 MG TABLET ^{MM,SP}	*	QL(60 per 30 days)
PREZISTA 75 MG TABLET ^{MM,SP}	*	QL(480 per 30 days)
PREZISTA 800 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
PRIFTIN 150 MG TABLET	3	
PRIOSEC 10 MG ORAL SUSPENSION,DELAYED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
PRIOSEC 2.5 MG ORAL SUSPENSION,DELAYED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
PRIMACARE 30 MG-1 MG-300 MG CAPSULE ^{MM}	3	
primaquine 26.3 mg tablet	1	
PRIMEAIRE SPACER	3	
primidone 125 mg tablet ^{MM}	1	
primidone 250 mg tablet ^{MM}	1	
primidone 50 mg tablet ^{MM}	1	
primlev 10 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
primlev 5 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
primlev 7.5 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
PRIMSOL 50 MG/5 ML ORAL SOLUTION	3	
PRINIVIL 20 MG TABLET ^{MM}	3	
PRIORIX (PF) 10EXP3.4-4.2-3.3 CCID50/0.5ML SUBCUTANEOUS SUSPENSION	3	
PRISTIQ 100 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
PRISTIQ 25 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
PRISTIQ 50 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
PRO COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PRO COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
PRO COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
PRO COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
PRO COMFORT LANCET 30 GAUGE ^{MM}	2	
PRO COMFORT LANCET 31 GAUGE ^{MM}	2	
PRO COMFORT PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
PRO COMFORT PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
PRO COMFORT PEN NEEDLE 32 GAUGE X 3/16" ^{MM}	2	
PRO COMFORT PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
PRO COMFORT SAFETY LANCET 30 GAUGE ^{MM}	2	
PRO HEALTH MINI TALK BP MONITOR KIT	3	ST
PRO VOICE V8 GLUCOSE MONITOR ^{MM}	3	ST
PRO VOICE V8-V9 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
PRO VOICE V9 GLUCOSE MONITOR ^{MM}	3	ST
PROAIR DIGIHALER 90 MCG/ACTUATION AEROSOL POWDER BREATH ACT, SENSOR ^{MM}	3	ST,QL(2 per 30 days)
PROAIR HFA 90 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(36 per 30 days)
PROAIR RESPICLICK 90 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(2 per 30 days)
probenecid 500 mg tablet ^{MM}	1	
probenecid 500 mg-colchicine 0.5 mg tablet ^{MM}	1	
PROCALAMINE 3% INTRAVENOUS SOLUTION	3	
PROCARDIA 10 MG CAPSULE ^{MM}	3	
PROCARDIA XL 30 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
PROCARDIA XL 60 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
PROCARDIA XL 90 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
PROCARE SPACER WITH ADULT MASK	3	
PROCARE SPACER WITH CHILD MASK	3	
procentra 5 mg/5 ml oral solution ^{MM}	1	ST,QL(1800 per 30 days)
PROCHAMBER	2	
prochlorperazine 25 mg rectal suppository	1	
prochlorperazine maleate 10 mg tablet	1	
prochlorperazine maleate 5 mg tablet	1	
PROCRIT 10,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
PROCRIT 2,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
PROCRIT 20,000 UNIT/2 ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
PROCRIT 20,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
PROCRIT 3,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
PROCRIT 4,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
PROCRIT 40,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
procto-med hc 2.5 % topical cream perineal applicator	1	
PROCTOCORT 1 % TOPICAL CREAM	1	
PROCTOFOAM HC 1 %-1 %	3	
proctosol hc 2.5 % topical cream perineal applicator	1	
proctozone-hc 2.5 % topical cream perineal applicator	1	
PROCYSBI 25 MG CAPSULE,DELAYED RELEASE SPRINKLE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
PROCYSBI 300 MG ORAL DR GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(210 per 30 days)
PROCYSBI 75 MG CAPSULE,DELAYED RELEASE SPRINKLE ^{DL,MM,SP}	*	PA,QL(780 per 30 days)
PROCYSBI 75 MG ORAL DR GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(780 per 30 days)
PRODIGY AUTOCODE BLOOD GLUCOSE MONITORING SYSTEM ^{MM}	3	ST
PRODIGY AUTOCODE METER KIT ^{MM}	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PRODIGY CONTROL SOLUTION, LOW ^{MM}	3	
PRODIGY CONTROL SOLUTION,HIGH ^{MM}	3	
PRODIGY INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
PRODIGY INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
PRODIGY INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
PRODIGY LANCETS 26 GAUGE ^{MM}	2	
PRODIGY LANCETS 28 GAUGE ^{MM}	2	
PRODIGY LANCING DEVICE	2	
PRODIGY NO CODING STRIPS ^{MM}	3	ST,QL(150 per 30 days)
PRODIGY POCKET METER KIT ^{MM}	3	ST
PRODIGY TWIST TOP LANCET 28 GAUGE ^{MM}	2	
PRODIGY VOICE GLUCOSE METER KIT ^{MM}	3	ST
progesterone micronized 100 mg capsule ^{MM}	1	
progesterone micronized 200 mg capsule ^{MM}	1	
PROGLYCEM 50 MG/ML ORAL SUSPENSION ^{MM}	3	ST
PROGRAF 0.2 MG ORAL GRANULES IN PACKET ^{MM}	3	
PROGRAF 0.5 MG CAPSULE ^{MM}	3	ST
PROGRAF 1 MG CAPSULE ^{MM}	3	ST
PROGRAF 1 MG ORAL GRANULES IN PACKET ^{MM}	3	
PROGRAF 5 MG CAPSULE ^{MM}	3	ST,QL(180 per 30 days)
prolate 10 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
PROLATE 10 MG-300 MG/5 ML ORAL SOLUTION ^{DL,SP}	*	QL(900 per 30 days)
prolate 5 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
prolate 7.5 mg-300 mg tablet ^{DL,SP}	*	QL(390 per 30 days)
PROLENSA 0.07 % EYE DROPS	3	ST,QL(3 per 30 days)
PROMACTA 12.5 MG ORAL POWDER PACKET ^{DL,LD,MM,SP}	*	PA,QL(360 per 30 days)
PROMACTA 12.5 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
PROMACTA 25 MG ORAL POWDER PACKET ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
PROMACTA 25 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
PROMACTA 50 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(90 per 30 days)
PROMACTA 75 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
promethazine 12.5 mg rectal suppository	1	
promethazine 12.5 mg tablet	1	
promethazine 25 mg rectal suppository	1	
promethazine 25 mg tablet	1	
promethazine 50 mg rectal suppository	1	
promethazine 50 mg tablet	1	
promethazine 6.25 mg-codeine 10 mg/5 ml syrup	1	
promethazine 6.25 mg/5 ml oral syrup	1	
promethazine vc 6.25 mg-5 mg/5 ml oral syrup	1	
promethazine vc-codeine 6.25 mg-5 mg-10 mg/5 ml oral syrup	1	
promethazine-dm 6.25 mg-15 mg/5 ml oral syrup	1	
promethazine-phenylephrine 6.25 mg-5 mg/5 ml oral syrup	1	
promethazine-phenylephrine-codeine 6.25 mg-5 mg-10 mg/5 ml oral syrup	1	
promethegan 12.5 mg rectal suppository	1	
promethegan 25 mg rectal suppository	1	
promethegan 50 mg rectal suppository	1	
PROMETRIUM 100 MG CAPSULE ^{MM}	3	ST
PROMETRIUM 200 MG CAPSULE ^{MM}	3	ST
propafenone 150 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
propafenone 225 mg tablet ^{MM}	1	
propafenone 300 mg tablet ^{MM}	1	
propafenone er 225 mg capsule,extended release 12 hr ^{MM}	1	
propafenone er 325 mg capsule,extended release 12 hr ^{MM}	1	
propafenone er 425 mg capsule,extended release 12 hr ^{MM}	1	
proparacaine 0.5 % eye drops	1	
propranolol 10 mg tablet ^{MM}	1	
propranolol 20 mg tablet ^{MM}	1	
propranolol 20 mg/5 ml (4 mg/ml) oral solution ^{MM}	1	
propranolol 40 mg tablet ^{MM}	1	
propranolol 40 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
propranolol 40 mg/5 ml (8 mg/ml) oral solution ^{MM}	1	
propranolol 60 mg tablet ^{MM}	1	
propranolol 80 mg tablet ^{MM}	1	
propranolol 80 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
propranolol er 120 mg capsule,24 hr,extended release ^{MM}	1	
propranolol er 160 mg capsule,24 hr,extended release ^{MM}	1	
propranolol er 60 mg capsule,24 hr,extended release ^{MM}	1	
propranolol er 80 mg capsule,24 hr,extended release ^{MM}	1	
propylthiouracil 50 mg tablet ^{MM}	1	
PROSCAR 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
PROTONIX 20 MG TABLET,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
PROTONIX 40 MG GRANULES DELAYED-RELEASE PACKET ^{MM}	3	ST,QL(30 per 30 days)
PROTONIX 40 MG TABLET,DELAYED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
PROTOPIC 0.03 % TOPICAL OINTMENT	3	
PROTOPIC 0.1 % TOPICAL OINTMENT	3	
protriptyline 10 mg tablet ^{MM}	1	
protriptyline 5 mg tablet ^{MM}	1	
PROVENTIL HFA 90 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(36 per 30 days)
PROVERA 10 MG TABLET ^{MM}	3	
PROVERA 2.5 MG TABLET ^{MM}	3	
PROVERA 5 MG TABLET ^{MM}	3	
PROVIDA OB 40 MG IRON-1.25 MG CAPSULE ^{MM}	2	
PROVIGIL 100 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
PROVIGIL 200 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
PROZAC 10 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
PROZAC 20 MG CAPSULE ^{MM}	3	ST,QL(120 per 30 days)
PROZAC 40 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
PRUDOXIN 5 % TOPICAL CREAM	3	PA,QL(45 per 30 days)
PULMICORT 0.25 MG/2 ML SUSPENSION FOR NEBULIZATION ^{MM}	3	ST,QL(240 per 30 days)
PULMICORT 0.5 MG/2 ML SUSPENSION FOR NEBULIZATION ^{MM}	3	ST,QL(240 per 30 days)
PULMICORT 1 MG/2 ML SUSPENSION FOR NEBULIZATION ^{MM}	3	ST,QL(120 per 30 days)
PULMICORT FLEXHALER 180 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(2 per 30 days)
PULMICORT FLEXHALER 90 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(2 per 30 days)
pulmosal 7 % solution for nebulization	1	
PULMOZYME 1 MG/ML SOLUTION FOR INHALATION ^{DL,MM,SP}	*	QL(150 per 30 days)
PURE COMFORT LANCETS 30 GAUGE ^{MM}	2	
PURE COMFORT PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
PURE COMFORT PEN NEEDLE 32 GAUGE X 3/16" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
PURE COMFORT PEN NEEDLE 32 GAUGE X 5/16 ^{MM}	2	
PURE COMFORT PEN NEEDLE 32 GAUGE X 5/32 ^{MM}	2	
PURE COMFORT SAFETY LANCETS 30 GAUGE ^{MM}	2	
PUREFE PLUS 106 MG IRON-1 MG CAPSULE	3	
PURIXAN 20 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	QL(300 per 30 days)
PUSH BUTTON SAFETY LANCETS 28 GAUGE ^{MM}	2	
PYLERA 140 MG-125 MG-125 MG CAPSULE ^{DL,SP}	*	QL(144 per 30 days)
pyrazinamide 500 mg tablet	1	
PYRIDIDIUM 100 MG TABLET	3	
PYRIDIDIUM 200 MG TABLET	3	
pyridostigmine bromide 30 mg tablet ^{MM}	1	
pyridostigmine bromide 60 mg tablet ^{MM}	1	
pyridostigmine bromide 60 mg/5 ml oral syrup ^{MM}	1	
pyridostigmine bromide er 180 mg tablet,extended release ^{MM}	1	
pyrimethamine 25 mg tablet ^{DL,SP}	*	
PYRUKYND 20 MG (7)-5 MG (7) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(14 per 14 days)
PYRUKYND 20 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
PYRUKYND 5 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
PYRUKYND 50 MG (7)-20 MG (7) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(14 per 14 days)
PYRUKYND 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
QBRELIS 1 MG/ML ORAL SOLUTION ^{MM}	3	QL(1200 per 30 days)
QBREXZA 2.4 % TOWELETTE	3	PA,QL(30 per 30 days)
QDOLO 5 MG/ML ORAL SOLUTION ^{DL,SP}	*	PA,QL(2400 per 30 days)
QELBREE 100 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
QELBREE 150 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
QELBREE 200 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
QINLOCK 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
QNASL 40 MCG/ACTUATION NASAL AEROSOL SPRAY ^{MM}	3	ST,QL(6.8 per 30 days)
QNASL 80 MCG/ACTUATION NASAL AEROSOL SPRAY ^{MM}	3	ST,QL(10.6 per 30 days)
QTERN 10 MG-5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
QTERN 5 MG-5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
QUALAQUIN 324 MG CAPSULE	3	PA,QL(42 per 7 days)
QUARTETTE 0.15 MG-20 MCG/0.15 MG-25 MCG TABLETS,3 MONTH DOSE PACK ^{MM}	3	QL(91 per 90 days)
quazepam 15 mg tablet ^{DL}	1	QL(30 per 30 days)
QUDEXY XR 100 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
QUDEXY XR 150 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
QUDEXY XR 200 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(60 per 30 days)
QUDEXY XR 25 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(90 per 30 days)
QUDEXY XR 50 MG CAPSULE SPRINKLE,EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
QUESTRAN 4 GRAM ORAL POWDER ^{MM}	3	
QUESTRAN 4 GRAM POWDER FOR SUSP IN A PACKET ^{MM}	3	
QUESTRAN LIGHT 4 GRAM ORAL POWDER ^{MM}	1	
quetiapine 100 mg tablet ^{MM}	1	QL(90 per 30 days)
quetiapine 150 mg tablet ^{MM}	1	QL(30 per 30 days)
quetiapine 200 mg tablet ^{MM}	1	QL(120 per 30 days)
quetiapine 25 mg tablet ^{MM}	1	QL(120 per 30 days)
quetiapine 300 mg tablet ^{MM}	1	QL(60 per 30 days)
quetiapine 400 mg tablet ^{MM}	1	QL(60 per 30 days)
quetiapine 50 mg tablet ^{MM}	1	QL(120 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
quetiapine er 150 mg tablet,extended release 24 hr ^{MM}	1	QL(90 per 30 days)
quetiapine er 200 mg tablet,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
quetiapine er 300 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
quetiapine er 400 mg tablet,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
quetiapine er 50 mg tablet,extended release 24 hr ^{MM}	1	QL(120 per 30 days)
QUICKVUE AT-HOME COVID-19 TEST KIT	3	
QUILLICHEW ER 20 MG CHEWABLE TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
QUILLICHEW ER 30 MG CHEWABLE TABLET, EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
QUILLICHEW ER 40 MG CHEWABLE, EXTENDED RELEASE TABLET ^{MM}	2	QL(30 per 30 days)
QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION,EXTEND RELEASE 24HR ^{MM}	2	QL(360 per 30 days)
quinapril 10 mg tablet ^{MM}	1	
quinapril 10 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
quinapril 20 mg tablet ^{MM}	1	
quinapril 20 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	
quinapril 20 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
quinapril 40 mg tablet ^{MM}	1	
quinapril 5 mg tablet ^{MM}	1	
quinidine gluconate er 324 mg tablet,extended release ^{MM}	1	
quinidine sulfate 200 mg tablet ^{MM}	1	
quinidine sulfate 300 mg tablet ^{MM}	1	
quinine 324 mg capsule	1	PA,QL(42 per 7 days)
QUINTET AC METER ^{MM}	3	ST
QUINTET AC STRIPS ^{MM}	3	ST,QL(150 per 30 days)
QUINTET BLOOD GLUCOSE METER ^{MM}	3	ST
QUINTET GLUCOSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
QULIPTA 10 MG TABLET ^{MM}	2	PA,QL(30 per 30 days)
QULIPTA 30 MG TABLET ^{MM}	2	PA,QL(30 per 30 days)
QULIPTA 60 MG TABLET ^{MM}	2	PA,QL(30 per 30 days)
QUVIVIQ 25 MG TABLET	3	ST,QL(30 per 30 days)
QUVIVIQ 50 MG TABLET	3	ST,QL(30 per 30 days)
QVAR REDIHALER 40 MCG/ACTUATION HFA BREATH ACTIVATED AEROSOL ^{MM}	3	ST,QL(10.6 per 30 days)
QVAR REDIHALER 80 MCG/ACTUATION HFA BREATH ACTIVATED AEROSOL ^{MM}	3	ST,QL(21.2 per 30 days)
r-natal ob 20 mg iron-1 mg-320 mg capsule ^{MM}	1	
rabeprazole 10 mg capsule,delayed release sprinkle ^{MM}	1	ST,QL(60 per 30 days)
rabeprazole 20 mg tablet,delayed release ^{MM}	1	QL(60 per 30 days)
RADICAVA ORS 105 MG/5 ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(70 per 28 days)
RADICAVA ORS STARTER KIT SUSPENSION 105 MG/5 ML ORAL ^{DL,MM,SP}	*	PA,QL(70 per 28 days)
RADIOGARDASE 0.5 GRAM CAPSULE ^{DL,SP}	*	
RAGWITEK 12 AMB A 1 UNIT SUBLINGUAL TABLET ^{MM}	3	ST,QL(30 per 30 days)
raloxifene 60 mg tablet ^{MM}	1	QL(30 per 30 days)
ramelteon 8 mg tablet	1	ST,QL(30 per 30 days)
ramipril 1.25 mg capsule ^{MM}	1	
ramipril 10 mg capsule ^{MM}	1	
ramipril 2.5 mg capsule ^{MM}	1	
ramipril 5 mg capsule ^{MM}	1	
RANEXA 1,000 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(120 per 30 days)
RANEXA 500 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(120 per 30 days)
ranolazine er 1,000 mg tablet,extended release,12 hr ^{MM}	1	QL(120 per 30 days)
ranolazine er 500 mg tablet,extended release,12 hr ^{MM}	1	QL(120 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
RAPAFLO 4 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
RAPAFLO 8 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
RAPAMUNE 0.5 MG TABLET ^{MM}	3	
RAPAMUNE 1 MG TABLET ^{MM}	3	QL(300 per 30 days)
RAPAMUNE 1 MG/ML ORAL SOLUTION ^{MM}	3	
RAPAMUNE 2 MG TABLET ^{MM}	3	QL(150 per 30 days)
RAPID SARS-COV-2 AG HOME TEST KIT	3	
rasagiline 0.5 mg tablet ^{MM}	1	
rasagiline 1 mg tablet ^{MM}	1	
RASUVO (PF) 10 MG/0.2 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(0.8 per 28 days)
RASUVO (PF) 12.5 MG/0.25 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1 per 28 days)
RASUVO (PF) 15 MG/0.3 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.2 per 28 days)
RASUVO (PF) 17.5 MG/0.35 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.4 per 28 days)
RASUVO (PF) 20 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.6 per 28 days)
RASUVO (PF) 22.5 MG/0.45 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(1.8 per 28 days)
RASUVO (PF) 25 MG/0.5 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(2 per 28 days)
RASUVO (PF) 30 MG/0.6 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(2.4 per 28 days)
RASUVO (PF) 7.5 MG/0.15 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(0.6 per 28 days)
RAVICTI 1.1 GRAM/ML ORAL LIQUID ^{DL,MM,SP}	*	PA,QL(525 per 30 days)
RAYALDEE 30 MCG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
RAYOS 1 MG TABLET,DELAYED RELEASE ^{DL,SP}	*	ST
RAYOS 2 MG TABLET,DELAYED RELEASE ^{DL,SP}	*	ST
RAYOS 5 MG TABLET,DELAYED RELEASE ^{DL,SP}	*	ST
RAZADYNE ER 16 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
RAZADYNE ER 24 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
RAZADYNE ER 8 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
READYLANCE SAFETY LANCETS 21 GAUGE ^{MM}	2	
READYLANCE SAFETY LANCETS 23 GAUGE ^{MM}	2	
READYLANCE SAFETY LANCETS 26 GAUGE ^{MM}	2	
READYLANCE SAFETY LANCETS 28 GAUGE ^{MM}	2	
READYLANCE SAFETY LANCETS 30 GAUGE ^{MM}	2	
REBIF (WITH ALBUMIN) 22 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(6 per 28 days)
REBIF (WITH ALBUMIN) 44 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(6 per 28 days)
REBIF REBIDOSE 22 MCG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(6 per 28 days)
REBIF REBIDOSE 44 MCG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{DL,LD,MM,SP}	*	PA,QL(6 per 28 days)
REBIF REBIDOSE 8.8 MCG/0.2 ML-22 MCG/0.5 ML (6) SUBCUTANEOUS PEN INJ. ^{DL,LD,SP}	*	PA,QL(4.2 per 28 days)
REBIF TITRATION PACK 8.8 MCG/0.2 ML-22 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,LD,SP}	*	PA,QL(4.2 per 28 days)
reclipsen (28) 0.15 mg-0.03 mg tablet ^{MM}	1	
RECOMBIVAX HB (PF) 10 MCG/ML INTRAMUSCULAR SUSPENSION	3	
RECOMBIVAX HB (PF) 10 MCG/ML INTRAMUSCULAR SYRINGE	3	
RECOMBIVAX HB (PF) 40 MCG/ML INTRAMUSCULAR SUSPENSION	3	
RECOMBIVAX HB (PF) 5 MCG/0.5 ML INTRAMUSCULAR SUSPENSION	3	
RECOMBIVAX HB (PF) 5 MCG/0.5 ML INTRAMUSCULAR SYRINGE	3	
RECORLEV 150 MG TABLET ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
RECTIV 0.4 % (W/W) OINTMENT	2	QL(30 per 30 days)
REDITREX (PF) 10 MG/0.4 ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(1.6 per 28 days)
REDITREX (PF) 12.5 MG/0.5 ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(2 per 28 days)
REDITREX (PF) 15 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(2.4 per 28 days)
REDITREX (PF) 17.5 MG/0.7 ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(2.8 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
REDITREX (PF) 20 MG/0.8 ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(3.2 per 28 days)
REDITREX (PF) 22.5 MG/0.9 ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(3.6 per 28 days)
REDITREX (PF) 25 MG/ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(4 per 28 days)
REDITREX (PF) 7.5 MG/0.3 ML SUBCUTANEOUS SYRINGE ^{MM}	3	ST,QL(1.2 per 28 days)
REFUAH PLUS GLUCOSE CONTROL SOLUTION ^{MM}	3	
REFUAH PLUS GLUCOSE MONITOR KIT ^{MM}	3	ST
REFUAH PLUS STRIPS ^{MM}	3	ST,QL(150 per 30 days)
REGLAN 10 MG TABLET	3	
REGLAN 5 MG TABLET	3	
REGRANEX 0.01 % TOPICAL GEL ^{DL,SP}	*	PA
RELAFEN 500 MG TABLET	1	ST
RELAFEN 750 MG TABLET	1	ST
RELAFEN DS 1,000 MG TABLET ^{DL,SP}	*	ST,QL(60 per 30 days)
RELENZA DISKHALER 5 MG/ACTUATION POWDER FOR INHALATION	3	QL(60 per 180 days)
RELEUKO 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(7 per 30 days)
RELEUKO 300 MCG/ML INJECTION SOLUTION ^{DL,SP}	*	PA,QL(14 per 30 days)
RELEUKO 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(11.2 per 30 days)
RELEUKO 480 MCG/1.6 ML INJECTION SOLUTION ^{DL,SP}	*	PA,QL(22.4 per 30 days)
RELEXXII 45 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
RELEXXII 63 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
relexxii 72 mg tablet,extended release ^{MM}	1	ST,QL(30 per 30 days)
RELIAMED LANCET 23 GAUGE ^{MM}	3	
RELIAMED LANCET 28 GAUGE ^{MM}	3	
RELIAMED LANCET 30 GAUGE ^{MM}	3	
RELIAMED MINI LANCING DEVICE	3	
RELIAMED SAFETY SEAL LANCETS 28 GAUGE ^{MM}	2	
RELIAMED SAFETY SEAL LANCETS 30 GAUGE ^{MM}	2	
RELIAMED TWIST AND CAP LANCET 28 GAUGE ^{MM}	3	
RELION ALL-IN-ONE METER KIT ^{MM}	3	ST
RELION CONFIRM KIT ^{MM}	3	ST
RELION CONFIRM-MICRO STRIPS ^{MM}	3	ST,QL(150 per 30 days)
RELION MICRO GLUCOSE MONITOR ^{MM}	3	ST
RELION MICRO GLUCOSE MONITOR KIT ^{MM}	3	ST
RELION PRIME METER ^{MM}	3	ST
RELION PRIME TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
RELION ULTIMA STRIPS ^{MM}	3	ST,QL(150 per 30 days)
RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SOLUTION ^{DL,SP}	*	PA,QL(21.6 per 30 days)
RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(36 per 28 days)
RELISTOR 150 MG TABLET ^{DL,SP}	*	PA,QL(90 per 30 days)
RELISTOR 8 MG/0.4 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(4.8 per 30 days)
RELPAK 20 MG TABLET	3	ST,QL(9 per 30 days)
RELPAK 40 MG TABLET	3	ST,QL(9 per 30 days)
RELTONE 200 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
RELTONE 400 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
RELYVRIO 3 GRAM-1 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
REMERON 15 MG TABLET ^{MM}	3	QL(30 per 30 days)
REMERON 30 MG TABLET ^{MM}	3	QL(30 per 30 days)
REMERON SOLTAB 15 MG DISINTEGRATING TABLET ^{MM}	3	QL(30 per 30 days)
REMERON SOLTAB 30 MG DISINTEGRATING TABLET ^{MM}	3	QL(30 per 30 days)
REMERON SOLTAB 45 MG DISINTEGRATING TABLET ^{MM}	3	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
RENACIDIN 1980.6 MG-59.4MG-980.4MG/30ML IRRIGATION SOLUTION	3	
RENAGEL 800 MG TABLET ^{MM}	3	ST
renal caps 1 mg capsule	1	
reno caps 1 mg capsule	1	
REVELA 0.8 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	ST,QL(540 per 30 days)
REVELA 2.4 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	ST,QL(180 per 30 days)
REVELA 800 MG TABLET ^{MM}	3	ST,QL(540 per 30 days)
repaglinide 0.5 mg tablet ^{MM}	1	
repaglinide 1 mg tablet ^{MM}	1	
repaglinide 2 mg tablet ^{MM}	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR ^{MM}	2	PA,QL(3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	PA,QL(3 per 28 days)
REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE ^{MM}	2	PA,QL(3 per 28 days)
RESPA-AR 8 MG-90 MG-0.24 MG TABLET,EXTENDED RELEASE	3	
RESTASIS 0.05 % EYE DROPS IN A DROPPERETTE ^{MM}	2	QL(60 per 30 days)
RESTASIS MULTIDOSE 0.05 % EYE DROPS ^{MM}	2	QL(5.5 per 25 days)
RESTORIL 15 MG CAPSULE ^{DL}	3	QL(30 per 30 days)
RESTORIL 22.5 MG CAPSULE ^{DL}	3	QL(30 per 30 days)
RESTORIL 30 MG CAPSULE ^{DL}	3	QL(30 per 30 days)
RESTORIL 7.5 MG CAPSULE ^{DL}	3	QL(30 per 30 days)
RETACRIT 10,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
RETACRIT 2,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
RETACRIT 20,000 UNIT/2 ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
RETACRIT 20,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
RETACRIT 3,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
RETACRIT 4,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
RETACRIT 40,000 UNIT/ML INJECTION SOLUTION ^{DL,MM,SP}	*	PA,QL(14 per 30 days)
RETEVMO 40 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
RETEVMO 80 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
RETIN-A 0.01 % TOPICAL GEL	3	PA
RETIN-A 0.025 % TOPICAL CREAM	3	PA
RETIN-A 0.025 % TOPICAL GEL	3	PA
RETIN-A 0.05 % TOPICAL CREAM	3	PA
RETIN-A 0.1 % TOPICAL CREAM	3	PA
RETIN-A MICRO 0.04 % TOPICAL GEL	3	PA
RETIN-A MICRO 0.1 % TOPICAL GEL	3	PA
RETIN-A MICRO PUMP 0.04 % TOPICAL GEL	3	PA
RETIN-A MICRO PUMP 0.06 % TOPICAL GEL	3	PA
RETIN-A MICRO PUMP 0.08 % TOPICAL GEL ^{DL,SP}	*	PA
RETIN-A MICRO PUMP 0.1 % TOPICAL GEL	3	PA
RETROVIR 10 MG/ML INTRAVENOUS SOLUTION	3	
RETROVIR 10 MG/ML ORAL SYRUP ^{MM}	3	QL(1680 per 28 days)
RETROVIR 100 MG CAPSULE ^{MM}	3	QL(180 per 30 days)
REVATIO 10 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
REVATIO 20 MG TABLET ^{MM,SP}	*	PA,QL(90 per 30 days)
REVEAL BLOOD GLUCOSE METER KIT ^{MM}	3	ST
REVEAL TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
REVLIMID 10 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
REVLIMID 15 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
REVLIMID 2.5 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
REVLIMID 20 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
REVLIMID 25 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
REVLIMID 5 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
REXULTI 0.25 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
REXULTI 0.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
REXULTI 1 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
REXULTI 2 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
REXULTI 3 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
REXULTI 4 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
REYATAZ 150 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
REYATAZ 200 MG CAPSULE ^{MM}	3	QL(60 per 30 days)
REYATAZ 300 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
REYATAZ 50 MG ORAL POWDER PACKET ^{MM,SP}	*	
REYVOW 100 MG TABLET	3	PA,QL(8 per 30 days)
REYVOW 50 MG TABLET	3	PA,QL(4 per 30 days)
REZLIDHIA 150 MG CAPSULE ^{MM,SP}	*	PA,QL(60 per 30 days)
REZUROCK 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
REZVOGLAR KWIKPEN 100 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST
RHOFADE 1 % TOPICAL CREAM	3	ST,QL(30 per 30 days)
RHOPRESSA 0.02 % EYE DROPS ^{MM}	3	PA,QL(2.5 per 25 days)
ribavirin 200 mg capsule	1	QL(168 per 28 days)
ribavirin 200 mg tablet	1	QL(168 per 28 days)
ribavirin 6 gram solution for inhalation	1	QL(8 per 30 days)
RIDAURA 3 MG CAPSULE ^{MM}	3	
rifabutin 150 mg capsule	1	
rifampin 150 mg capsule	1	
rifampin 300 mg capsule	1	
RIGHTEST CONTROL SOLUTION HIGH ^{MM}	3	
RIGHTEST CONTROL SOLUTION NORMAL ^{MM}	3	
RIGHTEST GC250S CONTROL SOLUTION NORMAL ^{MM}	3	
RIGHTEST GC700 LEVEL 2 CONTROL SOLUTION ^{MM}	3	
RIGHTEST GD500 LANCING DEVICE	3	
RIGHTEST GL300 LANCETS 30 GAUGE ^{MM}	2	
RIGHTEST GM250S GLUCOSE METER ^{MM}	3	ST
RIGHTEST GM260 GLUCOSE METER ^{MM}	3	ST
RIGHTEST GM550 SYSTEM KIT ^{MM}	3	ST
RIGHTEST GM700SB GLUCOSE METER ^{MM}	3	ST
RIGHTEST GS250S TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
RIGHTEST GS260 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
RIGHTEST GS550 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
RIGHTEST GS700 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
RIGHTEST GT333 GLUCOSE METER ^{MM}	3	ST
RIGHTEST GT333 LEVEL 2 CONTROL SOLUTION ^{MM}	3	
RIGHTEST GT333 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
RIGHTEST MAX PLUS GLUCOSE METER ^{MM}	3	ST
RIGHTEST MAX TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
RILUTEK 50 MG TABLET ^{MM}	3	
riluzole 50 mg tablet ^{MM}	1	
rimantadine 100 mg tablet	1	
ringer's irrigation solution	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
RINVOQ 15 MG TABLET,EXTENDED RELEASE ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
RINVOQ 30 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
RINVOQ 45 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(56 per 365 days)
RIOMET 500 MG/5 ML ORAL SOLUTION ^{DL,MM,SP}	*	QL(750 per 30 days)
RIOMET ER 500 MG/5 ML ORAL SUSPENSION,EXTENDED RELEASE ^{MM}	3	QL(750 per 30 days)
risedronate 150 mg tablet ^{MM}	1	QL(1 per 30 days)
risedronate 30 mg tablet	1	QL(30 per 30 days)
risedronate 35 mg tablet ^{MM}	1	QL(4 per 28 days)
risedronate 35 mg tablet,delayed release ^{MM}	1	QL(4 per 28 days)
risedronate 5 mg tablet ^{MM}	1	QL(30 per 30 days)
RISPERDAL 0.5 MG TABLET ^{MM}	3	QL(120 per 30 days)
RISPERDAL 1 MG TABLET ^{MM}	3	QL(60 per 30 days)
RISPERDAL 1 MG/ML ORAL SOLUTION ^{MM}	3	
RISPERDAL 2 MG TABLET ^{MM}	3	QL(60 per 30 days)
RISPERDAL 3 MG TABLET ^{MM}	3	QL(60 per 30 days)
RISPERDAL 4 MG TABLET ^{MM}	3	QL(60 per 30 days)
RISPERDAL CONSTA 12.5 MG/2 ML INTRAMUSCULAR SUSP,EXTENDED RELEASE ^{DL,MM,SP}	*	QL(2 per 28 days)
RISPERDAL CONSTA 25 MG/2 ML INTRAMUSCULAR SUSP,EXTENDED RELEASE ^{DL,MM,SP}	*	QL(2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML INTRAMUSCULAR SUSP,EXTENDED RELEASE ^{DL,MM,SP}	*	QL(2 per 28 days)
RISPERDAL CONSTA 50 MG/2 ML INTRAMUSCULAR SUSP,EXTENDED RELEASE ^{DL,MM,SP}	*	QL(2 per 28 days)
risperidone 0.25 mg disintegrating tablet ^{MM}	1	ST,QL(60 per 30 days)
risperidone 0.25 mg tablet ^{MM}	1	QL(60 per 30 days)
risperidone 0.5 mg disintegrating tablet ^{MM}	1	ST,QL(120 per 30 days)
risperidone 0.5 mg tablet ^{MM}	1	QL(120 per 30 days)
risperidone 1 mg disintegrating tablet ^{MM}	1	ST,QL(60 per 30 days)
risperidone 1 mg tablet ^{MM}	1	QL(60 per 30 days)
risperidone 1 mg/ml oral solution ^{MM}	1	
risperidone 2 mg disintegrating tablet ^{MM}	1	ST,QL(60 per 30 days)
risperidone 2 mg tablet ^{MM}	1	QL(60 per 30 days)
risperidone 3 mg disintegrating tablet ^{MM}	1	ST,QL(60 per 30 days)
risperidone 3 mg tablet ^{MM}	1	QL(60 per 30 days)
risperidone 4 mg disintegrating tablet ^{MM}	1	ST,QL(60 per 30 days)
risperidone 4 mg tablet ^{MM}	1	QL(60 per 30 days)
RITALIN 10 MG TABLET ^{MM}	3	QL(90 per 30 days)
RITALIN 20 MG TABLET ^{MM}	3	QL(90 per 30 days)
RITALIN 5 MG TABLET ^{MM}	3	QL(90 per 30 days)
RITALIN LA 10 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
RITALIN LA 20 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
RITALIN LA 30 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
RITALIN LA 40 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
RITEFLO AEROCHAMBER	3	
ritonavir 100 mg tablet ^{MM}	1	QL(360 per 30 days)
rivastigmine 1.5 mg capsule ^{MM}	1	QL(90 per 30 days)
rivastigmine 13.3 mg/24 hour transdermal patch ^{MM}	1	QL(30 per 30 days)
rivastigmine 3 mg capsule ^{MM}	1	QL(90 per 30 days)
rivastigmine 4.5 mg capsule ^{MM}	1	QL(60 per 30 days)
rivastigmine 4.6 mg/24 hour transdermal patch ^{MM}	1	QL(30 per 30 days)
rivastigmine 6 mg capsule ^{MM}	1	QL(60 per 30 days)
rivastigmine 9.5 mg/24 hour transdermal patch ^{MM}	1	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
rivelsa 0.15 mg-20 mcg/0.15 mg-25 mcg tablets,3 month dose pack ^{MM}	3	QL(91 per 90 days)
rizatriptan 10 mg disintegrating tablet	1	QL(12 per 30 days)
rizatriptan 10 mg tablet	1	QL(12 per 30 days)
rizatriptan 5 mg disintegrating tablet	1	QL(12 per 30 days)
rizatriptan 5 mg tablet	1	QL(12 per 30 days)
ROBINUL 1 MG TABLET ^{MM}	3	ST
ROBINUL FORTE 2 MG TABLET ^{MM}	3	ST
ROCALTROL 0.25 MCG CAPSULE ^{MM}	3	
ROCALTROL 0.5 MCG CAPSULE ^{MM}	3	
ROCALTROL 1 MCG/ML ORAL SOLUTION ^{MM}	3	
ROCKLATAN 0.02 %-0.005 % EYE DROPS ^{MM}	3	ST,QL(2.5 per 25 days)
roflumilast 250 mcg tablet ^{MM}	1	QL(28 per 365 days)
roflumilast 500 mcg tablet ^{MM}	1	QL(30 per 30 days)
ropinirole 0.25 mg tablet ^{MM}	1	QL(180 per 30 days)
ropinirole 0.5 mg tablet ^{MM}	1	QL(90 per 30 days)
ropinirole 1 mg tablet ^{MM}	1	QL(90 per 30 days)
ropinirole 2 mg tablet ^{MM}	1	QL(90 per 30 days)
ropinirole 3 mg tablet ^{MM}	1	QL(180 per 30 days)
ropinirole 4 mg tablet ^{MM}	1	QL(180 per 30 days)
ropinirole 5 mg tablet ^{MM}	1	QL(120 per 30 days)
ropinirole er 12 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(90 per 30 days)
ropinirole er 2 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(90 per 30 days)
ropinirole er 4 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(90 per 30 days)
ropinirole er 6 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(90 per 30 days)
ropinirole er 8 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(90 per 30 days)
rosadan 0.75 % topical cream	1	
rosadan 0.75 % topical gel	1	
rosuvastatin 10 mg tablet ^{MM}	1	
rosuvastatin 20 mg tablet ^{MM}	1	
rosuvastatin 40 mg tablet ^{MM}	1	
rosuvastatin 5 mg tablet ^{MM}	1	
ROSZET 10 MG-10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ROSZET 10 MG-20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ROSZET 10 MG-40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ROSZET 10 MG-5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ROWASA 4 GRAM/60 ML ENEMA ^{MM}	3	QL(1800 per 30 days)
roweepra 1,000 mg tablet ^{MM}	1	
roweepra 500 mg tablet ^{MM}	1	
roweepra 750 mg tablet ^{MM}	1	
roweepra xr 500 mg tablet,extended release ^{MM}	1	
roweepra xr 750 mg tablet,extended release ^{MM}	1	
ROXICODONE 15 MG TABLET ^{DL}	3	QL(360 per 30 days)
ROXICODONE 30 MG TABLET ^{DL}	3	QL(360 per 30 days)
ROXYBOND 15 MG TABLET,ORAL ONLY (NOT FEEDING TUBES) ^{DL,SP}	*	PA,QL(180 per 30 days)
ROXYBOND 30 MG TABLET,ORAL ONLY (NOT FEEDING TUBES) ^{DL,SP}	*	PA,QL(180 per 30 days)
ROXYBOND 5 MG TABLET,ORAL ONLY (NOT FEEDING TUBES) ^{DL,SP}	*	PA,QL(360 per 30 days)
ROZEREM 8 MG TABLET	3	ST,QL(30 per 30 days)
ROZLYTREK 100 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(150 per 30 days)
ROZLYTREK 200 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(90 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
RUBRACA 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
RUBRACA 250 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
RUBRACA 300 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
rufinamide 200 mg tablet ^{DL,MM,SP}	*	PA,QL(480 per 30 days)
rufinamide 40 mg/ml oral suspension ^{DL,MM}	1	PA,QL(2760 per 30 days)
rufinamide 400 mg tablet ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
RUKOBIA 600 MG TABLET,EXTENDED RELEASE ^{MM,SP}	*	QL(60 per 30 days)
RUZURGI 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
RYALTRIS 665 MCG-25 MCG/SPRAY NASAL SPRAY	3	ST,QL(29 per 30 days)
RYBELSUS 14 MG TABLET ^{MM}	2	QL(30 per 30 days)
RYBELSUS 3 MG TABLET	2	QL(30 per 30 days)
RYBELSUS 7 MG TABLET ^{MM}	2	QL(30 per 30 days)
RYCLORA 2 MG/5 ML ORAL SOLUTION ^{DL}	3	PA
RYDAPT 25 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(224 per 28 days)
RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(360 per 30 days)
RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(270 per 30 days)
RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(360 per 30 days)
RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	ST,QL(300 per 30 days)
RYTHMOL SR 225 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
RYTHMOL SR 325 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
RYTHMOL SR 425 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
RYVENT 6 MG TABLET	3	QL(120 per 30 days)
SABRIL 500 MG ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
SABRIL 500 MG TABLET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
SAFESNAP INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
SAFESNAP INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
SAFESNAP INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
SAFESNAP INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
SAFESNAP INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
SAFETY LANCETS 21 GAUGE ^{MM}	2	
SAFETY LANCETS 26 GAUGE ^{MM}	3	
SAFETY LANCETS 28 GAUGE ^{MM}	2	
SAFETY NEEDLES 18 GAUGE X 1 1/2"	3	
SAFETY PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
SAFETY SEAL LANCETS 28 GAUGE ^{MM}	2	
SAFETY SEAL LANCETS 30 GAUGE ^{MM}	2	
SAFETY-LET LANCETS 30 GAUGE ^{MM}	2	
SAFYRAL 3 MG-0.03 MG-0.451 MG (21)/0.451 MG (7) TABLET ^{MM}	3	
SAIZEN 5 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
SAIZEN 8.8 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
SAIZEN SAIZENPREP 8.8 MG/1.51 ML (FINAL CONC.) SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(18 per 30 days)
sajazir 30 mg/3 ml subcutaneous syringe ^{DL,SP}	*	PA,QL(9 per 30 days)
SALAGEN (PILOCARPINE) 5 MG TABLET ^{MM}	3	
SALAGEN (PILOCARPINE) 7.5 MG TABLET ^{MM}	3	
SAMSCA 15 MG TABLET ^{DL,MM,SP}	*	QL(60 per 30 days)
SAMSCA 30 MG TABLET ^{DL,MM,SP}	*	QL(60 per 30 days)
SANCUSO 3.1 MG/24 HOUR TRANSDERMAL PATCH	3	PA,QL(4 per 30 days)
SANDIMMUNE 100 MG CAPSULE ^{MM}	3	QL(720 per 30 days)
SANDIMMUNE 100 MG/ML ORAL SOLUTION ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SANDIMMUNE 25 MG CAPSULE ^{MM}	3	
SANDOSTATIN 100 MCG/ML INJECTION SOLUTION ^{MM}	3	PA
SANDOSTATIN 50 MCG/ML INJECTION SOLUTION ^{MM}	3	PA
SANDOSTATIN 500 MCG/ML INJECTION SOLUTION ^{MM}	3	PA
SANTYL 250 UNIT/GRAM TOPICAL OINTMENT	3	PA
SAPHRIS 10 MG SUBLINGUAL TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
SAPHRIS 2.5 MG SUBLINGUAL TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
SAPHRIS 5 MG SUBLINGUAL TABLET ^{MM,SP}	*	PA,QL(60 per 30 days)
sapropterin 100 mg oral powder packet ^{DL,MM,SP}	*	PA
sapropterin 100 mg soluble tablet ^{DL,MM,SP}	*	PA
sapropterin 500 mg oral powder packet ^{DL,MM,SP}	*	PA
SAVAYSA 15 MG TABLET ^{MM}	3	QL(30 per 30 days)
SAVAYSA 30 MG TABLET ^{MM}	3	QL(30 per 30 days)
SAVAYSA 60 MG TABLET ^{MM}	3	QL(30 per 30 days)
SAVELLA 100 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK	3	PA,QL(60 per 30 days)
SAVELLA 12.5 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SAVELLA 25 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SAVELLA 50 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SCEMBLIX 20 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SCEMBLIX 40 MG TABLET ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
scopolamine 1 mg over 3 days transdermal patch	1	QL(10 per 30 days)
se-natal 19 chewable 29 mg iron-1 mg tablet ^{MM}	1	
SEASONIQUE 0.15 MG-30 MCG (84)/10 MCG(7) TABLETS,3 MONTH DOSE PACK ^{MM}	3	QL(91 per 90 days)
SECONAL SODIUM 100 MG CAPSULE	3	
SECUADO 3.8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
SECUADO 5.7 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
SECUADO 7.6 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
SECURESAFE INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
SECURESAFE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
SECURESAFE PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
SEGLENTIS 44 MG-56 MG TABLET ^{DL}	3	PA,QL(120 per 30 days)
SEGLUOMET 2.5 MG-1,000 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SEGLUOMET 2.5 MG-500 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SEGLUOMET 7.5 MG-1,000 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SEGLUOMET 7.5 MG-500 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
SELECT-OB (FOLIC ACID) 29 MG IRON-1 MG CHEWABLE TABLET ^{MM}	2	
SELECT-OB + DHA 29 MG IRON-1 MG-250 MG ORAL PACK ^{MM}	3	
SELECT-OB 29 MG IRON-1 MG CHEWABLE TABLET ^{MM}	3	
selegiline 5 mg capsule ^{MM}	1	
selegiline 5 mg tablet ^{MM}	1	
selenium sulfide 2.5 % lotion	1	
SELZENTRY 150 MG TABLET ^{MM,SP}	*	QL(240 per 30 days)
SELZENTRY 20 MG/ML ORAL SOLUTION ^{MM,SP}	*	QL(1800 per 30 days)
SELZENTRY 25 MG TABLET ^{MM,SP}	*	QL(240 per 30 days)
SELZENTRY 300 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
SELZENTRY 75 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
SEMGLEE (INSULIN GLARGINE-YFGN) 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
SEMGLEE (INSULIN GLARGINE-YFGN) PEN 100 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SEMGLEE PEN U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS ^{MM}	3	ST
SEMGLEE U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	3	ST
SENSIPAR 30 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
SENSIPAR 60 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
SENSIPAR 90 MG TABLET ^{MM}	3	ST,QL(120 per 30 days)
SEREVENT DISKUS 50 MCG/DOSE POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
SERNIVO 0.05 % TOPICAL SPRAY WITH PUMP ^{DL,SP}	*	ST,QL(120 per 28 days)
SEROQUEL 100 MG TABLET ^{MM}	3	QL(90 per 30 days)
SEROQUEL 200 MG TABLET ^{MM}	3	QL(120 per 30 days)
SEROQUEL 25 MG TABLET ^{MM}	3	QL(120 per 30 days)
SEROQUEL 300 MG TABLET ^{MM}	3	QL(60 per 30 days)
SEROQUEL 400 MG TABLET ^{MM}	3	QL(60 per 30 days)
SEROQUEL 50 MG TABLET ^{MM}	3	QL(120 per 30 days)
SEROQUEL XR 150 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(90 per 30 days)
SEROQUEL XR 200 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
SEROQUEL XR 300 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
SEROQUEL XR 400 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(60 per 30 days)
SEROQUEL XR 50 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(120 per 30 days)
SEROQUEL XR 50 MG(3)-200 MG(1)-300 MG(11) TABLET, ER 24 HR DOSE PACK	3	PA,QL(15 per 30 days)
SEROSTIM 4 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
SEROSTIM 5 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
SEROSTIM 6 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(28 per 28 days)
sertraline 100 mg tablet ^{MM}	1	QL(60 per 30 days)
SERTRALINE 150 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
sertraline 20 mg/ml oral concentrate ^{MM}	1	QL(60 per 30 days)
SERTRALINE 200 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
sertraline 25 mg tablet ^{MM}	1	QL(90 per 30 days)
sertraline 50 mg tablet ^{MM}	1	QL(90 per 30 days)
setlakin 0.15 mg-30 mcg (91) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
sevelamer carbonate 0.8 gram oral powder packet ^{DL,MM,SP}	*	QL(540 per 30 days)
sevelamer carbonate 2.4 gram oral powder packet ^{DL,MM,SP}	*	QL(180 per 30 days)
sevelamer carbonate 800 mg tablet ^{MM}	1	QL(540 per 30 days)
sevelamer hcl 400 mg tablet ^{MM}	1	ST
sevelamer hcl 800 mg tablet ^{MM}	1	ST
SEYSARA 100 MG TABLET ^{DL,SP}	*	ST,QL(30 per 30 days)
SEYSARA 150 MG TABLET ^{DL,SP}	*	ST,QL(30 per 30 days)
SEYSARA 60 MG TABLET ^{DL,SP}	*	ST,QL(30 per 30 days)
SFROWASA 4 GRAM/60 ML ENEMA ^{MM}	3	QL(1800 per 30 days)
sharobel 0.35 mg tablet ^{MM}	1	
SHINGRIX (PF) 50 MCG/0.5 ML INTRAMUSCULAR SUSPENSION, KIT	3	
SIGNIFOR 0.3 MG/ML (1 ML) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SIGNIFOR 0.6 MG/ML (1 ML) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SIGNIFOR 0.9 MG/ML (1 ML) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SIKLOS 1,000 MG TABLET ^{DL,MM,SP}	*	PA
SIKLOS 100 MG TABLET ^{DL,MM,SP}	*	PA
sildenafil (pulmonary hypertension) 10 mg/ml oral suspension ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
sildenafil (pulmonary hypertension) 20 mg tablet ^{MM}	1	PA,QL(90 per 30 days)
SILENOR 3 MG TABLET	3	ST,QL(30 per 30 days)
SILENOR 6 MG TABLET	3	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SILICONE MASK - INFANT	3	
SILIQ 210 MG/1.5 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(42 per 365 days)
silodosin 4 mg capsule ^{MM}	1	ST,QL(30 per 30 days)
silodosin 8 mg capsule ^{MM}	1	ST,QL(30 per 30 days)
SILVADENE 1 % TOPICAL CREAM	3	
silver sulfadiazine 1 % topical cream	1	
SIMBRINZA 1 %-0.2 % EYE DROPS,SUSPENSION ^{MM}	3	ST,QL(16 per 30 days)
simliya (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet ^{MM}	1	
simpesse 0.15 mg-30 mcg (84)/10 mcg(7) tablets,3 month dose pack ^{MM}	1	QL(91 per 90 days)
SIMPONI 100 MG/ML SUBCUTANEOUS PEN INJECTOR ^{MM,SP}	*	PA,QL(16 per 365 days)
SIMPONI 100 MG/ML SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(16 per 365 days)
SIMPONI 50 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(0.5 per 30 days)
SIMPONI 50 MG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(0.5 per 30 days)
simvastatin 10 mg tablet ^{MM}	1	
simvastatin 20 mg tablet ^{MM}	1	
simvastatin 40 mg tablet ^{MM}	1	
simvastatin 5 mg tablet ^{MM}	1	
simvastatin 80 mg tablet ^{MM}	1	
SINEMET 10 MG-100 MG TABLET ^{MM}	3	
SINEMET 25 MG-100 MG TABLET ^{MM}	3	
SINGLE-LET MISC ^{MM}	2	
SINGULAIR 10 MG TABLET ^{MM}	3	QL(30 per 30 days)
SINGULAIR 4 MG CHEWABLE TABLET ^{MM}	3	QL(30 per 30 days)
SINGULAIR 4 MG ORAL GRANULES IN PACKET ^{MM}	3	QL(30 per 30 days)
SINGULAIR 5 MG CHEWABLE TABLET ^{MM}	3	QL(30 per 30 days)
sirolimus 0.5 mg tablet ^{MM}	1	
sirolimus 1 mg tablet ^{MM}	1	QL(300 per 30 days)
sirolimus 1 mg/ml oral solution ^{MM}	1	
sirolimus 2 mg tablet ^{MM}	1	QL(150 per 30 days)
SIRTURO 100 MG TABLET	3	PA,QL(68 per 28 days)
SIRTURO 20 MG TABLET	3	PA,QL(340 per 28 days)
SITAVIG 50 MG BUCCAL TABLET	3	PA,QL(1 per 28 days)
SIVEXTRO 200 MG TABLET	3	QL(6 per 28 days)
SKELAXIN 800 MG TABLET	3	ST,QL(120 per 30 days)
SKLICE 0.5 % LOTION	3	
SKY SAFETY PEN NEEDLE 30 GAUGE X 3/16" ^{MM}	2	
SKY SAFETY PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
SKYCLARYS 50 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
SKYLA 14 MCG/24 HRS (3 YRS) 13.5 MG INTRAUTERINE DEVICE ^{DL,LD,MM,SP}	*	
SKYRIZI 150 MG/1.66 ML(75 MG/0.83 ML X 2) SUBCUTANEOUS SYRINGE KIT ^{LD,MM,SP}	*	PA,QL(6 per 365 days)
SKYRIZI 150 MG/ML SUBCUTANEOUS PEN INJECTOR ^{MM,SP}	*	PA,QL(6 per 365 days)
SKYRIZI 150 MG/ML SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(6 per 365 days)
SKYRIZI 180 MG/1.2 ML (150 MG/ML) SUBCUTANEOUS WEARABLE INJECTOR ^{DL,MM,SP}	*	PA,QL(8.4 per 365 days)
SKYRIZI 360 MG/2.4 ML (150 MG/ML) SUBCUTANEOUS WEARABLE INJECTOR ^{DL,MM,SP}	*	PA,QL(16.8 per 365 days)
SKYRIZI 75 MG/0.83 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(9.96 per 365 days)
SKYTROFA 11 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
SKYTROFA 13.3 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
SKYTROFA 3 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
SKYTROFA 3.6 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
SKYTROFA 4.3 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SKYTROFA 5.2 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
SKYTROFA 6.3 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
SKYTROFA 7.6 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
SKYTROFA 9.1 MG SUBCUTANEOUS CARTRIDGE ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
SLYND 4 MG (28) TABLET ^{MM}	3	
SMART CARESENS N KIT ^{MM}	3	ST
SMART SENSE LANCETS 21 GAUGE ^{MM}	2	
SMART SENSE LANCETS 26 GAUGE ^{MM}	2	
SMART SENSE LANCETS 33 GAUGE ^{MM}	2	
SMART SENSE MONITORING SYSTEM ^{MM}	3	ST
SMART SENSE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
SMARTDIABETES VANTAGE	3	
SMARTTEST CONTROL SOLUTION ^{MM}	3	
SMARTTEST EJECT KIT ^{MM}	3	ST
SMARTTEST LANCET ^{MM}	2	
SMARTTEST PERSONA GLUCOSE METER ^{MM}	3	ST
SMARTTEST PERSONA STARTER KIT ^{MM}	3	ST
SMARTTEST PRONTO GLUCOSE METER ^{MM}	3	ST
SMARTTEST PRONTO STARTER KIT ^{MM}	3	ST
SMARTTEST PROTEGE KIT ^{MM}	3	ST
SMARTTEST SMART CODE METER KIT ^{MM}	3	ST
SMARTTEST TALKING METER KIT ^{MM}	3	ST
SMARTTEST TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
SOAANZ 20 MG TABLET ^{MM}	3	ST
SOAANZ 40 MG TABLET ^{MM}	3	ST
SOAANZ 60 MG TABLET ^{MM}	3	ST
sodium chloride 0.9 % for nebulization	1	
sodium chloride 0.9 % irrigation solution	1	
sodium chloride 10 % for nebulization	1	
sodium chloride 3 % for nebulization	1	
sodium chloride 7 % for nebulization	1	
sodium citrate 4 gram/100 ml (4 %) solution	1	
sodium oxybate 500 mg/ml oral solution ^{DL,MM,SP}	*	PA,QL(540 per 30 days)
sodium phenylbutyrate 0.94 gram/gram oral powder ^{DL,MM,SP}	*	
sodium phenylbutyrate 500 mg tablet ^{DL,MM,SP}	*	
sodium polystyrene sulfonate (sorbitol free) 15 gram/60 ml oral susp	1	
sodium polystyrene sulfonate oral powder	1	
sodium,potassium,mag sulfates 17.5 gram-3.13 gram-1.6 gram oral soln	3	ST
sofosbuvir 400 mg-velpatasvir 100 mg tablet ^{DL,SP}	*	PA,QL(28 per 28 days)
SOFT TOUCH LANCETS ^{MM}	2	
SOLARAZE 3 % TOPICAL GEL	3	PA
solifenacin 10 mg tablet ^{MM}	1	QL(30 per 30 days)
solifenacin 5 mg tablet ^{MM}	1	QL(30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML SUBCUTANEOUS INSULIN PEN ^{MM}	2	QL(15 per 24 days)
SOLODYN 105 MG TABLET,EXTENDED RELEASE	3	ST,QL(30 per 30 days)
SOLODYN 115 MG TABLET,EXTENDED RELEASE	3	ST,QL(30 per 30 days)
SOLODYN 55 MG TABLET,EXTENDED RELEASE	3	ST,QL(30 per 30 days)
SOLODYN 65 MG TABLET,EXTENDED RELEASE	3	ST,QL(30 per 30 days)
SOLODYN 80 MG TABLET,EXTENDED RELEASE	3	ST,QL(30 per 30 days)
SOLOSEC 2 GRAM ORAL DR GRANULES IN PACKET	3	PA

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SOLTAMOX 20 MG/10 ML ORAL SOLUTION ^{MM}	3	QL(600 per 30 days)
SOLUS V2 AUDIBLE METER ^{MM}	3	ST
SOLUS V2 AUDIBLE METER KIT ^{MM}	3	ST
SOLUS V2 CONTROL SOLUTION, LOW ^{MM}	3	
SOLUS V2 CONTROL SOLUTION,HIGH ^{MM}	3	
SOLUS V2 LANCETS 28 GAUGE ^{MM}	2	
SOLUS V2 LANCETS 30 GAUGE ^{MM}	2	
SOLUS V2 LANCING DEVICE KIT ^{MM}	3	
SOLUS V2 TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
SOMA 250 MG TABLET	3	QL(120 per 30 days)
SOMA 350 MG TABLET	3	QL(120 per 30 days)
SOMATULINE DEPOT 120 MG/0.5 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(0.5 per 28 days)
SOMATULINE DEPOT 60 MG/0.2 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(0.2 per 28 days)
SOMATULINE DEPOT 90 MG/0.3 ML SUBCUTANEOUS SYRINGE ^{DL,LD,MM,SP}	*	PA,QL(0.3 per 28 days)
SOMAVERT 10 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
SOMAVERT 15 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
SOMAVERT 20 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
SOMAVERT 25 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
SOMAVERT 30 MG SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
SOOLANTRA 1 % TOPICAL CREAM	3	ST
sorafenib 200 mg tablet ^{DL,SP}	*	PA,QL(120 per 30 days)
sorbitol 2.7 gram-mannitol 0.54 gram/100 ml transurethral solution	1	
SORIATANE 10 MG CAPSULE ^{DL}	3	PA
SORIATANE 25 MG CAPSULE ^{DL}	3	PA
SORILUX 0.005 % TOPICAL FOAM ^{DL,SP}	*	PA,QL(120 per 28 days)
sorine 120 mg tablet ^{MM}	1	
sorine 160 mg tablet ^{MM}	1	
sorine 240 mg tablet ^{MM}	1	
sorine 80 mg tablet ^{MM}	1	
sotalol 120 mg tablet ^{MM}	1	
sotalol 160 mg tablet ^{MM}	1	
sotalol 240 mg tablet ^{MM}	1	
sotalol 80 mg tablet ^{MM}	1	
sotalol af 120 mg tablet ^{MM}	1	
sotalol af 160 mg tablet ^{MM}	1	
sotalol af 80 mg tablet ^{MM}	1	
SOTYKTU 6 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
SOTYLIZE 5 MG/ML ORAL SOLUTION ^{MM}	3	
SOVALDI 150 MG ORAL PELLETS IN PACKET ^{DL,SP}	*	PA,QL(28 per 28 days)
SOVALDI 200 MG ORAL PELLETS IN PACKET ^{DL,SP}	*	PA,QL(56 per 28 days)
SOVALDI 200 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
SOVALDI 400 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
SPACE CHAMBER	2	
SPACE CHAMBER PLUS	2	
SPACE CHAMBER WITH LARGE MASK	2	
SPACE CHAMBER WITH MEDIUM MASK	2	
SPACE CHAMBER WITH SMALL MASK	2	
SPEEDYSWAB COVID-19 HOME TEST KIT	3	
SPIKEVAX (PF) 100 MCG/0.5 ML INTRAMUSCULAR SUSPENSION	3	
spinosad 0.9 % topical suspension	1	QL(240 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION SOLUTION FOR INHALATION ^{MM}	2	QL(4 per 28 days)
SPIRIVA RESPIMAT 2.5 MCG/ACTUATION SOLUTION FOR INHALATION ^{MM}	2	QL(4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES ^{MM}	2	QL(30 per 30 days)
spironolactone 100 mg tablet ^{MM}	1	
spironolactone 25 mg tablet ^{MM}	1	
spironolactone 25 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
spironolactone 50 mg tablet ^{MM}	1	
SPORANOX 10 MG/ML ORAL SOLUTION	3	QL(150 per 30 days)
SPORANOX 100 MG CAPSULE	3	QL(120 per 30 days)
SPORANOX PULSEPAK 100 MG CAPSULE	3	QL(120 per 30 days)
SPRAVATO 28 MG NASAL SPRAY ^{DL,MM,SP}	*	PA
SPRAVATO 56 MG (28 MG X 2) NASAL SPRAY ^{DL,LD,MM,SP}	*	PA,QL(16 per 28 days)
SPRAVATO 84 MG (28 MG X 3) NASAL SPRAY ^{DL,LD,MM,SP}	*	PA,QL(24 per 28 days)
sprintec (28) 0.25 mg-35 mcg tablet ^{MM}	1	
SPRITAM 1,000 MG TABLET FOR ORAL SUSPENSION ^{MM}	3	ST,QL(90 per 30 days)
SPRITAM 250 MG TABLET FOR ORAL SUSPENSION ^{MM}	3	ST,QL(360 per 30 days)
SPRITAM 500 MG TABLET FOR ORAL SUSPENSION ^{MM}	3	ST,QL(180 per 30 days)
SPRITAM 750 MG TABLET FOR ORAL SUSPENSION ^{MM}	3	ST,QL(120 per 30 days)
SPRIX 15.75 MG/SPRAY NASAL SPRAY ^{DL,SP}	*	PA,QL(5 per 30 days)
SPRYCEL 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SPRYCEL 140 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
SPRYCEL 20 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
SPRYCEL 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SPRYCEL 70 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SPRYCEL 80 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SPS (WITH SORBITOL) 15 GRAM-20 GRAM/60 ML ORAL SUSPENSION	3	
SPS (WITH SORBITOL) 30 GRAM-40 GRAM/120 ML ENEMA	3	
sronyx 0.1 mg-20 mcg tablet ^{MM}	1	
SSD 1 % TOPICAL CREAM	3	
sski 1 gram/ml oral solution	1	
STALEVO 100 25 MG-100 MG-200 MG TABLET ^{MM}	3	
STALEVO 125 31.25 MG-125 MG-200 MG TABLET ^{MM}	3	
STALEVO 150 37.5 MG-150 MG-200 MG TABLET ^{MM}	3	
STALEVO 200 50 MG-200 MG-200 MG TABLET ^{MM}	3	
STALEVO 50 12.5 MG-50 MG-200 MG TABLET ^{MM}	3	
STALEVO 75 18.75 MG-75 MG-200 MG TABLET ^{MM}	3	
stavudine 15 mg capsule ^{MM}	1	QL(120 per 30 days)
stavudine 20 mg capsule ^{MM}	1	QL(120 per 30 days)
stavudine 30 mg capsule ^{MM}	1	QL(60 per 30 days)
stavudine 40 mg capsule ^{MM}	1	QL(60 per 30 days)
STEGLATRO 15 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
STEGLATRO 5 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
STEGLUJAN 15 MG-100 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
STEGLUJAN 5 MG-100 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
STELARA 45 MG/0.5 ML SUBCUTANEOUS SOLUTION ^{MM,SP}	*	PA,QL(1.5 per 84 days)
STELARA 45 MG/0.5 ML SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(1.5 per 84 days)
STELARA 90 MG/ML SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(3 per 84 days)
STERILANCE TL 30 GAUGE ^{MM}	2	
STERILANCE TL 32 GAUGE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
STIMUFEND 6 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.2 per 28 days)
STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION ^{MM}	2	QL(4 per 28 days)
STIVARGA 40 MG TABLET ^{DL,LD,SP}	*	PA,QL(84 per 28 days)
STRATTERA 10 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
STRATTERA 100 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
STRATTERA 18 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
STRATTERA 25 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
STRATTERA 40 MG CAPSULE ^{MM}	3	ST,QL(60 per 30 days)
STRATTERA 60 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
STRATTERA 80 MG CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
STRENSIQ 18 MG/0.45 ML SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(10.8 per 28 days)
STRENSIQ 28 MG/0.7 ML SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(16.8 per 28 days)
STRENSIQ 40 MG/ML SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(24 per 28 days)
STRENSIQ 80 MG/0.8 ML SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(38.4 per 28 days)
STRIBILD 150 MG-150 MG-200 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION SOLUTION FOR INHALATION ^{MM}	2	QL(4 per 30 days)
STROMECTOL 3 MG TABLET	3	
strong iodine 5 % oral solution	1	
SUBOXONE 12 MG-3 MG SUBLINGUAL FILM ^{MM}	3	PA,QL(60 per 30 days)
SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM ^{MM}	3	PA,QL(90 per 30 days)
SUBOXONE 4 MG-1 MG SUBLINGUAL FILM ^{MM}	3	PA,QL(90 per 30 days)
SUBOXONE 8 MG-2 MG SUBLINGUAL FILM ^{MM}	3	PA,QL(90 per 30 days)
SUBSYS 1,200 MCG (600 MCG/SPRAY X2) SUBLINGUAL SPRAY ^{DL,SP}	*	PA,QL(120 per 30 days)
SUBSYS 1,600 MCG (800 MCG/SPRAY X2) SUBLINGUAL SPRAY ^{DL,SP}	*	PA,QL(120 per 30 days)
SUBSYS 100 MCG/SPRAY SUBLINGUAL SPRAY ^{DL,SP}	*	PA,QL(120 per 30 days)
SUBSYS 200 MCG/SPRAY SUBLINGUAL SPRAY ^{DL,SP}	*	PA,QL(120 per 30 days)
SUBSYS 400 MCG/SPRAY SUBLINGUAL SPRAY ^{DL,SP}	*	PA,QL(120 per 30 days)
SUBSYS 600 MCG/SPRAY SUBLINGUAL SPRAY ^{DL,SP}	*	PA,QL(120 per 30 days)
SUBSYS 800 MCG/SPRAY SUBLINGUAL SPRAY ^{DL,SP}	*	PA,QL(120 per 30 days)
subvenite 100 mg tablet ^{MM}	1	
subvenite 150 mg tablet ^{MM}	1	
subvenite 200 mg tablet ^{MM}	1	
subvenite 25 mg tablet ^{MM}	1	
subvenite starter (blue) kit 25 mg (35) tablets in a dose pack	1	
subvenite starter (green) kit 25 mg (84)-100 mg (14) tablet, dose pack	1	
subvenite starter (orange) kit 25 mg (42)-100 mg (7) tablet, dose pack	1	
SUCRAID 8,500 UNIT/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA
sucralfate 1 gram tablet ^{MM}	1	
sucralfate 100 mg/ml oral suspension ^{MM}	1	
SULAR 17 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
SULAR 34 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
SULAR 8.5 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
sulconazole 1 % topical cream	1	ST
sulconazole 1 % topical solution	1	ST
sulfacetamide sodium (acne) 10 % lotion (suspension)	1	
sulfacetamide sodium 10 % eye drops	1	
sulfacetamide sodium 10 % eye ointment	1	
sulfacetamide-prednisolone 10 %-0.23 % (0.25 %) eye drops	1	
sulfadiazine 500 mg tablet	1	
sulfamethoxazole 200 mg-trimethoprim 40 mg/5 ml oral suspension	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
sulfamethoxazole 400 mg-trimethoprim 80 mg tablet	1	
sulfamethoxazole 800 mg-trimethoprim 160 mg tablet	1	
SULFAMYLON 50 GRAM TOPICAL PACKET	3	
SULFAMYLON 85 MG/G TOPICAL CREAM	3	
sulfasalazine 500 mg tablet ^{MM}	1	QL(240 per 30 days)
sulfasalazine 500 mg tablet,delayed release ^{MM}	1	QL(240 per 30 days)
SULFATRIM 200 MG-40 MG/5 ML ORAL SUSPENSION	3	
sulindac 150 mg tablet	1	
sulindac 200 mg tablet	1	
sumatriptan 100 mg tablet	1	QL(9 per 30 days)
sumatriptan 20 mg/actuation nasal spray	1	QL(12 per 30 days)
sumatriptan 25 mg tablet	1	QL(9 per 30 days)
sumatriptan 4 mg/0.5 ml subcutaneous cartridge (refill)	1	QL(6 per 30 days)
sumatriptan 4 mg/0.5 ml subcutaneous pen injector	1	QL(6 per 30 days)
sumatriptan 5 mg/actuation nasal spray	1	QL(12 per 30 days)
sumatriptan 50 mg tablet	1	QL(9 per 30 days)
sumatriptan 6 mg/0.5 ml subcutaneous cartridge (refill)	1	QL(6 per 30 days)
sumatriptan 6 mg/0.5 ml subcutaneous pen injector	1	QL(6 per 30 days)
sumatriptan 6 mg/0.5 ml subcutaneous solution	1	QL(6 per 30 days)
sumatriptan 6 mg/0.5 ml subcutaneous syringe	1	QL(3 per 30 days)
sumatriptan 85 mg-naproxen 500 mg tablet	1	ST,QL(18 per 30 days)
sunitinib malate 12.5 mg capsule ^{DL,SP}	*	PA,QL(28 per 28 days)
sunitinib malate 25 mg capsule ^{DL,SP}	*	PA,QL(28 per 28 days)
sunitinib malate 37.5 mg capsule ^{DL,SP}	*	PA,QL(28 per 28 days)
sunitinib malate 50 mg capsule ^{DL,SP}	*	PA,QL(28 per 28 days)
SUNLENCA 300 MG TABLET ^{DL,SP}	*	PA,QL(10 per 365 days)
SUNLENCA 309 MG/ML SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(9 per 365 days)
SUNOSI 150 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
SUNOSI 75 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
SUPER THIN LANCETS ^{MM}	2	
SUPER THIN LANCETS 28 GAUGE ^{MM}	2	
SUPER THIN LANCETS 30 GAUGE ^{MM}	2	
SUPRANE 100 % INHALATION LIQUID	3	
SUPRAX 100 MG CHEWABLE TABLET	3	
SUPRAX 100 MG/5 ML ORAL SUSPENSION	3	
SUPRAX 200 MG CHEWABLE TABLET	3	
SUPRAX 200 MG/5 ML ORAL SUSPENSION	3	
SUPRAX 400 MG CAPSULE	3	
SUPRAX 500 MG/5 ML ORAL SUSPENSION	3	
SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION	3	ST
SURE COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SURE COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 1/4" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4" ^{MM}	2	
SURE COMFORT INSULIN SYRINGE U-100 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT LANCETS 18 GAUGE ^{MM}	2	
SURE COMFORT LANCETS 21 GAUGE ^{MM}	2	
SURE COMFORT LANCETS 23 GAUGE ^{MM}	2	
SURE COMFORT LANCETS 28 GAUGE ^{MM}	2	
SURE COMFORT LANCETS 30 GAUGE ^{MM}	2	
SURE COMFORT LANCING PEN	2	
SURE COMFORT PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
SURE COMFORT PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
SURE COMFORT PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
SURE COMFORT PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
SURE COMFORT PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
SURE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
SURE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
SURE-FINE PEN NEEDLES 29 GAUGE X 1/2" ^{MM}	2	
SURE-FINE PEN NEEDLES 31 GAUGE X 3/16" ^{MM}	2	
SURE-FINE PEN NEEDLES 31 GAUGE X 5/16" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
SURE-JECT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
SURE-LANCE ^{MM}	2	
SURE-LANCE 26 GAUGE ^{MM}	2	
SURE-LANCE 28 GAUGE ^{MM}	2	
SURE-LANCE ULTRA THIN 30 GAUGE ^{MM}	2	
SURE-PEN LANCING DEVICE	3	
SURE-TEST EASYPLUS MINI METER ^{MM}	3	ST
SURE-TEST EASYPLUS MINI SOLUTION ^{MM}	3	
SURE-TEST EASYPLUS MINI STRIPS ^{MM}	3	ST,QL(150 per 30 days)
SURE-TOUCH LANCET ^{MM}	3	
SUREFLEX LANCING DEVICE	3	
SUREFLEX LANCING DEVICE WITH LANCETS KIT ^{MM}	3	
SURGUARD2 SAFETY 1 ML 25 GAUGE X 5/8" SYRINGE	2	
SURGUARD2 SAFETY 1 ML 26 GAUGE X 3/8" SYRINGE	2	
SURGUARD2 SAFETY 1 ML 27 GAUGE X 1/2" SYRINGE	2	
SURGUARD2 SAFETY 10 ML 20 GAUGE X 1 1/2" SYRINGE	2	
SURGUARD2 SAFETY 10 ML 20 GAUGE X 1" SYRINGE	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SURGUARD2 SAFETY 18 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 18 GAUGE X 1" NEEDLE	2	
SURGUARD2 SAFETY 19 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 19 GAUGE X 1" NEEDLE	2	
SURGUARD2 SAFETY 20 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 20 GAUGE X 1" NEEDLE	2	
SURGUARD2 SAFETY 21 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 21 GAUGE X 1" NEEDLE	2	
SURGUARD2 SAFETY 22 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 22 GAUGE X 1" NEEDLE	2	
SURGUARD2 SAFETY 23 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 23 GAUGE X 1" NEEDLE	2	
SURGUARD2 SAFETY 25 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 25 GAUGE X 1" NEEDLE	2	
SURGUARD2 SAFETY 25 GAUGE X 5/8" NEEDLE	2	
SURGUARD2 SAFETY 26 GAUGE X 1/2" NEEDLE	2	
SURGUARD2 SAFETY 27 GAUGE X 1/2" NEEDLE	2	
SURGUARD2 SAFETY 3 ML 20 GAUGE X 1 1/2" SYRINGE	2	
SURGUARD2 SAFETY 3 ML 20 GAUGE X 1" SYRINGE	2	
SURGUARD2 SAFETY 3 ML 21 GAUGE X 1" SYRINGE	2	
SURGUARD2 SAFETY 3 ML 22 GAUGE X 1 1/2" SYRINGE	2	
SURGUARD2 SAFETY 3 ML 22 GAUGE X 1" SYRINGE	2	
SURGUARD2 SAFETY 3 ML 23 GAUGE X 1" SYRINGE	2	
SURGUARD2 SAFETY 3 ML 25 GAUGE X 5/8" SYRINGE	2	
SURGUARD2 SAFETY 30 GAUGE X 1 1/2" NEEDLE	2	
SURGUARD2 SAFETY 5 ML 20 GAUGE X 1 1/2" SYRINGE	2	
SURGUARD2 SAFETY 5 ML 20 GAUGE X 1" SYRINGE	2	
SURGUARD2 SAFETY 5 ML 21 GAUGE X 1 1/2" SYRINGE	2	
SURGUARD2 SAFETY SYRINGE 10 ML 21 GAUGE X 1 1/2"	2	
SURGUARD2 SAFETY SYRINGE 3 ML 21 GAUGE X 1 1/2"	2	
SURGUARD2 SAFETY SYRINGE 3 ML 25 GAUGE X 1"	2	
SURVANTA 25 MG/ML INTRATRACHEAL SUSPENSION	3	
SUSTIVA 200 MG CAPSULE ^{MM}	3	QL(120 per 30 days)
SUSTIVA 50 MG CAPSULE ^{MM}	3	QL(480 per 30 days)
SUSTIVA 600 MG TABLET ^{MM}	3	QL(30 per 30 days)
SUSTOL 10 MG/0.4 ML LIQUID,EXTENDED RELEASE SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.6 per 28 days)
SUTAB 1.479-0.188-0.225 GRAM TABLET	3	ST
SUTENT 12.5 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(28 per 28 days)
SUTENT 25 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(28 per 28 days)
SUTENT 37.5 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(28 per 28 days)
SUTENT 50 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(28 per 28 days)
syeda 3 mg-0.03 mg tablet ^{MM}	1	
symax fastabs 0.125 mg disintegrating tablet ^{MM}	1	
symax-sl 0.125 mg sublingual tablet ^{MM}	1	
symax-sr 0.375 mg tablet,extended release ^{MM}	1	
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER ^{MM}	3	ST,QL(10.2 per 30 days)
SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER ^{MM}	3	ST,QL(10.2 per 30 days)
SYMBYAX 12 MG-50 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
SYMBYAX 3 MG-25 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
SYMBYAX 6 MG-25 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
SYMBYAX 6 MG-50 MG CAPSULE ^{MM}	3	QL(30 per 30 days)
SYMDEKO 100 MG-150 MG (DAY)/150 MG (NIGHT) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
SYMDEKO 50 MG-75 MG (DAY)/75 MG (NIGHT) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
SYMFI 600 MG-300 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
SYMFI LO 400 MG-300 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
SYMJEPI 0.15 MG/0.3 ML INJECTION SYRINGE (FOR 33 LB TO 66 LB PATIENTS)	2	QL(4 per 30 days)
SYMJEPI 0.3 MG/0.3 ML INJECTION SYRINGE	2	QL(4 per 30 days)
SYMLINPEN 120 2,700 MCG/2.7 ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	QL(10.8 per 30 days)
SYMLINPEN 60 1,500 MCG/1.5 ML SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	QL(10.5 per 28 days)
SYMPAZAN 10 MG ORAL FILM ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SYMPAZAN 20 MG ORAL FILM ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SYMPAZAN 5 MG ORAL FILM ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
SYMPROIC 0.2 MG TABLET	3	PA,QL(30 per 30 days)
SYMITUZA 800 MG-150 MG-200 MG-10 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
SYNALAR 0.01 % TOPICAL SOLUTION	3	
SYNALAR 0.025 % TOPICAL CREAM	3	
SYNALAR 0.025 % TOPICAL OINTMENT	3	
SYNAREL 2 MG/ML NASAL SPRAY ^{DL,SP}	*	PA,QL(32 per 25 days)
SYNDROS 5 MG/ML ORAL SOLUTION ^{DL,SP}	*	PA,QL(120 per 30 days)
SYNERA 70 MG-70 MG PATCH	3	PA
SYNJARDY 12.5 MG-1,000 MG TABLET ^{MM}	2	QL(60 per 30 days)
SYNJARDY 12.5 MG-500 MG TABLET ^{MM}	2	QL(60 per 30 days)
SYNJARDY 5 MG-1,000 MG TABLET ^{MM}	2	QL(60 per 30 days)
SYNJARDY 5 MG-500 MG TABLET ^{MM}	2	QL(60 per 30 days)
SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
SYNTHROID 100 MCG TABLET ^{MM}	2	
SYNTHROID 112 MCG TABLET ^{MM}	2	
SYNTHROID 125 MCG TABLET ^{MM}	2	
SYNTHROID 137 MCG TABLET ^{MM}	2	
SYNTHROID 150 MCG TABLET ^{MM}	2	
SYNTHROID 175 MCG TABLET ^{MM}	2	
SYNTHROID 200 MCG TABLET ^{MM}	2	
SYNTHROID 25 MCG TABLET ^{MM}	2	
SYNTHROID 300 MCG TABLET ^{MM}	2	
SYNTHROID 50 MCG TABLET ^{MM}	2	
SYNTHROID 75 MCG TABLET ^{MM}	2	
SYNTHROID 88 MCG TABLET ^{MM}	2	
SYPRINE 250 MG CAPSULE ^{DL,SP}	*	PA
SYRINGE (DISPOSABLE) 30 ML	3	
SYRINGE (DISPOSABLE) 5 ML	3	
SYRINGE (DISPOSABLE) 60 ML	3	
SYRINGE (REUSABLE) 3 ML	3	
SYRINGE WITH NEEDLE, SAFETY 1 ML 25 GAUGE X 5/8"	3	
SYRINGE WITH NEEDLE, SAFETY 3 ML 22 GAUGE X 1"	3	
TABLOID 40 MG TABLET	3	QL(360 per 30 days)
TABRECTA 150 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(112 per 28 days)
TABRECTA 200 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(112 per 28 days)
TACLONEX 0.005 %-0.064 % TOPICAL OINTMENT	3	PA,QL(60 per 30 days)
TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION ^{DL,SP}	*	PA,QL(420 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
tacrolimus 0.03 % topical ointment	1	
tacrolimus 0.1 % topical ointment	1	
tacrolimus 0.5 mg capsule, immediate-release ^{MM}	1	
tacrolimus 1 mg capsule, immediate-release ^{MM}	1	
tacrolimus 5 mg capsule, immediate-release ^{MM}	1	QL(180 per 30 days)
tadalafil 20 mg tablet (pulmonary hypertension) ^{MM}	1	PA,QL(60 per 30 days)
TADLIQ 20 MG/5 ML (4 MG/ML) ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
TAFINLAR 50 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
TAFINLAR 75 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
tafluprost (pf) 0.0015 % eye drops in a dropperette ^{MM}	3	ST,QL(30 per 30 days)
TAGRISSO 40 MG TABLET ^{DL,SP}	*	PA,QL(30 per 30 days)
TAGRISSO 80 MG TABLET ^{DL,SP}	*	PA,QL(30 per 30 days)
TAKHZYRO 150 MG/ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(2 per 28 days)
TAKHZYRO 300 MG/2 ML (150 MG/ML) SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
TAKHZYRO 300 MG/2 ML (150 MG/ML) SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
TALICIA 10 MG-250 MG-12.5 MG CAPSULE,IMMEDIATE - DELAY RELEASE	3	ST,QL(168 per 30 days)
TALTZ AUTOINJECTOR (2 PACK) 80 MG/ML SUBCUTANEOUS ^{DL,LD,MM,SP}	*	PA,QL(18 per 365 days)
TALTZ AUTOINJECTOR (3 PACK) 80 MG/ML SUBCUTANEOUS ^{DL,LD,MM,SP}	*	PA,QL(18 per 365 days)
TALTZ AUTOINJECTOR 80 MG/ML SUBCUTANEOUS ^{DL,LD,MM,SP}	*	PA,QL(18 per 365 days)
TALTZ SYRINGE 80 MG/ML SUBCUTANEOUS ^{DL,LD,MM,SP}	*	PA,QL(18 per 365 days)
TALZENNA 0.25 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(90 per 30 days)
TALZENNA 0.5 MG CAPSULE ^{DL,SP}	*	PA,QL(30 per 30 days)
TALZENNA 0.75 MG CAPSULE ^{DL,SP}	*	PA,QL(30 per 30 days)
TALZENNA 1 MG CAPSULE ^{DL,LD,SP}	*	PA,QL(30 per 30 days)
TAMIFLU 30 MG CAPSULE	3	QL(224 per 365 days)
TAMIFLU 45 MG CAPSULE	3	QL(112 per 365 days)
TAMIFLU 6 MG/ML ORAL SUSPENSION	3	QL(1440 per 365 days)
TAMIFLU 75 MG CAPSULE	3	QL(112 per 365 days)
tamoxifen 10 mg tablet ^{MM}	1	
tamoxifen 20 mg tablet ^{MM}	1	
tamsulosin 0.4 mg capsule ^{MM}	1	QL(60 per 30 days)
TANDEM PLUS 162 MG-115.2 MG (106 MG)-1 MG CAPSULE	3	
TAPAZOLE 10 MG TABLET ^{MM}	3	
TAPAZOLE 5 MG TABLET ^{MM}	3	
taperdex 1.5 mg (21 tabs) tablets in a dose pack	1	
taperdex 1.5 mg (27 tabs) tablets in a dose pack	1	
taperdex 1.5 mg (49 tabs) tablets in a dose pack	1	
TARCEVA 100 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
TARCEVA 150 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
TARCEVA 25 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(90 per 30 days)
TARGADOX 50 MG TABLET ^{DL,SP}	*	ST,QL(180 per 30 days)
TARGETIN 1 % TOPICAL GEL ^{DL,SP}	*	PA,QL(240 per 30 days)
TARGETIN 75 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
tarina 24 fe 1 mg-20 mcg (24)/75 mg (4) tablet ^{MM}	1	
tarina fe 1-20 eq (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
tarina fe 1/20 (28) 1 mg-20 mcg (21)/75 mg (7) tablet ^{MM}	1	
TARKA 2 MG-180 MG TABLET, EXTENDED RELEASE ^{MM}	3	
TARKA 2 MG-240 MG TABLET, EXTENDED RELEASE ^{MM}	3	
TARKA 4 MG-240 MG TABLET, EXTENDED RELEASE ^{MM}	3	
TARPEYO 4 MG CAPSULE,DELAYED RELEASE ^{DL,SP}	*	PA,QL(120 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TASCENSO ODT 0.25 MG DISINTEGRATING TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
TASCENSO ODT 0.5 MG DISINTEGRATING TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
TASIGNA 150 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
TASIGNA 200 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
TASIGNA 50 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
tasimelteon 20 mg capsule ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
TASMAR 100 MG TABLET ^{MM}	3	PA,QL(90 per 30 days)
TAVALISSE 100 MG TABLET ^{DL,SP}	*	PA,QL(60 per 30 days)
TAVALISSE 150 MG TABLET ^{DL,SP}	*	PA,QL(60 per 30 days)
TAVNEOS 10 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
taysofy 1 mg-20 mcg (24)/75 mg (4) capsule ^{MM}	1	
TAYTULLA 1 MG-20 MCG (24)/75 MG (4) CAPSULE ^{MM}	2	
tazarotene 0.05 % topical gel	1	PA
tazarotene 0.1 % topical cream	1	PA
tazarotene 0.1 % topical foam	3	PA
tazarotene 0.1 % topical gel	1	PA
TAZORAC 0.05 % TOPICAL CREAM	3	PA
TAZORAC 0.05 % TOPICAL GEL	3	PA
TAZORAC 0.1 % TOPICAL CREAM	3	PA
TAZORAC 0.1 % TOPICAL GEL	3	PA
taztia xt 120 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
taztia xt 180 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
taztia xt 240 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
taztia xt 300 mg capsule,extended release ^{MM}	1	QL(30 per 30 days)
taztia xt 360 mg capsule,extended release ^{MM}	1	QL(30 per 30 days)
TAZVERIK 200 MG TABLET ^{DL,MM,SP}	*	PA
TD GOLD BLOOD GLUCOSE MONITOR ^{MM}	3	ST
TD GOLD LEVEL 1 CONTROL SOLUTION ^{MM}	3	
TD GOLD LEVEL 2 CONTROL SOLUTION ^{MM}	3	
TD GOLD LEVEL 3 CONTROL SOLUTION ^{MM}	3	
TD GOLD TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
TD GOLD VOICE GLUCOSE MONITOR ^{MM}	3	ST
TDVAX 2 LF UNIT-2 LF UNIT/0.5 ML INTRAMUSCULAR SUSPENSION	1	
TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE ^{DL,LD,SP}	*	PA,QL(60 per 30 days)
TECFIDERA 120 MG CAPSULE,DELAYED RELEASE ^{DL,LD,MM,SP}	*	PA,QL(14 per 30 days)
TECFIDERA 240 MG CAPSULE,DELAYED RELEASE ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" ^{MM}	2	
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 15/64" ^{MM}	2	
TECHLITE INSULIN SYRINGE (HALF UNIT) 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
TECHLITE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
TECHLITE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
TECHLITE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 15/64" ^{MM}	2	
TECHLITE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
TECHLITE LANCETS 25 GAUGE ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TECHLITE LANCETS 28 GAUGE ^{MM}	2	
TECHLITE LANCETS 30 GAUGE ^{MM}	2	
TECHLITE PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
TECHLITE PEN NEEDLE 29 GAUGE X 3/8" ^{MM}	2	
TECHLITE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
TECHLITE PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
TECHLITE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
TECHLITE PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
TECHLITE PEN NEEDLE 32 GAUGE X 5/16" ^{MM}	2	
TECHLITE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
TEGRETOL 100 MG/5 ML ORAL SUSPENSION ^{MM}	3	
TEGRETOL 200 MG TABLET ^{MM}	3	
TEGRETOL XR 100 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(120 per 30 days)
TEGRETOL XR 200 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(120 per 30 days)
TEGRETOL XR 400 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(120 per 30 days)
TEGSEDI 284 MG/1.5 ML SUBCUTANEOUS SYRINGE ^{DL,MM,SP}	*	PA,QL(6 per 28 days)
TEKURNA 150 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TEKURNA 300 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TEKURNA HCT 150 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TEKURNA HCT 150 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TEKURNA HCT 300 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TEKURNA HCT 300 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TELCARE BGM KIT ^{MM}	3	ST
TELCARE BLOOD GLUCOSE KIT ^{MM}	3	ST
TELCARE CONTROL SOLUTION ^{MM}	3	
TELCARE LANCETS 30 GAUGE ^{MM}	3	
TELCARE TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
telmisartan 20 mg tablet ^{MM}	1	QL(30 per 30 days)
telmisartan 40 mg tablet ^{MM}	1	QL(30 per 30 days)
telmisartan 40 mg-amlodipine 10 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
telmisartan 40 mg-amlodipine 5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
telmisartan 40 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
telmisartan 80 mg tablet ^{MM}	1	QL(60 per 30 days)
telmisartan 80 mg-amlodipine 10 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
telmisartan 80 mg-amlodipine 5 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
telmisartan 80 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	ST,QL(60 per 30 days)
telmisartan 80 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
temazepam 15 mg capsule ^{DL}	1	QL(30 per 30 days)
temazepam 22.5 mg capsule ^{DL}	1	QL(30 per 30 days)
temazepam 30 mg capsule ^{DL}	1	QL(30 per 30 days)
temazepam 7.5 mg capsule ^{DL}	1	QL(30 per 30 days)
TEMBEXA 10 MG/ML ORAL SUSPENSION	3	QL(40 per 14 days)
TEMBEXA 100 MG TABLET	3	QL(4 per 14 days)
TEMIXYS 300 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
TEMODAR 100 MG CAPSULE ^{DL,SP}	*	PA,QL(60 per 30 days)
TEMODAR 140 MG CAPSULE ^{DL,SP}	*	PA,QL(60 per 30 days)
TEMODAR 180 MG CAPSULE ^{DL,SP}	*	PA,QL(60 per 30 days)
TEMODAR 250 MG CAPSULE ^{DL,SP}	*	PA,QL(10 per 30 days)
TEMOVATE 0.05 % TOPICAL CREAM	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TEMOVATE 0.05 % TOPICAL OINTMENT	3	ST
temozolomide 100 mg capsule ^{DL,SP}	*	PA,QL(60 per 30 days)
temozolomide 140 mg capsule ^{DL,SP}	*	PA,QL(60 per 30 days)
temozolomide 180 mg capsule ^{DL,SP}	*	PA,QL(60 per 30 days)
temozolomide 20 mg capsule ^{DL,SP}	*	PA,QL(270 per 30 days)
temozolomide 250 mg capsule ^{DL,SP}	*	PA,QL(10 per 30 days)
temozolomide 5 mg capsule ^{DL,SP}	*	PA,QL(90 per 30 days)
tencon 50 mg-325 mg tablet	1	QL(180 per 30 days)
TENIVAC (PF) 5 LF UNIT-2 LF UNIT/0.5 ML INTRAMUSCULAR SUSPENSION	3	
TENIVAC (PF) 5 LF UNIT-2 LF UNIT/0.5 ML INTRAMUSCULAR SYRINGE	3	
tenofovir disoproxil fumarate 300 mg tablet ^{MM}	1	QL(30 per 30 days)
TENORETIC 100 100 MG-25 MG TABLET ^{MM}	3	
TENORETIC 50 50 MG-25 MG TABLET ^{MM}	3	
TENORMIN 100 MG TABLET ^{MM}	3	
TENORMIN 25 MG TABLET ^{MM}	3	
TENORMIN 50 MG TABLET ^{MM}	3	
TEPMETKO 225 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
terazosin 1 mg capsule ^{MM}	1	
terazosin 10 mg capsule ^{MM}	1	
terazosin 2 mg capsule ^{MM}	1	
terazosin 5 mg capsule ^{MM}	1	
terbutaline 2.5 mg tablet ^{MM}	1	
terbutaline 5 mg tablet ^{MM}	1	
terconazole 0.4 % vaginal cream	1	
terconazole 0.8 % vaginal cream	1	
terconazole 80 mg vaginal suppository	1	
teriflunomide 14 mg tablet ^{MM}	1	PA,QL(30 per 30 days)
teriflunomide 7 mg tablet ^{MM}	1	PA,QL(30 per 30 days)
TERIPARATIDE 20 MCG/DOSE (620 MCG/2.48 ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(2.48 per 30 days)
TERUMO INSULIN SYRINGE 0.3 ML 30 X 3/8" ^{MM}	2	
TERUMO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
TERUMO INSULIN SYRINGE 1 ML 27 GAUGE X 1/2" ^{MM}	2	
TERUMO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
TERUMO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
TERUMO INSULIN SYRINGE 1/2 ML 27 GAUGE X 1/2" ^{MM}	2	
TERUMO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
TERUMO INSULIN SYRINGE 1/2 ML 30 X 3/8" ^{MM}	2	
TESSALON PERLES 100 MG CAPSULE	3	
TEST N'GO BLOOD GLUCOSE SYSTEM ^{MM}	3	ST
TEST N'GO TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
TESTIM 50 MG/5 GRAM (1 %) TRANSDERMAL GEL ^{MM}	3	PA,QL(300 per 30 days)
TESTOPEL 75 MG IMPLANT PELLETT ^{MM}	3	PA,QL(12 per 180 days)
testosterone 1 % (25 mg/2.5 gram) transdermal gel packet ^{MM}	1	PA,QL(300 per 30 days)
testosterone 1 % (50 mg/5 gram) transdermal gel packet ^{MM}	1	PA,QL(300 per 30 days)
testosterone 1.62 % (20.25 mg/1.25 gram) transdermal gel packet ^{MM}	1	PA,QL(37.5 per 30 days)
testosterone 1.62 % (40.5 mg/2.5 gram) transdermal gel packet ^{MM}	1	PA,QL(150 per 30 days)
testosterone 10 mg/0.5 gram/actuation transdermal gel pump ^{MM}	1	PA,QL(120 per 30 days)
testosterone 12.5 mg/1.25 gram per pump actuation (1%) transdermal gel ^{MM}	1	PA,QL(300 per 30 days)
testosterone 20.25 mg/1.25 gram per pump act.(1.62 %) transdermal gel ^{MM}	1	PA,QL(150 per 30 days)
testosterone 30 mg/actuation (1.5 ml) transderm solution metered pump ^{MM}	1	PA,QL(180 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
testosterone 50 mg/5 gram (1 %) transdermal gel ^{MM}	1	PA,QL(300 per 30 days)
testosterone cypionate 100 mg/ml intramuscular oil ^{MM}	1	QL(24 per 90 days)
testosterone cypionate 200 mg/ml intramuscular oil ^{MM}	1	QL(24 per 90 days)
testosterone enanthate 200 mg/ml intramuscular oil	1	QL(24 per 90 days)
TESTRED 10 MG CAPSULE ^{DL,MM,SP}	*	
tetrabenazine 12.5 mg tablet ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
tetrabenazine 25 mg tablet ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
tetracycline 250 mg capsule	1	
tetracycline 500 mg capsule	1	
TEXACORT 2.5 % TOPICAL SOLUTION	3	
TEZSPIRE 210 MG/1.91 ML (110 MG/ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(1.91 per 28 days)
THALITONE 15 MG TABLET ^{MM}	3	
THALOMID 100 MG CAPSULE ^{LD,MM}	3	PA,QL(30 per 30 days)
THALOMID 150 MG CAPSULE ^{LD,MM}	3	PA,QL(60 per 30 days)
THALOMID 200 MG CAPSULE ^{LD,MM}	3	PA,QL(30 per 30 days)
THALOMID 50 MG CAPSULE ^{LD,MM}	3	PA,QL(30 per 30 days)
THEO-24 100 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
THEO-24 200 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
THEO-24 300 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
THEO-24 400 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	
theophylline 80 mg/15 ml oral elixir ^{MM}	1	
theophylline 80 mg/15 ml oral solution ^{MM}	1	
theophylline er 300 mg tablet,extended release,12 hr ^{MM}	1	
theophylline er 400 mg tablet,extended release 24 hr ^{MM}	1	
theophylline er 450 mg tablet,extended release,12 hr ^{MM}	1	
theophylline er 600 mg tablet,extended release 24 hr ^{MM}	1	
THIN LANCETS 26 GAUGE ^{MM}	2	
THINPRO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
THINPRO INSULIN SYRINGE 0.3 ML 30 X 3/8" ^{MM}	2	
THINPRO INSULIN SYRINGE 0.3 ML 31 X 3/8" ^{MM}	2	
THINPRO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
THINPRO INSULIN SYRINGE 0.5 ML 31 X 3/8" ^{MM}	2	
THINPRO INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
THINPRO INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
THINPRO INSULIN SYRINGE 1 ML 30 GAUGE X 3/8" ^{MM}	2	
THINPRO INSULIN SYRINGE 1 ML 31 X 3/8" ^{MM}	2	
THINPRO INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
THINPRO INSULIN SYRINGE 1/2 ML 30 X 3/8" ^{MM}	2	
THIOLA 100 MG TABLET ^{DL,MM,SP}	*	PA
THIOLA EC 100 MG TABLET,DELAYED RELEASE ^{DL,MM,SP}	*	PA
THIOLA EC 300 MG TABLET,DELAYED RELEASE ^{DL,MM,SP}	*	PA
thioridazine 10 mg tablet ^{MM}	1	
thioridazine 100 mg tablet ^{MM}	1	
thioridazine 25 mg tablet ^{MM}	1	
thioridazine 50 mg tablet ^{MM}	1	
thiothixene 1 mg capsule ^{MM}	1	
thiothixene 10 mg capsule ^{MM}	1	
thiothixene 2 mg capsule ^{MM}	1	
thiothixene 5 mg capsule ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
THRESHOLD IMT TRAINER DEVICE	3	
THRESHOLD PEP DEVICE	3	
THYQUIDITY 20 MCG/ML ORAL SOLUTION ^{MM}	3	
tiadylt er 120 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
tiadylt er 180 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
tiadylt er 240 mg capsule,extended release ^{MM}	1	QL(60 per 30 days)
tiadylt er 300 mg capsule,extended release ^{MM}	1	QL(30 per 30 days)
tiadylt er 360 mg capsule,extended release ^{MM}	1	QL(30 per 30 days)
tiadylt er 420 mg capsule,extended release ^{MM}	1	QL(30 per 30 days)
tiagabine 12 mg tablet ^{DL,MM,SP}	*	QL(140 per 30 days)
tiagabine 16 mg tablet ^{DL,MM,SP}	*	QL(105 per 30 days)
tiagabine 2 mg tablet ^{DL,MM,SP}	*	QL(840 per 30 days)
tiagabine 4 mg tablet ^{DL,MM,SP}	*	QL(120 per 30 days)
TIAZAC 120 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
TIAZAC 180 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
TIAZAC 240 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
TIAZAC 300 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
TIAZAC 360 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
TIAZAC 420 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
TIBSOVO 250 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
TIGAN 300 MG CAPSULE	3	
TIGLUTIK 50 MG/10 ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(600 per 30 days)
TIKOSYN 125 MCG CAPSULE ^{MM}	3	QL(240 per 30 days)
TIKOSYN 250 MCG CAPSULE ^{MM}	3	QL(120 per 30 days)
TIKOSYN 500 MCG CAPSULE ^{MM}	3	QL(60 per 30 days)
tilia fe 1-20 (5)/1-30(7)/1mg-35mcg(9) tablet ^{MM}	1	
timolol 10 mg tablet ^{MM}	1	
timolol 20 mg tablet ^{MM}	1	
timolol 5 mg tablet ^{MM}	1	
timolol maleate (pf) 0.25 % eye drops in a dropperette ^{MM}	1	
timolol maleate (pf) 0.5 % eye drops in a dropperette ^{MM}	1	
timolol maleate 0.25 % eye drops ^{MM}	1	QL(25 per 90 days)
timolol maleate 0.25 % eye gel forming solution ^{MM}	1	
timolol maleate 0.5 % eye drops ^{MM}	1	QL(25 per 90 days)
timolol maleate 0.5 % eye gel forming solution ^{MM}	1	QL(5 per 50 days)
timolol maleate 0.5 % once daily eye drops ^{MM}	1	
TIMOPTIC 0.25 % EYE DROPS ^{MM}	3	QL(25 per 90 days)
TIMOPTIC 0.5 % EYE DROPS ^{MM}	3	QL(25 per 90 days)
TIMOPTIC OCUDOSE (PF) 0.25 % EYE DROPS IN A DROPPERETTE ^{MM}	3	
TIMOPTIC OCUDOSE (PF) 0.5 % EYE DROPS IN A DROPPERETTE ^{MM}	3	
TIMOPTIC-XE 0.25 % EYE GEL ^{MM}	3	
TIMOPTIC-XE 0.5 % EYE GEL ^{MM}	3	QL(5 per 50 days)
tinidazole 250 mg tablet	1	
tinidazole 500 mg tablet	1	
tiopronin 100 mg tablet ^{DL,MM,SP}	*	PA
TIROSINT 100 MCG CAPSULE ^{MM}	3	ST
TIROSINT 112 MCG CAPSULE ^{MM}	3	ST
TIROSINT 125 MCG CAPSULE ^{MM}	3	ST
TIROSINT 13 MCG CAPSULE ^{MM}	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TIROSINT 137 MCG CAPSULE ^{MM}	3	ST
TIROSINT 150 MCG CAPSULE ^{MM}	3	ST
TIROSINT 175 MCG CAPSULE ^{MM}	3	ST
TIROSINT 200 MCG CAPSULE ^{MM}	3	ST
TIROSINT 25 MCG CAPSULE ^{MM}	3	ST
TIROSINT 37.5 MCG CAPSULE ^{MM}	3	ST
TIROSINT 44 MCG CAPSULE ^{MM}	3	ST
TIROSINT 50 MCG CAPSULE ^{MM}	3	ST
TIROSINT 62.5 MCG CAPSULE ^{MM}	3	ST
TIROSINT 75 MCG CAPSULE ^{MM}	3	ST
TIROSINT 88 MCG CAPSULE ^{MM}	3	ST
TIROSINT-SOL 100 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 112 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 125 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 13 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 137 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 150 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 175 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 200 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 25 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 37.5 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 44 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 50 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 62.5 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 75 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIROSINT-SOL 88 MCG/ML ORAL SOLUTION ^{MM}	3	ST
TIS-U-SOL PENTALYTE 800-40-20-8.75-6.25 MG/100 ML IRRIGATION SOLUTION	3	
TIVICAY 10 MG TABLET ^{MM,SP}	*	QL(60 per 30 days)
TIVICAY 25 MG TABLET ^{MM,SP}	*	QL(60 per 30 days)
TIVICAY 50 MG TABLET ^{MM,SP}	*	QL(60 per 30 days)
TIVICAY PD 5 MG TABLET FOR ORAL SUSPENSION ^{MM,SP}	*	QL(180 per 30 days)
TIVORBEX 20 MG CAPSULE ^{DL,SP}	*	PA,QL(90 per 30 days)
tizanidine 2 mg capsule ^{MM}	1	ST
tizanidine 2 mg tablet ^{MM}	1	
tizanidine 4 mg capsule ^{MM}	1	ST
tizanidine 4 mg tablet ^{MM}	1	
tizanidine 6 mg capsule ^{MM}	1	ST
TLANDO 112.5 MG CAPSULE ^{MM}	3	PA,QL(120 per 30 days)
TOBI 300 MG/5 ML SOLUTION FOR NEBULIZATION ^{DL,LD,MM,SP}	*	PA,QL(280 per 28 days)
TOBI PODHALER 28 MG CAPSULE WITH INHALATION DEVICE ^{DL,LD,MM,SP}	*	PA,QL(224 per 28 days)
TOBRADEX 0.3 %-0.1 % EYE DROPS,SUSPENSION	3	
TOBRADEX 0.3 %-0.1 % EYE OINTMENT	3	
TOBRADEX ST 0.3 %-0.05 % EYE DROPS,SUSPENSION	3	
tobramycin 0.3 % eye drops	1	
tobramycin 0.3 %-dexamethasone 0.1 % eye drops,suspension	1	
tobramycin 300 mg/4 ml solution for nebulization ^{DL,MM,SP}	*	PA,QL(224 per 28 days)
tobramycin 300 mg/5 ml in 0.225 % sodium chloride for nebulization ^{DL,MM,SP}	*	PA,QL(280 per 28 days)
tobramycin with nebulizer 300 mg/5 ml solution for nebulization ^{DL,MM,SP}	*	PA,QL(280 per 28 days)
TOBREX 0.3 % EYE DROPS	3	
TOBREX 0.3 % EYE OINTMENT	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
tolcapone 100 mg tablet ^{MM}	1	PA,QL(90 per 30 days)
tolmetin 200 mg tablet	1	
TOLSURA 65 MG ORAL SOLID DISPERSION CAPSULE ^{DL,SP}	*	PA,QL(120 per 30 days)
tolterodine 1 mg tablet ^{MM}	1	QL(60 per 30 days)
tolterodine 2 mg tablet ^{MM}	1	QL(60 per 30 days)
tolterodine er 2 mg capsule,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
tolterodine er 4 mg capsule,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
tolvaptan 15 mg tablet ^{DL,MM,SP}	*	QL(60 per 30 days)
tolvaptan 30 mg tablet ^{DL,MM,SP}	*	QL(60 per 30 days)
TOOMEY SYRINGE 70 ML	3	
TOPAMAX 100 MG TABLET ^{MM}	3	ST,QL(120 per 30 days)
TOPAMAX 15 MG SPRINKLE CAPSULE ^{MM}	3	QL(120 per 30 days)
TOPAMAX 200 MG TABLET ^{MM}	3	ST,QL(120 per 30 days)
TOPAMAX 25 MG SPRINKLE CAPSULE ^{MM}	3	QL(180 per 30 days)
TOPAMAX 25 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
TOPAMAX 50 MG TABLET ^{MM}	3	ST,QL(120 per 30 days)
TOPCARE CLICKFINE 31 GAUGE X 1/4" NEEDLE ^{MM}	2	
TOPCARE CLICKFINE 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
TOPCARE ULTRA COMFORT 0.3 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 0.3 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 0.3 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 0.5 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 0.5 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 0.5 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 1 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 1 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
TOPCARE ULTRA COMFORT 1 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
TOPCARE UNIVERSAL1 LANCET ^{MM}	2	
TOPCARE UNIVERSAL1 LANCET 33 GAUGE ^{MM}	2	
TOPICORT 0.05 % TOPICAL CREAM	3	ST
TOPICORT 0.05 % TOPICAL GEL	3	ST
TOPICORT 0.05 % TOPICAL OINTMENT	3	ST
TOPICORT 0.25 % TOPICAL CREAM	3	ST
TOPICORT 0.25 % TOPICAL OINTMENT	3	ST
TOPICORT 0.25 % TOPICAL SPRAY	3	ST
topiramate 100 mg tablet ^{MM}	1	QL(120 per 30 days)
topiramate 15 mg sprinkle capsule ^{MM}	1	QL(120 per 30 days)
topiramate 200 mg tablet ^{MM}	1	QL(120 per 30 days)
topiramate 25 mg sprinkle capsule ^{MM}	1	QL(180 per 30 days)
topiramate 25 mg tablet ^{MM}	1	QL(90 per 30 days)
topiramate 50 mg tablet ^{MM}	1	QL(120 per 30 days)
topiramate xr 100 mg capsule sprinkle,extended release 24 hr ^{MM}	1	PA,QL(30 per 30 days)
topiramate xr 100 mg capsule,extended release 24 hr ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
topiramate xr 150 mg capsule sprinkle,extended release 24 hr ^{MM}	1	PA,QL(60 per 30 days)
topiramate xr 200 mg capsule sprinkle,extended release 24 hr ^{MM}	1	PA,QL(60 per 30 days)
topiramate xr 200 mg capsule,extended release 24 hr ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
topiramate xr 25 mg capsule sprinkle,extended release 24 hr ^{MM}	1	PA,QL(90 per 30 days)
topiramate xr 25 mg capsule,extended release 24 hr ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
topiramate xr 50 mg capsule sprinkle,extended release 24 hr ^{MM}	1	PA,QL(30 per 30 days)
topiramate xr 50 mg capsule,extended release 24 hr ^{DL,MM,SP}	*	PA,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TOPROL XL 100 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
TOPROL XL 200 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
TOPROL XL 25 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(90 per 30 days)
TOPROL XL 50 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
toremifene 60 mg tablet ^{DL,MM,SP}	*	QL(30 per 30 days)
toremide 10 mg tablet ^{MM}	1	
toremide 100 mg tablet ^{MM}	1	
toremide 20 mg tablet ^{MM}	1	
toremide 5 mg tablet ^{MM}	1	
TOSYMRA 10 MG/ACTUATION NASAL SPRAY ^{DL,SP}	*	ST,QL(12 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN ^{MM}	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) SUBCUTANEOUS PEN ^{MM}	2	
tovet emollient 0.05 % topical foam	1	ST
TOVIAZ 4 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
TOVIAZ 8 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
TRACLEER 125 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
TRACLEER 32 MG TABLET FOR ORAL SUSPENSION ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
TRACLEER 62.5 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
TRADJENTA 5 MG TABLET ^{MM}	2	QL(30 per 30 days)
tramadol 100 mg tablet ^{DL}	1	QL(120 per 30 days)
tramadol 37.5 mg-acetaminophen 325 mg tablet ^{DL}	1	QL(240 per 30 days)
tramadol 5 mg/ml oral solution ^{DL,SP}	*	PA,QL(2400 per 30 days)
tramadol 50 mg tablet ^{DL}	1	QL(240 per 30 days)
tramadol er 100 mg capsule 24h,extended release(25-75) ^{DL}	1	ST,QL(30 per 30 days)
tramadol er 100 mg tablet,extended release 24 hr ^{DL}	1	QL(30 per 30 days)
tramadol er 100 mg tablet,extended release 24hr mphase ^{DL}	1	QL(30 per 30 days)
tramadol er 200 mg capsule 24h,extended release(25-75) ^{DL}	1	ST,QL(30 per 30 days)
tramadol er 200 mg tablet,extended release 24 hr ^{DL}	1	QL(30 per 30 days)
tramadol er 200 mg tablet,extended release 24hr mphase ^{DL}	1	QL(30 per 30 days)
tramadol er 300 mg capsule 24 hr,extended release ^{DL}	1	ST,QL(30 per 30 days)
tramadol er 300 mg tablet,extended release 24 hr ^{DL}	1	QL(30 per 30 days)
tramadol er 300 mg tablet,extended release 24hr mphase ^{DL}	1	QL(30 per 30 days)
trandolapril 1 mg tablet ^{MM}	1	
trandolapril 1 mg-verapamil er 240 mg tablet,immed-exten release 24 hr ^{MM}	1	
trandolapril 2 mg tablet ^{MM}	1	
trandolapril 2 mg-verapamil er 180 mg tablet,immed-exten release 24 hr ^{MM}	1	
trandolapril 2 mg-verapamil er 240 mg tablet,immed-exten release 24 hr ^{MM}	1	
trandolapril 4 mg tablet ^{MM}	1	
trandolapril 4 mg-verapamil er 240 mg tablet,immed-exten release 24 hr ^{MM}	1	
tranexamic acid 650 mg tablet ^{MM}	1	QL(30 per 5 days)
TRANSDERM-SCOP 1 MG OVER 3 DAYS TRANSDERMAL PATCH	3	QL(10 per 30 days)
TRANXENE T-TAB 7.5 MG TABLET ^{DL}	3	
tranylcypromine 10 mg tablet ^{MM}	1	QL(270 per 30 days)
TRAVATAN Z 0.004 % EYE DROPS ^{MM}	3	ST,QL(2.5 per 25 days)
travoprost 0.004 % eye drops ^{MM}	1	QL(2.5 per 25 days)
trazodone 100 mg tablet ^{MM}	1	
trazodone 150 mg tablet ^{MM}	1	
trazodone 300 mg tablet ^{MM}	1	
trazodone 50 mg tablet ^{MM}	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TRECTOR 250 MG TABLET	3	
TRELEGY ELLIPTA 100 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
TRELEGY ELLIPTA 200 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION ^{MM}	2	QL(60 per 30 days)
TREMFYA 100 MG/ML SUBCUTANEOUS AUTO-INJECTOR ^{MM,SP}	*	PA,QL(2 per 56 days)
TREMFYA 100 MG/ML SUBCUTANEOUS SYRINGE ^{MM,SP}	*	PA,QL(2 per 56 days)
TRESIBA FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	2	
TRESIBA FLEXTOUCH U-200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS PEN ^{MM}	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION ^{MM}	2	
TRETIN-X 0.075 % TOPICAL CREAM	3	PA
tretinoin (antineoplastic) 10 mg capsule ^{DL,SP}	*	PA,QL(360 per 30 days)
tretinoin 0.01 % topical gel	1	PA
tretinoin 0.025 % topical cream	1	PA
tretinoin 0.025 % topical gel	1	PA
tretinoin 0.05 % topical cream	1	PA
tretinoin 0.05 % topical gel	1	PA
tretinoin 0.1 % topical cream	1	PA
tretinoin microspheres 0.04 % topical gel	1	PA
tretinoin microspheres 0.04 % topical gel with pump	1	PA
tretinoin microspheres 0.1 % topical gel	1	PA
tretinoin microspheres 0.1 % topical gel with pump	1	PA
TREXALL 10 MG TABLET ^{MM}	3	
TREXALL 15 MG TABLET ^{MM}	3	
TREXALL 5 MG TABLET ^{MM}	3	
TREXALL 7.5 MG TABLET ^{MM}	3	
TREXIMET 85 MG-500 MG TABLET	3	ST,QL(18 per 30 days)
TREZIX 320.5 MG-30 MG-16 MG CAPSULE ^{DL}	3	QL(300 per 30 days)
tri femynor (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet ^{MM}	1	
tri-estarylla (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet ^{MM}	1	
tri-legest fe 1-20 (5)/1-30(7)/1mg-35mcg(9) tablet ^{MM}	1	
tri-linyah (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet ^{MM}	1	
tri-lo-estarylla 0.18 mg/0.215 mg/0.25 mg-25 mcg tablet ^{MM}	1	
tri-lo-marzia 0.18 mg/0.215 mg/0.25 mg-25 mcg tablet ^{MM}	1	
tri-lo-mili 0.18/0.215/0.25 mg-25 mcg tablet ^{MM}	1	
tri-lo-sprintec 0.18 mg/0.215 mg/0.25 mg-25 mcg tablet ^{MM}	1	
tri-mili (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet ^{MM}	1	
tri-nymyo 0.18/0.215/0.25 mg-35 mcg(28) tablet ^{MM}	1	
tri-previfem (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet ^{MM}	1	
tri-sprintec (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet ^{MM}	1	
tri-vylibra (28) 0.18 mg(7)/0.215 mg(7)/0.25 mg(7)-35 mcg tablet ^{MM}	1	
tri-vylibra lo 0.18/0.215/0.25 mg-25 mcg tablet ^{MM}	1	
triamcinolone acetonide 0.025 % lotion	1	
triamcinolone acetonide 0.025 % topical cream	1	
triamcinolone acetonide 0.025 % topical ointment	1	
triamcinolone acetonide 0.05 % topical ointment	1	ST
triamcinolone acetonide 0.1 % dental paste	1	
triamcinolone acetonide 0.1 % lotion	1	
triamcinolone acetonide 0.1 % topical cream	1	
triamcinolone acetonide 0.1 % topical ointment	1	
triamcinolone acetonide 0.147 mg/gram topical aerosol ^{DL,SP}	*	ST
triamcinolone acetonide 0.5 % topical cream	1	
triamcinolone acetonide 0.5 % topical ointment	1	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
triamterene 100 mg capsule ^{MM}	1	
triamterene 37.5 mg-hydrochlorothiazide 25 mg capsule ^{MM}	1	
triamterene 37.5 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	
triamterene 50 mg capsule ^{MM}	1	
triamterene 75 mg-hydrochlorothiazide 50 mg tablet ^{MM}	1	
trianex 0.05 % topical ointment	1	ST
triazolam 0.125 mg tablet ^{DL}	1	QL(30 per 30 days)
triazolam 0.25 mg tablet ^{DL}	1	QL(30 per 30 days)
TRIBENZOR 20 MG-5 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TRIBENZOR 40 MG-10 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TRIBENZOR 40 MG-10 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TRIBENZOR 40 MG-5 MG-12.5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TRIBENZOR 40 MG-5 MG-25 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TRICARE 27 MG IRON-1 MG TABLET ^{MM}	2	
tricon 110 mg-0.5 mg capsule	1	
TRICOR 145 MG TABLET ^{MM}	3	QL(30 per 30 days)
TRICOR 48 MG TABLET ^{MM}	3	QL(60 per 30 days)
triderm 0.1 % topical cream	1	
triderm 0.5 % topical cream	1	
TRIDESILON 0.05 % TOPICAL CREAM	3	
trientine 250 mg capsule ^{DL,SP}	*	PA
trifluoperazine 1 mg tablet ^{MM}	1	
trifluoperazine 10 mg tablet ^{MM}	1	
trifluoperazine 2 mg tablet ^{MM}	1	
trifluoperazine 5 mg tablet ^{MM}	1	
trifluridine 1 % eye drops	1	
trigels-f forte 460 mg-60 mg-0.01 mg-1 mg capsule	1	
trihexyphenidyl 0.4 mg/ml oral elixir ^{MM}	1	
trihexyphenidyl 2 mg tablet ^{MM}	1	
trihexyphenidyl 5 mg tablet ^{MM}	1	
TRIJARDY XR 10 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
TRIJARDY XR 12.5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
TRIJARDY XR 25 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
TRIJARDY XR 5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
TRIKAFTA 100-50-75 MG (D)/150 MG (N) TABLETS ^{DL,MM,SP}	*	PA,QL(84 per 28 days)
TRIKAFTA 50-25-37.5 MG (D)/75 MG (N) TABLETS ^{DL,MM,SP}	*	PA,QL(84 per 28 days)
TRILEPTAL 150 MG TABLET ^{MM}	3	ST
TRILEPTAL 300 MG TABLET ^{MM}	3	ST
TRILEPTAL 300 MG/5 ML (60 MG/ML) ORAL SUSPENSION ^{MM}	3	
TRILEPTAL 600 MG TABLET ^{MM}	3	ST
TRILIPIX 135 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
TRILIPIX 45 MG CAPSULE,DELAYED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
trilyte with flavor packets 420 gram oral solution	1	
trimethobenzamide 300 mg capsule	1	
trimethoprim 100 mg tablet	1	
trimipramine 100 mg capsule ^{MM}	1	
trimipramine 25 mg capsule ^{MM}	1	
trimipramine 50 mg capsule ^{MM}	1	
trinatal rx 1 60 mg iron-1 mg tablet ^{MM}	1	
TRINATE 28 MG IRON-1 MG TABLET ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TRINTELLIX 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TRINTELLIX 20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TRINTELLIX 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
triphrocaps 1 mg capsule	1	
TRISTART DHA 31 MG IRON-1 MG-200 MG CAPSULE ^{MM}	3	
tritocin 0.05 % topical ointment	1	ST
TRIUMEQ 600 MG-50 MG-300 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
TRIUMEQ PD 60 MG-5 MG-30 MG TABLET FOR ORAL SUSPENSION ^{MM,SP}	*	QL(180 per 30 days)
triveen-duo dha 29 mg-1 mg-400 mg oral pack ^{MM}	1	
trivora (28) 50-30 (6)/75-40(5)/125-30(10) tablet ^{MM}	1	
TRIZIVIR 300 MG-150 MG-300 MG TABLET ^{MM}	3	QL(60 per 30 days)
TROKENDI XR 100 MG CAPSULE, EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
TROKENDI XR 200 MG CAPSULE, EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
TROKENDI XR 25 MG CAPSULE,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
TROKENDI XR 50 MG CAPSULE, EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
TROPHAMINE 10 % INTRAVENOUS SOLUTION	3	
tropicamide 0.5 % eye drops	1	
tropicamide 1 % eye drops	1	
tropium 20 mg tablet ^{MM}	1	QL(60 per 30 days)
tropium er 60 mg capsule,extended release 24 hr ^{MM}	1	QL(30 per 30 days)
TRUDHESA 0.725 MG/PUMP ACT. (4 MG/ML) NASAL SPRAY ^{DL,SP}	*	PA,QL(8 per 30 days)
TRUE COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT LANCET 30 GAUGE ^{MM}	2	
TRUE COMFORT PEN NEEDLE 31 GAUGE X 1/4 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 31 GAUGE X 3/16 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 31 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 32 GAUGE X 1/4 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 32 GAUGE X 3/16 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 32 GAUGE X 5/32 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 33 GAUGE X 1/4 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 33 GAUGE X 3/16 ^{MM}	2	
TRUE COMFORT PEN NEEDLE 33 GAUGE X 5/32 ^{MM}	2	
TRUE COMFORT PRO ALCOHOL PADS	3	
TRUE COMFORT PRO INS SYRINGE 0.5 ML 30 GAUGE X 1/2 ^{MM}	2	
TRUE COMFORT PRO INS SYRINGE 0.5 ML 30 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT PRO INS SYRINGE 0.5 ML 31 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT PRO INS SYRINGE 1 ML 30 GAUGE X 1/2 ^{MM}	2	
TRUE COMFORT PRO INS SYRINGE 1 ML 30 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT PRO INS SYRINGE 1 ML 31 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT PRO INS SYRINGE 1 ML 32 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT PRO INS SYRINGE 1/2 ML 32 GAUGE X 5/16 ^{MM}	2	
TRUE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 1/4 ^{MM}	2	
TRUE COMFORT SAFETY PEN NEEDLE 31 GAUGE X 3/16 ^{MM}	2	
TRUE COMFORT SAFETY PEN NEEDLE 32 GAUGE X 5/32 ^{MM}	2	
TRUE METRIX AIR GLUCOSE METER ^{MM}	2	
TRUE METRIX AIR GLUCOSE METER KIT ^{MM}	2	
TRUE METRIX GLUCOSE METER ^{MM}	2	
TRUE METRIX GLUCOSE METER KIT ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TRUE METRIX GLUCOSE TEST STRIP ^{MM}	2	QL(150 per 30 days)
TRUE METRIX GO GLUCOSE METER ^{MM}	2	
TRUE METRIX LEVEL 1 SOLUTION ^{MM}	3	
TRUE METRIX LEVEL 2 SOLUTION ^{MM}	3	
TRUE METRIX LEVEL 3 SOLUTION ^{MM}	3	
TRUE METRIX PRO TEST STRIP ^{MM}	2	QL(150 per 30 days)
TRUE2GO BLOOD GLUCOSE SYSTEM KIT ^{MM}	2	
TRUECONTROL LEVEL 0 SOLUTION ^{MM}	3	
TRUECONTROL LEVEL 1 SOLUTION ^{MM}	3	
TRUEDRAW LANCING DEVICE	3	
TRUEPLUS INSULIN 0.3 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 0.3 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 0.3 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 0.5 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 0.5 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 0.5 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 1 ML 28 GAUGE X 1/2" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 1 ML 29 GAUGE X 1/2" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 1 ML 30 GAUGE X 5/16" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 1 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
TRUEPLUS INSULIN 1/2 ML 28 GAUGE X 1/2" SYRINGE ^{MM}	2	
TRUEPLUS LANCETS 28 GAUGE ^{MM}	2	
TRUEPLUS LANCETS 30 GAUGE ^{MM}	2	
TRUEPLUS LANCETS 33 GAUGE ^{MM}	2	
TRUEPLUS PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
TRUEPLUS PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
TRUEPLUS PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
TRUEPLUS PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
TRUEPLUS PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
TRUERESULT BLOOD GLUCOSE SYSTEM KIT ^{MM}	2	
TRUETEST TEST STRIPS ^{MM}	2	QL(150 per 30 days)
TRUETRACK BLOOD GLUCOSE SYSTEM KIT ^{MM}	2	
TRUETRACK SMART SYSTEM KIT ^{MM}	2	
TRUETRACK TEST STRIPS ^{MM}	2	QL(150 per 30 days)
TRULANCE 3 MG TABLET ^{MM}	3	PA,QL(30 per 30 days)
TRULICITY 0.75 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
TRULICITY 1.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
TRULICITY 3 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
TRULICITY 4.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(2 per 28 days)
TRUSELTIQ 100 MG/DAY (100 MG X 1) CAPSULE ^{DL,MM,SP}	*	PA,QL(21 per 28 days)
TRUSELTIQ 125MG/DAY(100 MG X1-25MG X1) CAPSULE ^{DL,MM,SP}	*	PA,QL(42 per 28 days)
TRUSELTIQ 50 MG/DAY (25 MG X 2) CAPSULE ^{DL,MM,SP}	*	PA,QL(42 per 28 days)
TRUSELTIQ 75 MG/DAY (25 MG X 3) CAPSULE ^{DL,MM,SP}	*	PA,QL(63 per 28 days)
TRUSOPT 2 % EYE DROPS ^{MM}	3	QL(10 per 30 days)
TRUVADA 100 MG-150 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
TRUVADA 133 MG-200 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
TRUVADA 167 MG-250 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
TRUVADA 200 MG-300 MG TABLET ^{MM}	3	QL(30 per 30 days)
TRUZONE PEAK FLOW METER	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
TUBERCULIN SYRINGE 1 ML 25 GAUGE X 1"	3	
TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED ^{MM}	3	ST,QL(1 per 30 days)
TUKYSA 150 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
TUKYSA 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
tulana 0.35 mg tablet ^{MM}	1	
TURALIO 125 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
TURALIO 200 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
TUSSICAPS 10 MG-8 MG CAPSULE,EXTENDED RELEASE	3	QL(60 per 30 days)
TUXARIN ER 8 MG-54.3 MG TABLET,EXTENDED RELEASE	3	QL(60 per 30 days)
TUZISTRA XR 14.7 MG-2.8 MG/5 ML ORAL SUSPENSION,EXTENDED RELEASE	3	
TWINRIX (PF) 720 ELISA UNIT-20 MCG/ML INTRAMUSCULAR SYRINGE	3	
TWIRLA 120 MCG-30 MCG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(3 per 28 days)
TWIST LANCETS 30 GAUGE ^{MM}	2	
TWIST LANCETS 32 GAUGE ^{MM}	2	
TWYNEO 0.1 %-3 % TOPICAL CREAM	3	ST,QL(30 per 30 days)
TWYNSTA 40 MG-10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TWYNSTA 40 MG-5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TWYNSTA 80 MG-10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TWYNSTA 80 MG-5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
TYBLUME 0.1 MG-20 MCG CHEWABLE TABLET ^{MM}	3	
TYBOST 150 MG TABLET ^{MM}	3	QL(30 per 30 days)
tydemy 3 mg-0.03 mg-0.451 mg (21)(7) tablet ^{MM}	1	
TYKERB 250 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
TYMLOS 80 MCG/DOSE (3,120 MCG/1.56 ML) SUBCUTANEOUS PEN INJECTOR ^{DL,MM,SP}	*	PA,QL(1.56 per 30 days)
TYRVAYA 0.03 MG/SPRAY NASAL SPRAY ^{MM}	3	PA,QL(8.4 per 30 days)
TYVASO 1.74 MG/2.9 ML (0.6 MG/ML) SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	PA,QL(89.9 per 28 days)
TYVASO DPI 16 (112)-32 (112)-48 (28) MCG CARTRIDGE WITH INHALER ^{DL,SP}	*	PA,QL(252 per 28 days)
TYVASO DPI 16 MCG (112)-32 MCG (84) CARTRIDGE WITH INHALER ^{DL,SP}	*	PA,QL(196 per 28 days)
TYVASO DPI 16 MCG CARTRIDGE WITH INHALER ^{DL,MM,SP}	*	PA,QL(112 per 28 days)
TYVASO DPI 32 MCG CARTRIDGE WITH INHALER ^{DL,MM,SP}	*	PA,QL(112 per 28 days)
TYVASO DPI 32 MCG-48 MCG CARTRIDGE WITH INHALER ^{DL,MM,SP}	*	PA,QL(224 per 28 days)
TYVASO DPI 48 MCG CARTRIDGE WITH INHALER ^{DL,MM,SP}	*	PA,QL(112 per 28 days)
TYVASO DPI 64 MCG CARTRIDGE WITH INHALER ^{DL,MM,SP}	*	PA,QL(112 per 28 days)
TYVASO INSTITUTIONAL STARTER KIT 1.74 MG/2.9 ML SOLN FOR NEBULIZATION ^{DL,SP}	*	PA,QL(89.9 per 28 days)
TYVASO REFILL KIT 1.74 MG/2.9 ML (0.6 MG/ML) SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	PA,QL(89.9 per 28 days)
TYVASO STARTER KIT 1.74 MG/2.9 ML SOLUTION FOR NEBULIZATION ^{DL,SP}	*	PA,QL(89.9 per 28 days)
UBRELVY 100 MG TABLET	2	PA,QL(16 per 30 days)
UBRELVY 50 MG TABLET	2	PA,QL(16 per 30 days)
UCERIS 2 MG/ACTUATION RECTAL FOAM	3	PA
UCERIS 9 MG TABLET, EXTENDED RELEASE ^{DL,SP}	*	PA,QL(30 per 30 days)
UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.2 per 28 days)
ULESFIA 5 % LOTION	3	
ULORIC 40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ULORIC 80 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ULTI-LANCE KIT ^{MM}	3	
ULTI-LANCE MISC	3	
ULTICARE 0.3 ML 30 GAUGE X 1/2" SYRINGE ^{MM}	2	
ULTICARE 0.3 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
ULTICARE 0.5 ML 30 GAUGE X 1/2" SYRINGE ^{MM}	2	
ULTICARE 0.5 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ULTICARE 1 ML 25 GAUGE X 5/8" SYRINGE	2	
ULTICARE 1 ML 30 GAUGE X 1/2" SYRINGE ^{MM}	2	
ULTICARE 1 ML 31 GAUGE X 5/16" SYRINGE ^{MM}	2	
ULTICARE INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 1/4" ^{MM}	2	
ULTICARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4" ^{MM}	2	
ULTICARE INSULIN SYRINGE 1 ML 31 GAUGE X 1/4" ^{MM}	2	
ULTICARE INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4" ^{MM}	2	
ULTICARE PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
ULTICARE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
ULTICARE PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
ULTICARE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
ULTICARE PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
ULTICARE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 3/16" ^{MM}	2	
ULTICARE SAFETY PEN NEEDLE 30 GAUGE X 5/16" ^{MM}	2	
ULTIGUARD SAFEPACK-INSULIN SYRINGE 0.3 ML 30 X 1/2" ^{MM}	2	
ULTIGUARD SAFEPACK-INSULIN SYRINGE 0.3 ML 31 X 5/16" ^{MM}	2	
ULTIGUARD SAFEPACK-INSULIN SYRINGE 1 ML 30 X 1/2" ^{MM}	2	
ULTIGUARD SAFEPACK-INSULIN SYRINGE 1 ML 31 X 5/16" ^{MM}	2	
ULTIGUARD SAFEPACK-INSULIN SYRINGE 1/2 ML 30 X 1/2" ^{MM}	2	
ULTIGUARD SAFEPACK-INSULIN SYRINGE 1/2 ML 31 X 5/16" ^{MM}	2	
ULTIGUARD SAFEPACK-PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
ULTIGUARD SAFEPACK-PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
ULTIGUARD SAFEPACK-PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
ULTIGUARD SAFEPACK-PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
ULTIGUARD SAFEPACK-PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
ULTIGUARD SAFEPACK-PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
ULTILET BASIC LANCETS 30 GAUGE ^{MM}	2	
ULTILET CLASSIC LANCETS ^{MM}	2	
ULTILET CLASSIC LANCETS 28 GAUGE ^{MM}	2	
ULTILET CLASSIC LANCETS 30 GAUGE ^{MM}	2	
ULTILET CLASSIC LANCETS 33 GAUGE ^{MM}	2	
ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE ^{MM}	2	
ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTILET INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTILET INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTILET INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTILET INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTILET INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTILET INSULIN SYRINGE 1 ML 29 GAUGE ^{MM}	2	
ULTILET INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTILET INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTILET INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTILET INSULIN SYRINGE 1/2 ML 29 ^{MM}	2	
ULTILET LANCETS 28 GAUGE ^{MM}	2	
ULTILET LANCETS 30 GAUGE ^{MM}	2	
ULTILET LANCETS 33 GAUGE ^{MM}	2	
ULTILET PEN NEEDLE 29 GAUGE ^{MM}	2	
ULTILET PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ULTILET SAFETY LANCETS 23 GAUGE ^{MM}	2	
ULTIMA MONITOR ^{MM}	3	ST
ULTIMA TEST STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30 ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1 ML 28 GAUGE ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1 ML 28 GAUGE X 1/2" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1 ML 29 GAUGE ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1 ML 30 GAUGE X 7/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE X 1/2" ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1/2 ML 29 ^{MM}	2	
ULTRA COMFORT INSULIN SYRINGE 1/2 ML 30 GAUGE ^{MM}	2	
ULTRA FINE LANCETS 30 GAUGE ^{MM}	2	
ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 1/2" ^{MM}	2	
ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRA FLO INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRA FLO INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTRA FLO INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRA FLO INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRA FLO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	2	
ULTRA FLO PEN NEEDLE 29 GAUGE X 1/2" ^{MM}	2	
ULTRA FLO PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
ULTRA FLO PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
ULTRA FLO PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
ULTRA FLO PEN NEEDLE 33 GAUGE X 5/32" ^{MM}	2	
ULTRA PRENATAL PLUS DHA 27 MG-800 MCG-250 MG-200 MG CAPSULE ^{MM}	2	
ULTRA THIN II LANCETS 30 GAUGE ^{MM}	2	
ULTRA THIN LANCETS ^{MM}	2	
ULTRA THIN LANCETS 28 GAUGE ^{MM}	2	
ULTRA THIN LANCETS 30 GAUGE ^{MM}	2	
ULTRA THIN LANCETS 31 GAUGE ^{MM}	2	
ULTRA THIN LANCETS 33 GAUGE ^{MM}	2	
ULTRA THIN PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
ULTRA THIN PLUS LANCETS 33 GAUGE ^{MM}	2	
ULTRA TLC LANCETS ^{MM}	2	
ULTRA-CARE LANCETS 30 GAUGE ^{MM}	2	
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	3	
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	3	
ULTRA-THIN II (SHORT) INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	3	
ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	3	
ULTRA-THIN II (SHORT) INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRA-THIN II (SHORT) PEN NDL 31 GAUGE X 5/16" NEEDLE ^{MM}	3	
ULTRA-THIN II INSULIN PEN NEEDLES 29 GAUGE X 1/2" ^{MM}	3	
ULTRA-THIN II INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2" ^{MM}	3	
ULTRA-THIN II INSULIN SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	3	
ULTRA-THIN II LANCETS 28 GAUGE ^{MM}	2	
ULTRACARE INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRACARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
ULTRACARE INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRACARE INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 1/2" ^{MM}	2	
ULTRACARE INSULIN SYRINGE 1 ML 30 GAUGE X 5/16" ^{MM}	2	
ULTRACARE INSULIN SYRINGE 1 ML 31 GAUGE X 5/16" ^{MM}	2	
ULTRACARE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
ULTRACARE PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
ULTRACARE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
ULTRACARE PEN NEEDLE 32 GAUGE X 1/4" ^{MM}	2	
ULTRACARE PEN NEEDLE 32 GAUGE X 3/16" ^{MM}	2	
ULTRACARE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
ULTRACARE PEN NEEDLE 33 GAUGE X 5/32" ^{MM}	2	
ULTRACET 37.5 MG-325 MG TABLET ^{DL}	3	QL(240 per 30 days)
ULTRALANCE LANCETS 26 GAUGE ^{MM}	2	
ULTRALANCE LANCETS 28 GAUGE ^{MM}	2	
ULTRAM 50 MG TABLET ^{DL}	3	QL(240 per 30 days)
ULTRATRAK GLUCOSE METER ^{MM}	3	ST
ULTRATRAK GLUCOSE METER KIT ^{MM}	3	ST
ULTRATRAK HIGH-LOW CONTROL SOLUTION ^{MM}	3	
ULTRATRAK NORMAL CONTROL SOLUTION ^{MM}	3	
ULTRATRAK STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ULTRATRAK ULTIMATE ^{MM}	3	ST
ULTRATRAK ULTIMATE SOLUTION ^{MM}	3	
ULTRATRAK ULTIMATE STRIPS ^{MM}	3	ST,QL(150 per 30 days)
ULTRAVATE 0.05 % LOTION	3	ST
UNIFINE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
UNIFINE PENTIPS 29 GAUGE NEEDLE ^{MM}	2	
UNIFINE PENTIPS 29 GAUGE X 1/2" NEEDLE ^{MM}	2	
UNIFINE PENTIPS 31 GAUGE X 1/4" NEEDLE ^{MM}	2	
UNIFINE PENTIPS 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
UNIFINE PENTIPS 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
UNIFINE PENTIPS 32 GAUGE X 1/4" NEEDLE ^{MM}	2	
UNIFINE PENTIPS 32 GAUGE X 5/32" NEEDLE ^{MM}	2	
UNIFINE PENTIPS 33 GAUGE X 5/32" NEEDLE ^{MM}	2	
UNIFINE PENTIPS MAXFLOW 30 GAUGE X 3/16" NEEDLE ^{MM}	2	
UNIFINE PENTIPS PLUS 29 GAUGE X 1/2" NEEDLE ^{MM}	2	
UNIFINE PENTIPS PLUS 31 GAUGE X 1/4" NEEDLE ^{MM}	2	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
UNIFINE PENTIPS PLUS 31 GAUGE X 3/16" NEEDLE ^{MM}	2	
UNIFINE PENTIPS PLUS 31 GAUGE X 5/16" NEEDLE ^{MM}	2	
UNIFINE PENTIPS PLUS 32 GAUGE X 5/32" NEEDLE ^{MM}	2	
UNIFINE PENTIPS PLUS 33 GAUGE X 5/32" NEEDLE ^{MM}	2	
UNIFINE PENTIPS PLUS MAXFLOW 30 GAUGE X 3/16" NEEDLE ^{MM}	2	
UNIFINE SAFECONTROL 30 GAUGE X 3/16" NEEDLE ^{MM}	2	
UNIFINE SAFECONTROL 30 GAUGE X 5/16" NEEDLE ^{MM}	2	
UNIFINE SAFECONTROL 32 GAUGE X 5/32" NEEDLE ^{MM}	2	
UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 3/16" ^{MM}	2	
UNIFINE ULTRA PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
UNIFINE ULTRA PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
UNILET COMFORTOUCH LANCET ^{MM}	2	
UNILET COMFORTOUCH LANCET 26 GAUGE ^{MM}	2	
UNILET EXCELITE II LANCET ^{MM}	3	
UNILET EXCELITE LANCET ^{MM}	3	
UNILET GP LANCET ^{MM}	2	
UNILET LANCET 28 GAUGE ^{MM}	2	
UNILET LANCET 33 GAUGE ^{MM}	2	
UNILET LANCETS 30 GAUGE ^{MM}	3	
UNILET SUPER THIN LANCETS 30 GAUGE ^{MM}	2	
UNISTIK 2 DEVICE KIT ^{MM}	3	
UNISTIK 2 EXTRA KIT ^{MM}	2	
UNISTIK 2 NORMAL LANCET AND DEVICE KIT ^{MM}	2	
UNISTIK 3 COMFORT DEVICE KIT ^{MM}	3	
UNISTIK 3 COMFORT LANCET ^{MM}	2	
UNISTIK 3 EXTRA LANCET 21 GAUGE ^{MM}	2	
UNISTIK 3 GENTLE 30 GAUGE ^{MM}	3	
UNISTIK 3 KIT ^{MM}	3	
UNISTIK 3 LANCETS 21 GAUGE ^{MM}	2	
UNISTIK 3 NEONATAL DEVICE KIT ^{MM}	3	
UNISTIK 3 NEONATAL KIT ^{MM}	3	
UNISTIK 3 NORMAL LANCET 23 GAUGE ^{MM}	2	
UNISTIK COMFORT LANCETS 28 GAUGE ^{MM}	3	
UNISTIK CZT LANCET 23 GAUGE ^{MM}	2	
UNISTIK CZT LANCET 28 GAUGE ^{MM}	2	
UNISTIK EXTRA LANCETS 21 GAUGE ^{MM}	3	
UNISTIK NORMAL LANCETS 23 GAUGE ^{MM}	2	
UNISTIK PRO LANCET 21 GAUGE ^{MM}	2	
UNISTIK PRO LANCET 25 GAUGE ^{MM}	2	
UNISTIK PRO LANCET 28 GAUGE ^{MM}	2	
UNISTIK SAFETY 28 GAUGE ^{MM}	2	
UNISTIK SAFETY 30 GAUGE ^{MM}	2	
UNISTIK TOUCH LANCETS 21 GAUGE ^{MM}	2	
UNISTIK TOUCH LANCETS 23 GAUGE ^{MM}	2	
UNISTIK TOUCH LANCETS 28 GAUGE ^{MM}	2	
UNISTIK TOUCH LANCETS 30 GAUGE ^{MM}	2	
UNISTRIP HIGH CONTROL SOLUTION ^{MM}	3	
UNISTRIP LOW CONTROL SOLUTION ^{MM}	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
UNISTRIP1 TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
UNITHROID 100 MCG TABLET ^{MM}	3	ST
UNITHROID 112 MCG TABLET ^{MM}	3	ST
UNITHROID 125 MCG TABLET ^{MM}	3	ST
UNITHROID 137 MCG TABLET ^{MM}	3	ST
UNITHROID 150 MCG TABLET ^{MM}	3	ST
UNITHROID 175 MCG TABLET ^{MM}	3	ST
UNITHROID 200 MCG TABLET ^{MM}	3	ST
UNITHROID 25 MCG TABLET ^{MM}	3	ST
UNITHROID 300 MCG TABLET ^{MM}	3	ST
UNITHROID 50 MCG TABLET ^{MM}	3	ST
UNITHROID 75 MCG TABLET ^{MM}	3	ST
UNITHROID 88 MCG TABLET ^{MM}	3	ST
UNIVERSAL 1 LANCETS 21 GAUGE ^{MM}	2	
UNIVERSAL 1 LANCETS 26 GAUGE ^{MM}	3	
UNIVERSAL 1 LANCETS 30 GAUGE ^{MM}	2	
UNIVERSAL 1 LANCETS 33 GAUGE ^{MM}	2	
UPNEEQ (PF) 0.1 % EYE DROPS IN A DROPPERETTE	3	PA,QL(30 per 30 days)
UPTRAVI 1,000 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UPTRAVI 1,200 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UPTRAVI 1,400 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UPTRAVI 1,600 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UPTRAVI 200 MCG (140)-800 MCG (60) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(200 per 30 days)
UPTRAVI 200 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UPTRAVI 400 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UPTRAVI 600 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UPTRAVI 800 MCG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
UROCIT-K 10 10 MEQ (1,080 MG) TABLET,EXTENDED RELEASE ^{MM}	3	
UROCIT-K 15 15 MEQ (1,620 MG) TABLET,EXTENDED RELEASE ^{MM}	3	
UROCIT-K 5 5 MEQ (540 MG) TABLET,EXTENDED RELEASE ^{MM}	3	
UROXATRAL 10 MG TABLET,EXTENDED RELEASE ^{MM}	3	ST,QL(30 per 30 days)
URSO 250 250 MG TABLET ^{MM}	3	
URSO FORTE 500 MG TABLET ^{MM}	3	
ursodiol 200 mg capsule ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
ursodiol 250 mg tablet ^{MM}	1	
ursodiol 300 mg capsule ^{MM}	1	
ursodiol 400 mg capsule ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ursodiol 500 mg tablet ^{MM}	1	
V-GO 20 DEVICE ^{MM}	3	PA
V-GO 30 DEVICE ^{MM}	3	PA
V-GO 40 DEVICE ^{MM}	3	PA
VAGIFEM 10 MCG VAGINAL TABLET ^{MM}	3	
valacyclovir 1 gram tablet ^{MM}	1	QL(90 per 30 days)
valacyclovir 500 mg tablet ^{MM}	1	QL(90 per 30 days)
VALCHLOR 0.016 % TOPICAL GEL ^{DL,MM,SP}	*	PA,QL(60 per 28 days)
VALCYTE 450 MG TABLET ^{DL,MM,SP}	*	QL(120 per 30 days)
VALCYTE 50 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	QL(1056 per 30 days)
valganciclovir 450 mg tablet ^{DL,MM,SP}	*	QL(120 per 30 days)
valganciclovir 50 mg/ml oral solution ^{DL,MM,SP}	*	QL(1056 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
VALIUM 10 MG TABLET ^{DL}	3	ST,QL(120 per 30 days)
VALIUM 2 MG TABLET ^{DL}	3	ST,QL(90 per 30 days)
VALIUM 5 MG TABLET ^{DL}	3	ST,QL(90 per 30 days)
valproic acid (as sodium salt) 250 mg/5 ml (5 ml) oral solution ^{MM}	1	
valproic acid (as sodium salt) 250 mg/5 ml oral solution ^{MM}	1	
valproic acid (as sodium salt) 500 mg/10 ml (10 ml) oral solution ^{MM}	1	
valproic acid 250 mg capsule ^{MM}	1	
valsartan 160 mg tablet ^{MM}	1	QL(60 per 30 days)
valsartan 160 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(30 per 30 days)
valsartan 160 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	QL(30 per 30 days)
valsartan 320 mg tablet ^{MM}	1	QL(60 per 30 days)
valsartan 320 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(30 per 30 days)
valsartan 320 mg-hydrochlorothiazide 25 mg tablet ^{MM}	1	QL(30 per 30 days)
VALSARTAN 4 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	ST,QL(2400 per 30 days)
valsartan 40 mg tablet ^{MM}	1	QL(60 per 30 days)
valsartan 80 mg tablet ^{MM}	1	QL(60 per 30 days)
valsartan 80 mg-hydrochlorothiazide 12.5 mg tablet ^{MM}	1	QL(30 per 30 days)
VALTOCO 10 MG/SPRAY (0.1 ML) NASAL SPRAY ^{DL,SP}	*	QL(10 per 30 days)
VALTOCO 15 MG/2 SPRAY(7.5MG/0.1ML X2) NASAL SPRAY ^{DL,SP}	*	QL(10 per 30 days)
VALTOCO 20 MG/2 SPRAY (10MG/0.1ML X2) NASAL SPRAY ^{DL,SP}	*	QL(10 per 30 days)
VALTOCO 5 MG/SPRAY (0.1 ML) NASAL SPRAY ^{DL,SP}	*	QL(10 per 30 days)
VALTRES 1 GRAM TABLET ^{MM}	3	QL(90 per 30 days)
VALTRES 500 MG TABLET ^{MM}	3	QL(90 per 30 days)
vanadom 350 mg tablet	1	QL(120 per 30 days)
VANOCIN 125 MG CAPSULE	3	PA,QL(120 per 30 days)
VANOCIN 250 MG CAPSULE	3	PA,QL(240 per 30 days)
vancomycin 125 mg capsule	1	PA,QL(120 per 30 days)
vancomycin 25 mg/ml oral solution	3	PA
vancomycin 250 mg capsule	1	PA,QL(240 per 30 days)
vancomycin 50 mg/ml oral solution	1	PA
VANDAZOLE 0.75 % (37.5 MG/5 GRAM) VAGINAL GEL	3	
VANISHPOINT INSULIN SYRINGE 1 ML 30 GAUGE X 3/16" ^{MM}	2	
VANISHPOINT SYRINGE 0.5 ML 30 GAUGE X 1/2" ^{MM}	2	
VANISHPOINT SYRINGE 1 ML 29 GAUGE X 1/2" ^{MM}	2	
VANOS 0.1 % TOPICAL CREAM	3	ST
VAQTA (PF) 25 UNIT/0.5 ML INTRAMUSCULAR SUSPENSION	3	
VAQTA (PF) 25 UNIT/0.5 ML INTRAMUSCULAR SYRINGE	3	
VAQTA (PF) 50 UNIT/ML INTRAMUSCULAR SUSPENSION	3	
VAQTA (PF) 50 UNIT/ML INTRAMUSCULAR SYRINGE	3	
VARUBI 90 MG TABLET ^{DL,SP}	*	PA,QL(4 per 28 days)
VASCEPA 0.5 GRAM CAPSULE ^{MM}	3	QL(240 per 30 days)
VASCEPA 1 GRAM CAPSULE ^{MM}	3	QL(120 per 30 days)
VASERETIC 10 MG-25 MG TABLET ^{MM}	3	
VASOTEC 10 MG TABLET ^{MM}	3	
VASOTEC 2.5 MG TABLET ^{MM}	3	
VASOTEC 20 MG TABLET ^{MM}	3	
VASOTEC 5 MG TABLET ^{MM}	3	
VAXELIS (PF) 15 UNIT-5 UNIT-10 MCG/0.5 ML INTRAMUSCULAR SUSPENSION	3	
VAXELIS (PF) 15 UNIT-5 UNIT-10 MCG/0.5 ML INTRAMUSCULAR SYRINGE	3	
VAXNEUVANCE (PF) 0.5 ML INTRAMUSCULAR SYRINGE	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
vecamyl 2.5 mg tablet	1	QL(300 per 30 days)
VECTICAL 3 MCG/GRAM TOPICAL OINTMENT	3	PA,QL(800 per 28 days)
velivet triphasic regimen (28) 0.1 mg/0.125 mg/0.15 mg-25 mcg tablet ^{MM}	1	
VELPHORO 500 MG CHEWABLE TABLET ^{MM}	3	ST
VELTASSA 16.8 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VELTASSA 25.2 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VELTASSA 8.4 GRAM ORAL POWDER PACKET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VELTIN 1.2 %-0.025 % TOPICAL GEL	3	ST
VELMIDY 25 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VENCLEXTA 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
VENCLEXTA 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
VENCLEXTA 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
VENCLEXTA STARTING PACK 10 MG-50 MG-100 MG TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(42 per 28 days)
venlafaxine 100 mg tablet ^{MM}	1	
venlafaxine 25 mg tablet ^{MM}	1	
venlafaxine 37.5 mg tablet ^{MM}	1	
venlafaxine 50 mg tablet ^{MM}	1	
venlafaxine 75 mg tablet ^{MM}	1	
VENLAFAXINE BESYLATE ER 112.5 MG TABLET,EXTENDED RELEASE 24 HR ^{MM}	3	ST,QL(60 per 30 days)
venlafaxine er 150 mg capsule,extended release 24 hr ^{MM}	1	QL(60 per 30 days)
venlafaxine er 150 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
venlafaxine er 225 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
venlafaxine er 37.5 mg capsule,extended release 24 hr ^{MM}	1	QL(90 per 30 days)
venlafaxine er 37.5 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(30 per 30 days)
venlafaxine er 75 mg capsule,extended release 24 hr ^{MM}	1	QL(90 per 30 days)
venlafaxine er 75 mg tablet,extended release 24 hr ^{MM}	1	ST,QL(60 per 30 days)
VENTAVIS 10 MCG/ML SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	PA,QL(150 per 30 days)
VENTAVIS 20 MCG/ML SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER ^{MM}	2	QL(36 per 30 days)
verapamil 120 mg tablet ^{MM}	1	QL(120 per 30 days)
verapamil 40 mg tablet ^{MM}	1	QL(120 per 30 days)
verapamil 80 mg tablet ^{MM}	1	QL(120 per 30 days)
verapamil er (pm) 100 mg capsule 24hr pellet ct,ext.release ^{MM}	1	QL(30 per 30 days)
verapamil er (pm) 200 mg capsule 24hr pellet ct,ext.release ^{MM}	1	QL(60 per 30 days)
verapamil er (pm) 300 mg capsule 24hr pellet ct,ext.release ^{MM}	1	QL(30 per 30 days)
verapamil er (sr) 120 mg tablet,extended release ^{MM}	1	QL(30 per 30 days)
verapamil er (sr) 180 mg tablet,extended release ^{MM}	1	QL(30 per 30 days)
verapamil er (sr) 240 mg tablet,extended release ^{MM}	1	QL(60 per 30 days)
verapamil er 120 mg 24 hr capsule,extended release ^{MM}	1	QL(60 per 30 days)
verapamil er 180 mg 24 hr capsule,extended release ^{MM}	1	QL(60 per 30 days)
verapamil er 240 mg 24 hr capsule,extended release ^{MM}	1	QL(60 per 30 days)
verapamil er 360 mg 24 hr capsule,extended release ^{MM}	1	QL(60 per 30 days)
VERDESO 0.05 % TOPICAL FOAM ^{DL,SP}	*	
VEREGEN 15 % TOPICAL OINTMENT ^{DL,SP}	*	PA,QL(30 per 30 days)
VERELAN 120 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
VERELAN 180 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
VERELAN 240 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
VERELAN 360 MG CAPSULE,EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
VERELAN PM 100 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
VERELAN PM 200 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	QL(60 per 30 days)
VERELAN PM 300 MG CAPSULE, EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
VERIFINE PEN NEEDLE 31 GAUGE X 1/4" ^{MM}	2	
VERIFINE PEN NEEDLE 31 GAUGE X 5/16" ^{MM}	2	
VERIFINE PEN NEEDLE 32 GAUGE X 3/16" ^{MM}	2	
VERIFINE PEN NEEDLE 32 GAUGE X 5/32" ^{MM}	2	
VERIPRED 20 20 MG/5 ML (4 MG/ML) ORAL SOLUTION	3	
VERKAZIA 0.1 % EYE DROPS IN A DROPPERETTE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
VERQUVO 10 MG TABLET ^{MM}	2	QL(30 per 30 days)
VERQUVO 2.5 MG TABLET ^{MM}	2	QL(30 per 30 days)
VERQUVO 5 MG TABLET ^{MM}	2	QL(30 per 30 days)
VERSACLOZ 50 MG/ML ORAL SUSPENSION ^{MM}	3	ST,QL(540 per 30 days)
VERZENIO 100 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
VERZENIO 150 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
VERZENIO 200 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
VERZENIO 50 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
VESICARE 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VESICARE 5 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VESICARE LS 1 MG/ML ORAL SUSPENSION ^{MM}	3	ST,QL(300 per 30 days)
vestura (28) 3 mg-0.02 mg tablet ^{MM}	1	
VFEND 200 MG TABLET ^{DL,SP}	*	PA,QL(120 per 30 days)
VFEND 200 MG/5 ML (40 MG/ML) ORAL SUSPENSION ^{DL,SP}	*	PA,QL(400 per 30 days)
VFEND 50 MG TABLET ^{DL,SP}	*	PA,QL(120 per 30 days)
VIBERZI 100 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
VIBERZI 75 MG TABLET ^{MM}	3	PA,QL(60 per 30 days)
VIBRAMYCIN (CALCIUM) 50 MG/5 ML ORAL SYRUP	3	
VIBRAMYCIN 100 MG CAPSULE	3	QL(90 per 30 days)
VICTOZA 2-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(9 per 30 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR ^{MM}	2	QL(9 per 30 days)
VIEKIRA PAK 12.5 MG-75 MG-50 MG/250 MG TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(112 per 28 days)
vienna 0.1 mg-20 mcg tablet ^{MM}	1	
vigabatrin 500 mg oral powder packet ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
vigabatrin 500 mg tablet ^{DL,LD,MM,SP}	*	PA,QL(180 per 30 days)
vigadrone 500 mg oral powder packet ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
VIGAMOX 0.5 % EYE DROPS	3	ST
VIIBRYD 10 MG (7)-20 MG (23) TABLETS IN A DOSE PACK	3	ST,QL(30 per 30 days)
VIIBRYD 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VIIBRYD 20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VIIBRYD 40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VIJOICE 125 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
VIJOICE 250 MG/DAY(200 MG X 1 AND 50 MG X 1) TABLET ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
VIJOICE 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
vilazodone 10 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
vilazodone 20 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
vilazodone 40 mg tablet ^{MM}	1	ST,QL(30 per 30 days)
VIMOVO 375 MG-20 MG TABLET,IMMEDIATE AND DELAY RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
VIMOVO 500 MG-20 MG TABLET,IMMEDIATE AND DELAY RELEASE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
VIMPAT 10 MG/ML ORAL SOLUTION ^{MM}	3	ST,QL(1395 per 30 days)
VIMPAT 100 MG TABLET ^{MM}	3	ST

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
VIMPAT 150 MG TABLET ^{MM}	3	ST
VIMPAT 200 MG TABLET ^{MM}	3	ST
VIMPAT 50 MG (14)-100 MG (14) TABLETS IN A DOSE PACK	3	ST
VIMPAT 50 MG TABLET ^{MM}	3	ST
VIOKACE 10,440 UNIT-39,150 UNIT-39,150 UNIT TABLET ^{MM}	3	ST
VIOKACE 20,880 UNIT-78,300 UNIT-78,300 UNIT TABLET ^{MM}	3	ST
viorele (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet ^{MM}	1	
VIRACEPT 250 MG TABLET ^{MM,SP}	*	QL(300 per 30 days)
VIRACEPT 625 MG TABLET ^{MM,SP}	*	QL(120 per 30 days)
VIRAMUNE 50 MG/5 ML ORAL SUSPENSION ^{MM}	3	QL(1200 per 30 days)
VIRAMUNE XR 400 MG TABLET,EXTENDED RELEASE ^{MM}	3	QL(30 per 30 days)
VIRAZOLE 6 GRAM SOLUTION FOR INHALATION	3	QL(8 per 30 days)
VIREAD 150 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
VIREAD 200 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
VIREAD 250 MG TABLET ^{MM,SP}	*	QL(30 per 30 days)
VIREAD 300 MG TABLET ^{MM}	3	QL(30 per 30 days)
VIREAD 40 MG/SCOOP (40 MG/GRAM) ORAL POWDER ^{MM,SP}	*	QL(240 per 30 days)
virt-caps 1 mg capsule	1	
virt-gard 2.2 mg-25 mg-1 mg tablet	1	
virt-nate dha 28 mg iron-1 mg-200 mg capsule ^{MM}	1	
virt-phos neutral 250 mg tablet	1	
VISTARIL 25 MG CAPSULE	3	
VISTARIL 50 MG CAPSULE	3	
VISTOGARD 10 GRAM ORAL GRANULES IN PACKET ^{DL,SP}	*	QL(20 per 365 days)
VITA-RESPA 2.2 MG-25 MG-1.3 MG TABLET	3	
VITAFOL 65 MG-1 MG TABLET	3	
VITAFOL NANO 18 MG IRON-1 MG TABLET ^{MM}	3	
VITAFOL ULTRA 29 MG IRON-1 MG-200 MG CAPSULE ^{MM}	3	
VITAFOL-OB 65 MG-1 MG TABLET ^{MM}	3	
VITAFOL-OB+DHA 65 MG-1 MG-250 MG ORAL PACK ^{MM}	3	
VITAFOL-ONE 29 MG IRON-1 MG-200 MG CAPSULE ^{MM}	2	
VITAMED MD ONE RX 30 MG IRON-1 MG-200 MG CAPSULE ^{MM}	2	
VITAMEDMD REDICHEW RX 1.4 MG CHEW TABLET,IMMEDIATE - DELAYED RELEASE ^{MM}	3	
vitamin d2 1,250 mcg (50,000 unit) capsule ^{MM}	1	
vitamin k 1 mg/0.5 ml injection solution	1	
vitamin k1 10 mg/ml injection solution	1	
VITAPEARL 30 MG-1.4 MG-200 MG CAPSULE,IMMEDIATE - DELAY RELEASE ^{MM}	3	
VITATRUE 30 MG IRON-1.4 MG-300 MG ORAL PACK ^{MM}	3	
VITRAKVI 100 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
VITRAKVI 20 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
VITRAKVI 25 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(180 per 30 days)
VIVAGUARD INO CONTROL SOLUTION-L1,L2,L3 ^{MM}	3	
VIVAGUARD INO CONTROL SOLUTION-L1,L3 ^{MM}	3	
VIVAGUARD INO CONTROL SOLUTION-L2 ^{MM}	3	
VIVAGUARD INO GLUCOSE METER ^{MM}	3	ST
VIVAGUARD INO SMART GLUCOSE METER ^{MM}	3	ST
VIVAGUARD INO TEST STRIP ^{MM}	3	ST,QL(150 per 30 days)
VIVAGUARD LANCET 30 GAUGE ^{MM}	2	
VIVAGUARD LANCING DEVICE	3	
VIVELLE-DOT 0.025 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
VIVELLE-DOT 0.0375 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
VIVELLE-DOT 0.05 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
VIVELLE-DOT 0.075 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
VIVELLE-DOT 0.1 MG/24 HR TRANSDERMAL PATCH ^{MM}	3	QL(8 per 28 days)
VIVITROL 380 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE ^{MM,SP}	*	QL(1 per 28 days)
VIVJOA 150 MG CAPSULE ^{DL,SP}	*	PA
VIVLODEX 10 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VIVLODEX 5 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VIZIMPRO 15 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
VIZIMPRO 30 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
VIZIMPRO 45 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
VOCABRIA 30 MG TABLET ^{DL,SP}	*	QL(30 per 30 days)
VOGELXO 1 % (50 MG/5 GRAM) TRANSDERMAL GEL PACKET ^{MM}	3	PA,QL(300 per 30 days)
VOGELXO 12.5 MG/1.25 GRAM PER PUMP ACTUATION (1 %) TRANSDERMAL GEL ^{MM}	3	PA,QL(300 per 30 days)
VOGELXO 50 MG/5 GRAM (1 %) TRANSDERMAL GEL ^{MM}	3	PA,QL(300 per 30 days)
volnea (28) 0.15 mg-0.02 mg (21)/0.01 mg (5) tablet ^{MM}	1	
VONJO 100 MG CAPSULE ^{DL,SP}	*	PA,QL(120 per 30 days)
VOQUEZNA DUAL PAK 20 MG (28)-500 MG (84) ORAL PACK ^{DL,SP}	*	ST,QL(112 per 30 days)
VOQUEZNA TRIPLE PAK 20 MG-500 MG-500 MG ORAL PACK ^{DL,SP}	*	ST,QL(112 per 30 days)
voriconazole 200 mg tablet ^{DL,SP}	*	PA,QL(120 per 30 days)
voriconazole 200 mg/5 ml (40 mg/ml) oral suspension ^{DL,SP}	*	PA,QL(400 per 30 days)
voriconazole 50 mg tablet ^{DL,SP}	*	PA,QL(120 per 30 days)
VORTEX HOLDING CHAMBER	2	
VORTEX VHC FROG MASK-CHILD	3	
VORTEX VHC LADYBUG MASK-TODDLER	2	
VOSEVI 400 MG-100 MG-100 MG TABLET ^{DL}	3	PA,QL(28 per 28 days)
VOTRIENT 200 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
VOXZOGO 0.4 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VOXZOGO 0.56 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VOXZOGO 1.2 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
VP-PNV-DHA 28 MG IRON-1 MG-200 MG CAPSULE ^{MM}	3	
VRAYLAR 1.5 MG (1)-3 MG (6) CAPSULES IN A DOSE PACK ^{SP}	*	PA
VRAYLAR 1.5 MG CAPSULE ^{MM,SP}	*	PA,QL(30 per 30 days)
VRAYLAR 3 MG CAPSULE ^{MM,SP}	*	PA,QL(30 per 30 days)
VRAYLAR 4.5 MG CAPSULE ^{MM,SP}	*	PA,QL(30 per 30 days)
VRAYLAR 6 MG CAPSULE ^{MM,SP}	*	PA,QL(30 per 30 days)
VTAMA 1 % TOPICAL CREAM ^{DL,SP}	*	PA,QL(60 per 30 days)
vtol iq 50 mg-325 mg-40 mg/15 ml oral solution ^{DL,SP}	*	QL(450 per 30 days)
VUITY 1.25 % EYE DROPS ^{MM}	2	
VUMERITY 231 MG CAPSULE,DELAYED RELEASE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
VUSION 0.25 %-15 %-81.35 % TOPICAL OINTMENT	3	
vyfemla (28) 0.4 mg-35 mcg tablet ^{MM}	1	
vylibra 0.25 mg-35 mcg tablet ^{MM}	1	
VYNDAMAX 61 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
VYNDAQEL 20 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
VYTORIN 10 MG-10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VYTORIN 10 MG-20 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VYTORIN 10 MG-40 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
VYTORIN 10 MG-80 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
VYVANSE 10 MG CAPSULE ^{MM}	2	QL(30 per 30 days)
VYVANSE 10 MG CHEWABLE TABLET ^{MM}	2	QL(30 per 30 days)
VYVANSE 20 MG CAPSULE ^{MM}	2	QL(30 per 30 days)
VYVANSE 20 MG CHEWABLE TABLET ^{MM}	2	QL(30 per 30 days)
VYVANSE 30 MG CAPSULE ^{MM}	2	QL(30 per 30 days)
VYVANSE 30 MG CHEWABLE TABLET ^{MM}	2	QL(30 per 30 days)
VYVANSE 40 MG CAPSULE ^{MM}	2	QL(30 per 30 days)
VYVANSE 40 MG CHEWABLE TABLET ^{MM}	2	QL(30 per 30 days)
VYVANSE 50 MG CAPSULE ^{MM}	2	QL(30 per 30 days)
VYVANSE 50 MG CHEWABLE TABLET ^{MM}	2	QL(30 per 30 days)
VYVANSE 60 MG CAPSULE ^{MM}	2	QL(30 per 30 days)
VYVANSE 60 MG CHEWABLE TABLET ^{MM}	2	QL(30 per 30 days)
VYVANSE 70 MG CAPSULE ^{MM}	2	QL(30 per 30 days)
VYZULTA 0.024 % EYE DROPS ^{MM}	3	ST,QL(5 per 30 days)
WAKIX 17.8 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
WAKIX 4.45 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
warfarin 1 mg tablet ^{MM}	1	
warfarin 10 mg tablet ^{MM}	1	
warfarin 2 mg tablet ^{MM}	1	
warfarin 2.5 mg tablet ^{MM}	1	
warfarin 3 mg tablet ^{MM}	1	
warfarin 4 mg tablet ^{MM}	1	
warfarin 5 mg tablet ^{MM}	1	
warfarin 6 mg tablet ^{MM}	1	
warfarin 7.5 mg tablet ^{MM}	1	
WAVESENSE AMP KIT ^{MM}	3	ST
WAVESENSE CONTROL SOLUTION ^{MM}	3	
WAVESENSE JAZZ STRIPS ^{MM}	3	ST,QL(150 per 30 days)
WAVESENSE PRESTO ^{MM}	3	ST
WAVESENSE PRESTO KIT ^{MM}	3	ST
WAVESENSE PRESTO STRIPS ^{MM}	3	ST,QL(150 per 30 days)
WELCHOL 3.75 GRAM ORAL POWDER PACKET ^{MM}	3	PA
WELCHOL 625 MG TABLET ^{MM}	3	PA
WELIREG 40 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
WELLBUTRIN SR 100 MG TABLET, 12 HR SUSTAINED-RELEASE ^{MM}	3	QL(120 per 30 days)
WELLBUTRIN SR 150 MG TABLET, 12 HR SUSTAINED-RELEASE ^{MM}	3	QL(90 per 30 days)
WELLBUTRIN SR 200 MG TABLET, 12 HR SUSTAINED-RELEASE ^{MM}	3	QL(60 per 30 days)
WELLBUTRIN XL 150 MG 24 HR TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(90 per 30 days)
WELLBUTRIN XL 300 MG 24 HR TABLET, EXTENDED RELEASE ^{MM}	3	PA,QL(30 per 30 days)
wera (28) 0.5 mg-35 mcg tablet ^{MM}	1	
westab plus 27 mg iron-1 mg tablet ^{MM}	1	
westgel dha 31 mg iron-1 mg-200 mg capsule ^{MM}	1	
WIDE-SEAL DIAPHRAGM 60 MM VAGINAL	3	
WIDE-SEAL DIAPHRAGM 65 MM VAGINAL	3	
WIDE-SEAL DIAPHRAGM 70 MM VAGINAL	3	
WIDE-SEAL DIAPHRAGM 75 MM VAGINAL	3	
WIDE-SEAL DIAPHRAGM 80 MM VAGINAL	3	
WIDE-SEAL DIAPHRAGM 85 MM VAGINAL	3	
WIDE-SEAL DIAPHRAGM 90 MM VAGINAL	3	
WIDE-SEAL DIAPHRAGM 95 MM VAGINAL	3	

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
WINLEVI 1 % TOPICAL CREAM	3	PA
wixela inhub 100 mcg-50 mcg/dose powder for inhalation ^{MM}	1	QL(60 per 30 days)
wixela inhub 250 mcg-50 mcg/dose powder for inhalation ^{MM}	1	QL(60 per 30 days)
wixela inhub 500 mcg-50 mcg/dose powder for inhalation ^{MM}	1	QL(60 per 30 days)
wymzya fe 0.4 mg-35 mcg (21)/75 mg (7) chewable tablet ^{MM}	1	
WYNZORA 0.005 %-0.064 % TOPICAL CREAM ^{DL,SP}	*	PA,QL(60 per 30 days)
XACIATO 2 % VAGINAL GEL	3	
XADAGO 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
XADAGO 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
XALATAN 0.005 % EYE DROPS ^{MM}	3	ST,QL(5 per 25 days)
XALKORI 200 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
XALKORI 250 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
XANAX 0.25 MG TABLET ^{DL}	3	QL(120 per 30 days)
XANAX 0.5 MG TABLET ^{DL}	3	QL(120 per 30 days)
XANAX 1 MG TABLET ^{DL}	3	QL(120 per 30 days)
XANAX 2 MG TABLET ^{DL}	3	QL(150 per 30 days)
XANAX XR 0.5 MG TABLET,EXTENDED RELEASE ^{DL}	3	QL(60 per 30 days)
XANAX XR 1 MG TABLET,EXTENDED RELEASE ^{DL}	3	QL(60 per 30 days)
XANAX XR 2 MG TABLET,EXTENDED RELEASE ^{DL}	3	QL(60 per 30 days)
XANAX XR 3 MG TABLET,EXTENDED RELEASE ^{DL}	3	QL(60 per 30 days)
XARELTO 1 MG/ML ORAL SUSPENSION ^{DL,MM}	2	ST,QL(600 per 30 days)
XARELTO 10 MG TABLET ^{MM}	2	QL(30 per 30 days)
XARELTO 15 MG TABLET ^{MM}	2	QL(60 per 30 days)
XARELTO 2.5 MG TABLET ^{MM}	2	QL(60 per 30 days)
XARELTO 20 MG TABLET ^{MM}	2	QL(30 per 30 days)
XARELTO DVT-PE TREATMENT 30-DAY STARTER 15 MG(42)-20 MG(9) TABLET PACK	2	QL(51 per 30 days)
XATMEP 2.5 MG/ML ORAL SOLUTION ^{MM}	3	PA,QL(120 per 28 days)
XCOPRI 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
XCOPRI 150 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
XCOPRI 200 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
XCOPRI 50 MG TABLET ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
XCOPRI MAINTENANCE PACK 250 MG/DAY (200 MG X 1 AND 50 MG X 1) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
XCOPRI MAINTENANCE PACK 250MG/DAY (150 MG X 1 AND 100 MG X 1) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
XCOPRI MAINTENANCE PACK 350 MG/DAY (200 MG X 1 AND 150 MG X 1) TABLETS ^{DL,MM,SP}	*	PA,QL(56 per 28 days)
XCOPRI TITRATION PACK 12.5 MG (14)-25 MG (14) TABLETS IN A DOSE PACK	3	PA,QL(28 per 28 days)
XCOPRI TITRATION PACK 150 MG (14)-200 MG (14) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(28 per 28 days)
XCOPRI TITRATION PACK 50 MG (14)-100 MG (14) TABLETS IN A DOSE PACK ^{DL,SP}	*	PA,QL(28 per 28 days)
XELJANZ 1 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(300 per 30 days)
XELJANZ 10 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
XELJANZ 5 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
XELJANZ XR 11 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
XELJANZ XR 22 MG TABLET,EXTENDED RELEASE ^{DL,MM,SP}	*	PA,QL(30 per 30 days)
XELODA 150 MG TABLET	3	PA,QL(630 per 30 days)
XELODA 500 MG TABLET	3	PA,QL(189 per 30 days)
XELPROS 0.005 % EYE DROP EMULSION ^{MM}	2	ST,QL(2.5 per 25 days)
XELSTRYM 13.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	ST,QL(30 per 30 days)
XELSTRYM 18 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	ST,QL(30 per 30 days)
XELSTRYM 4.5 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	ST,QL(30 per 30 days)
XELSTRYM 9 MG/9 HOUR TRANSDERMAL 24 HOUR PATCH ^{MM}	3	ST,QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
XEMBIFY 1 GRAM/5 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA
XEMBIFY 10 GRAM/50 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA
XEMBIFY 2 GRAM/10 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA
XEMBIFY 4 GRAM/20 ML (20 %) SUBCUTANEOUS SOLUTION ^{DL,LD,MM,SP}	*	PA
XENAZINE 12.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(240 per 30 days)
XENAZINE 25 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
XENLETA 600 MG TABLET ^{DL,SP}	*	QL(10 per 5 days)
XEPI 1 % TOPICAL CREAM	3	PA
XERESE 5 %-1 % TOPICAL CREAM	3	PA
XERMELO 250 MG TABLET ^{DL,SP}	*	PA,QL(84 per 28 days)
XHANCE 93 MCG/ACTUATION BREATH ACTIVATED AEROSOL ^{DL,MM,SP}	*	PA,QL(32 per 30 days)
XIFAXAN 200 MG TABLET	3	PA,QL(9 per 30 days)
XIFAXAN 550 MG TABLET ^{MM}	3	PA,QL(84 per 28 days)
XIGDUO XR 10 MG-1,000 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
XIGDUO XR 10 MG-500 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
XIGDUO XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
XIGDUO XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(60 per 30 days)
XIGDUO XR 5 MG-500 MG TABLET,EXTENDED RELEASE ^{MM}	2	QL(30 per 30 days)
XIIDRA 5 % EYE DROPS IN A DROPPERETTE ^{MM}	3	PA,QL(60 per 30 days)
XIMINO 135 MG CAPSULE, EXTENDED RELEASE	3	ST,QL(30 per 30 days)
XIMINO 45 MG CAPSULE, EXTENDED RELEASE	3	ST,QL(30 per 30 days)
XIMINO 90 MG CAPSULE, EXTENDED RELEASE	3	ST,QL(30 per 30 days)
XOFLUZA 20 MG TABLET	2	QL(10 per 365 days)
XOFLUZA 40 MG TABLET	2	QL(10 per 365 days)
XOFLUZA 80 MG TABLET	2	QL(5 per 365 days)
XOLEGEL 2 % TOPICAL	3	ST
XOPENEX 0.31 MG/3 ML SOLUTION FOR NEBULIZATION ^{MM}	3	
XOPENEX 0.63 MG/3 ML SOLUTION FOR NEBULIZATION ^{MM}	3	
XOPENEX 1.25 MG/3 ML SOLUTION FOR NEBULIZATION ^{MM}	3	
XOPENEX CONCENTRATE 1.25 MG/0.5 ML SOLUTION FOR NEBULIZATION ^{MM}	3	
XOPENEX HFA 45 MCG/ACTUATION AEROSOL INHALER ^{MM}	3	ST,QL(30 per 30 days)
XOSPATA 40 MG TABLET ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
XPOVIO 100 MG/WEEK (20 MG X 5) TABLET ^{DL,MM,SP}	*	PA,QL(20 per 28 days)
XPOVIO 100 MG/WEEK (50 MG X 2) TABLET ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
XPOVIO 40 MG TWICE WEEK (40 MG X 2) TABLET ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
XPOVIO 40 MG TWICE WEEKLY (80 MG/WEEK) (20 MG X 4) TABLET ^{DL,MM,SP}	*	PA,QL(16 per 28 days)
XPOVIO 40 MG/WEEK (20 MG X 2) TABLET ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
XPOVIO 40 MG/WEEK (40 MG X 1) TABLET ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
XPOVIO 60 MG TWICE WEEKLY (120 MG/WEEK) (20 MG X 6) TABLET ^{DL,MM,SP}	*	PA,QL(24 per 28 days)
XPOVIO 60 MG/WEEK (20 MG X 3) TABLET ^{DL,MM,SP}	*	PA,QL(12 per 28 days)
XPOVIO 60 MG/WEEK (60 MG X 1) TABLET ^{DL,MM,SP}	*	PA,QL(4 per 28 days)
XPOVIO 80 MG TWICE WEEKLY (160 MG/WEEK) (20 MG X 8) TABLET ^{DL,MM,SP}	*	PA,QL(32 per 28 days)
XPOVIO 80 MG/WEEK (20 MG X 4) TABLET ^{DL,MM,SP}	*	PA,QL(16 per 28 days)
XPOVIO 80 MG/WEEK (40 MG X 2) TABLET ^{DL,MM,SP}	*	PA,QL(8 per 28 days)
XTAMPZA ER 13.5 MG CAPSULE SPRINKLE ^{DL}	2	QL(60 per 30 days)
XTAMPZA ER 18 MG CAPSULE SPRINKLE ^{DL}	2	QL(60 per 30 days)
XTAMPZA ER 27 MG CAPSULE SPRINKLE ^{DL}	2	QL(60 per 30 days)
XTAMPZA ER 36 MG CAPSULE SPRINKLE ^{DL}	2	QL(60 per 30 days)
XTAMPZA ER 9 MG CAPSULE SPRINKLE ^{DL}	2	QL(60 per 30 days)
XTANDI 40 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
XTANDI 40 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
xulane 150 mcg-35 mcg/24 hr transdermal patch ^{MM}	1	QL(3 per 28 days)
XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN ^{MM}	2	QL(15 per 30 days)
XURIDEN 2 GRAM ORAL GRANULES IN PACKET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
XYOSTED 100 MG/0.5 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(2 per 28 days)
XYOSTED 50 MG/0.5 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(2 per 28 days)
XYOSTED 75 MG/0.5 ML SUBCUTANEOUS AUTO-INJECTOR ^{MM}	3	PA,QL(2 per 28 days)
XYREM 500 MG/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(540 per 30 days)
XYWAV 0.5 GRAM/ML ORAL SOLUTION ^{DL,MM,SP}	*	PA,QL(540 per 30 days)
YASMIN (28) 3 MG-0.03 MG TABLET ^{MM}	3	
YAZ (28) 3 MG-0.02 MG TABLET ^{MM}	3	
YONSA 125 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
YOSPRALA 325 MG-40 MG TABLET,IMMEDIATE AND DELAY RELEASE ^{MM}	3	PA,QL(30 per 30 days)
YOSPRALA 81 MG-40 MG TABLET,IMMEDIATE AND DELAY RELEASE ^{MM}	3	PA,QL(30 per 30 days)
YUPELRI 175 MCG/3 ML SOLUTION FOR NEBULIZATION ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
yuvaferm 10 mcg vaginal tablet ^{MM}	1	
zafemy 150 mcg-35 mcg/24 hr transdermal patch ^{MM}	1	QL(3 per 28 days)
zafirlukast 10 mg tablet ^{MM}	1	QL(60 per 30 days)
zafirlukast 20 mg tablet ^{MM}	1	QL(60 per 30 days)
zaleplon 10 mg capsule	1	QL(30 per 30 days)
zaleplon 5 mg capsule	1	QL(30 per 30 days)
ZANAFLEX 2 MG CAPSULE ^{MM}	3	ST
ZANAFLEX 4 MG CAPSULE ^{MM}	3	ST
ZANAFLEX 4 MG TABLET ^{MM}	3	ST
ZANAFLEX 6 MG CAPSULE ^{MM}	3	ST
zarah 3 mg-0.03 mg tablet ^{MM}	1	
ZARONTIN 250 MG CAPSULE ^{MM}	3	
ZARONTIN 250 MG/5 ML ORAL SOLUTION ^{MM}	3	
ZARXIO 300 MCG/0.5 ML INJECTION SYRINGE ^{DL,SP}	*	PA,QL(7 per 30 days)
ZARXIO 480 MCG/0.8 ML INJECTION SYRINGE ^{DL,SP}	*	PA,QL(11.2 per 30 days)
ZAVESCA 100 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ZCORT 1.5 MG (25 TABS) TABLETS IN A DOSE PACK	1	QL(25 per 7 days)
ZEBUTAL 50 MG-325 MG-40 MG CAPSULE	3	QL(180 per 30 days)
ZEGALOGUE 0.6 MG/0.6 ML SUBCUTANEOUS AUTO-INJECTOR	3	ST
ZEGALOGUE 0.6 MG/0.6 ML SUBCUTANEOUS SYRINGE	3	ST
ZEGERID 20 MG-1,680 MG ORAL PACKET ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
ZEGERID 20 MG-1.1 GRAM CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
ZEGERID 40 MG-1,680 MG ORAL PACKET ^{DL,MM,SP}	*	ST,QL(30 per 30 days)
ZEGERID 40 MG-1.1 GRAM CAPSULE ^{MM}	3	ST,QL(30 per 30 days)
ZEJULA 100 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(90 per 30 days)
ZELAPAR 1.25 MG DISINTEGRATING TABLET ^{MM}	3	
ZELBORAF 240 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(240 per 30 days)
ZELNORM 6 MG TABLET	3	PA,QL(60 per 30 days)
ZEMBRACE SYMTOUCH 3 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR ^{DL,SP}	*	QL(6 per 30 days)
ZEMPLAR 1 MCG CAPSULE ^{MM}	3	QL(30 per 30 days)
ZEMPLAR 2 MCG CAPSULE ^{MM}	3	QL(30 per 30 days)
zenatane 10 mg capsule	1	QL(60 per 30 days)
zenatane 20 mg capsule	1	QL(60 per 30 days)
zenatane 30 mg capsule	1	QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
zenatane 40 mg capsule	1	QL(120 per 30 days)
ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE ^{DL,MM,SP}	*	ST
zenzedi 10 mg tablet ^{MM}	1	ST,QL(180 per 30 days)
ZENZEDI 15 MG TABLET ^{MM}	3	ST,QL(120 per 30 days)
ZENZEDI 2.5 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ZENZEDI 20 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ZENZEDI 30 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
zenzedi 5 mg tablet ^{MM}	1	ST,QL(150 per 30 days)
ZENZEDI 7.5 MG TABLET ^{MM}	1	ST,QL(90 per 30 days)
ZEPATIER 50 MG-100 MG TABLET ^{DL,SP}	*	PA,QL(28 per 28 days)
ZEPOSIA 0.92 MG CAPSULE ^{DL,LD,MM,SP}	*	PA,QL(30 per 30 days)
ZEPOSIA STARTER KIT 0.23 MG-0.46 MG-0.92 MG CAPSULES IN A DOSE PACK ^{LD,SP}	*	PA,QL(37 per 37 days)
ZEPOSIA STARTER PACK 0.23 MG (4)-0.46 MG (3) CAPSULES IN A DOSE PACK ^{DL,LD,SP}	*	PA,QL(7 per 7 days)
ZERVIAE 0.24 % EYE DROPS IN A DROPPERETTE	3	ST,QL(60 per 30 days)
ZESTORETIC 10 MG-12.5 MG TABLET ^{MM}	3	
ZESTORETIC 20 MG-12.5 MG TABLET ^{MM}	3	
ZESTORETIC 20 MG-25 MG TABLET ^{MM}	3	
ZESTRIL 10 MG TABLET ^{MM}	3	
ZESTRIL 2.5 MG TABLET ^{MM}	3	
ZESTRIL 20 MG TABLET ^{MM}	3	
ZESTRIL 30 MG TABLET ^{MM}	3	
ZESTRIL 40 MG TABLET ^{MM}	3	
ZESTRIL 5 MG TABLET ^{MM}	3	
ZETIA 10 MG TABLET ^{MM}	3	ST,QL(30 per 30 days)
ZETONNA 37 MCG/ACTUATION NASAL HFA INHALER ^{MM}	3	ST,QL(6.1 per 28 days)
ZIAC 10 MG-6.25 MG TABLET ^{MM}	3	
ZIAC 2.5 MG-6.25 MG TABLET ^{MM}	3	
ZIAC 5 MG-6.25 MG TABLET ^{MM}	3	
ZIAGEN 20 MG/ML ORAL SOLUTION ^{MM}	3	QL(960 per 30 days)
ZIAGEN 300 MG TABLET ^{MM}	3	QL(60 per 30 days)
ZIANA 1.2 %-0.025 % TOPICAL GEL	3	ST
zidovudine 10 mg/ml oral syrup ^{MM}	1	QL(1680 per 28 days)
zidovudine 100 mg capsule ^{MM}	1	QL(180 per 30 days)
zidovudine 300 mg tablet ^{MM}	1	QL(60 per 30 days)
ZIEXTENZO 6 MG/0.6 ML SUBCUTANEOUS SYRINGE ^{DL,SP}	*	PA,QL(1.2 per 28 days)
zileuton er 600 mg tablet,extended release 12hr mphase ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
ZILXI 1.5 % TOPICAL FOAM	3	PA,QL(30 per 30 days)
ZIMHI 5 MG/0.5 ML INJECTION SYRINGE	2	
zingiber 1.2 mg-40 mg-124.1 mg-100 mg tablet ^{MM}	1	
ZIOPTAN (PF) 0.0015 % EYE DROPS IN A DROPPERETTE ^{MM}	3	ST,QL(30 per 30 days)
ziprasidone 20 mg capsule ^{MM}	1	QL(60 per 30 days)
ziprasidone 20 mg/ml (final concentration) intramuscular solution	1	
ziprasidone 40 mg capsule ^{MM}	1	QL(60 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ziprasidone 60 mg capsule ^{MM}	1	QL(60 per 30 days)
ziprasidone 80 mg capsule ^{MM}	1	QL(60 per 30 days)
ZIPSOR 25 MG CAPSULE ^{DL,SP}	*	ST,QL(120 per 30 days)
ZIRGAN 0.15 % EYE GEL	3	QL(5 per 30 days)
ZITHROMAX 1 GRAM ORAL PACKET	3	
ZITHROMAX 100 MG/5 ML ORAL SUSPENSION	3	
ZITHROMAX 200 MG/5 ML ORAL SUSPENSION	3	
ZITHROMAX 250 MG TABLET	3	
ZITHROMAX 500 MG TABLET	3	
ZITHROMAX TRI-PAK 500 MG TABLET	3	
ZITHROMAX Z-PAK 250 MG TABLET	3	
ZOCOR 10 MG TABLET ^{MM}	3	ST
ZOCOR 20 MG TABLET ^{MM}	3	ST
ZOCOR 40 MG TABLET ^{MM}	3	ST
ZOCOR 80 MG TABLET ^{MM}	3	ST
ZOFRAN 4 MG TABLET	3	QL(90 per 30 days)
ZOHDRO ER 10 MG CAPSULE, ORAL ONLY,EXTENDED RELEASE ^{DL}	3	ST,QL(90 per 30 days)
ZOHDRO ER 15 MG CAPSULE, ORAL ONLY,EXTENDED RELEASE ^{DL}	3	ST,QL(90 per 30 days)
ZOHDRO ER 20 MG CAPSULE, ORAL ONLY,EXTENDED RELEASE ^{DL}	3	ST,QL(90 per 30 days)
ZOHDRO ER 30 MG CAPSULE, ORAL ONLY,EXTENDED RELEASE ^{DL}	3	ST,QL(90 per 30 days)
ZOHDRO ER 40 MG CAPSULE, ORAL ONLY,EXTENDED RELEASE ^{DL}	3	ST,QL(90 per 30 days)
ZOHDRO ER 50 MG CAPSULE, ORAL ONLY,EXTENDED RELEASE ^{DL}	3	ST,QL(120 per 30 days)
ZOKINVY 50 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
ZOKINVY 75 MG CAPSULE ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
ZOLINZA 100 MG CAPSULE ^{DL,SP}	*	PA,QL(120 per 30 days)
zolmitriptan 2.5 mg disintegrating tablet	1	ST,QL(9 per 30 days)
zolmitriptan 2.5 mg nasal spray	3	ST,QL(12 per 30 days)
zolmitriptan 2.5 mg tablet	1	ST,QL(9 per 30 days)
zolmitriptan 5 mg disintegrating tablet	1	ST,QL(6 per 30 days)
zolmitriptan 5 mg nasal spray	1	ST,QL(12 per 30 days)
zolmitriptan 5 mg tablet	1	ST,QL(6 per 30 days)
ZOLOFT 100 MG TABLET ^{MM}	3	ST,QL(60 per 30 days)
ZOLOFT 20 MG/ML ORAL CONCENTRATE ^{MM}	3	ST,QL(60 per 30 days)
ZOLOFT 25 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
ZOLOFT 50 MG TABLET ^{MM}	3	ST,QL(90 per 30 days)
zolpidem 1.75 mg sublingual tablet	1	ST,QL(30 per 30 days)
zolpidem 10 mg tablet	1	QL(30 per 30 days)
zolpidem 3.5 mg sublingual tablet	1	ST,QL(30 per 30 days)
zolpidem 5 mg tablet	1	QL(30 per 30 days)
zolpidem er 12.5 mg tablet,extended release,multiphase	1	QL(30 per 30 days)
zolpidem er 6.25 mg tablet,extended release,multiphase	1	QL(30 per 30 days)
ZOLPIMIST 5 MG/SPRAY (0.1 ML) ORAL SPRAY	3	ST,QL(23.1 per 365 days)
ZOMACTON 10 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
ZOMACTON 5 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(28 per 28 days)
ZOMIG 2.5 MG NASAL SPRAY	3	ST,QL(12 per 30 days)
ZOMIG 2.5 MG TABLET	3	ST,QL(9 per 30 days)
ZOMIG 5 MG NASAL SPRAY	3	ST,QL(12 per 30 days)
zomig 5 mg tablet	3	ST,QL(6 per 30 days)
ZOMIG ZMT 2.5 MG DISINTEGRATING TABLET	3	ST,QL(9 per 30 days)
ZOMIG ZMT 5 MG DISINTEGRATING TABLET	3	ST,QL(6 per 30 days)
ZONALON 5 % TOPICAL CREAM	3	PA,QL(45 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ZONEGRAN 100 MG CAPSULE ^{MM}	3	
ZONEGRAN 25 MG CAPSULE ^{MM}	3	
ZONISADE 100 MG/5 ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(900 per 30 days)
zonisamide 100 mg capsule ^{MM}	1	
zonisamide 25 mg capsule ^{MM}	1	
zonisamide 50 mg capsule ^{MM}	1	
ZONTIVITY 2.08 MG TABLET ^{MM}	3	QL(30 per 30 days)
ZORBTIVE 8.8 MG SUBCUTANEOUS SOLUTION ^{DL,MM,SP}	*	PA,QL(28 per 30 days)
ZORTRESS 0.25 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ZORTRESS 0.5 MG TABLET ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
ZORTRESS 0.75 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ZORTRESS 1 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ZORVOLEX 18 MG CAPSULE	3	ST,QL(90 per 30 days)
ZORVOLEX 35 MG CAPSULE	3	ST,QL(90 per 30 days)
ZORYVE 0.3 % TOPICAL CREAM ^{DL,MM,SP}	*	PA,QL(120 per 30 days)
zovia 1-35 (28) 1 mg-35 mcg tablet ^{MM}	1	
zovia 1/35e (28) 1 mg-35 mcg tablet ^{MM}	1	
ZOVIRAX 200 MG/5 ML ORAL SUSPENSION ^{MM}	3	
ZOVIRAX 5 % TOPICAL CREAM	3	PA
ZOVIRAX 5 % TOPICAL OINTMENT	3	PA
ZTALMY 50 MG/ML ORAL SUSPENSION ^{DL,MM,SP}	*	PA,QL(1080 per 30 days)
ZTLIDO 1.8 % TOPICAL PATCH	3	PA,QL(90 per 30 days)
ZUBSOLV 0.7 MG-0.18 MG SUBLINGUAL TABLET ^{MM}	3	PA,QL(90 per 30 days)
ZUBSOLV 1.4 MG-0.36 MG SUBLINGUAL TABLET ^{MM}	3	PA,QL(90 per 30 days)
ZUBSOLV 11.4 MG-2.9 MG SUBLINGUAL TABLET ^{MM}	3	PA,QL(30 per 30 days)
ZUBSOLV 2.9 MG-0.71 MG SUBLINGUAL TABLET ^{MM}	3	PA,QL(90 per 30 days)
ZUBSOLV 5.7 MG-1.4 MG SUBLINGUAL TABLET ^{MM}	3	PA,QL(90 per 30 days)
ZUBSOLV 8.6 MG-2.1 MG SUBLINGUAL TABLET ^{MM}	3	PA,QL(60 per 30 days)
zumandimine (28) 3 mg-0.03 mg tablet ^{MM}	1	
ZUPLENZ 4 MG ORAL SOLUBLE FILM	3	PA,QL(90 per 30 days)
ZUPLENZ 8 MG ORAL SOLUBLE FILM	3	PA,QL(90 per 30 days)
ZYCLARA 2.5 % TOPICAL CREAM IN A PUMP ^{DL,SP}	*	ST,QL(15 per 30 days)
ZYCLARA 3.75 % TOPICAL CREAM IN A PUMP ^{DL,SP}	*	ST,QL(15 per 30 days)
ZYCLARA 3.75 % TOPICAL CREAM PACKET ^{DL,SP}	*	ST,QL(28 per 28 days)
ZYDELIG 100 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ZYDELIG 150 MG TABLET ^{DL,MM,SP}	*	PA,QL(60 per 30 days)
ZYFLO 600 MG TABLET ^{DL,MM,SP}	*	ST,QL(120 per 30 days)
ZYKADIA 150 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(150 per 30 days)
ZYLET 0.3 %-0.5 % EYE DROPS,SUSPENSION	3	ST
ZYLOPRIM 100 MG TABLET ^{MM}	3	
ZYLOPRIM 300 MG TABLET ^{MM}	3	
ZYMAXID 0.5 % EYE DROPS	3	ST,QL(2.5 per 25 days)
ZYPITAMAG 2 MG TABLET ^{MM}	2	ST,QL(30 per 30 days)
ZYPITAMAG 4 MG TABLET ^{MM}	2	ST,QL(30 per 30 days)
ZYPREXA 10 MG INTRAMUSCULAR SOLUTION	3	QL(60 per 30 days)
ZYPREXA 10 MG TABLET ^{MM}	3	QL(30 per 30 days)
ZYPREXA 15 MG TABLET ^{MM}	3	QL(60 per 30 days)
ZYPREXA 2.5 MG TABLET ^{MM}	3	QL(30 per 30 days)
ZYPREXA 20 MG TABLET ^{MM}	3	QL(60 per 30 days)
ZYPREXA 5 MG TABLET ^{MM}	3	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

DRUG NAME	DRUG LEVEL	UTILIZATION MANAGEMENT REQUIREMENTS
ZYPREXA 7.5 MG TABLET ^{MM}	3	QL(30 per 30 days)
ZYPREXA RELPREVV 210 MG INTRAMUSCULAR SUSPENSION ^{MM}	3	QL(4 per 28 days)
ZYPREXA RELPREVV 300 MG INTRAMUSCULAR SUSPENSION ^{MM}	3	QL(2 per 28 days)
ZYPREXA RELPREVV 405 MG INTRAMUSCULAR SUSPENSION ^{MM}	3	QL(1 per 28 days)
ZYPREXA ZYDIS 10 MG DISINTEGRATING TABLET ^{MM}	3	QL(30 per 30 days)
ZYPREXA ZYDIS 15 MG DISINTEGRATING TABLET ^{MM}	3	QL(60 per 30 days)
ZYPREXA ZYDIS 20 MG DISINTEGRATING TABLET ^{MM}	3	QL(60 per 30 days)
ZYPREXA ZYDIS 5 MG DISINTEGRATING TABLET ^{MM}	3	QL(30 per 30 days)
ZYTIGA 250 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(120 per 30 days)
ZYTIGA 500 MG TABLET ^{DL,LD,MM,SP}	*	PA,QL(60 per 30 days)
ZYVOX 100 MG/5 ML ORAL SUSPENSION	3	QL(1800 per 30 days)
ZYVOX 600 MG TABLET	3	QL(30 per 30 days)

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization

Your coverage may include medicines in the following drug classes when your insurance is issued through the state of:

- Illinois: Obesity and infertility
- Michigan: Obesity
- Kansas or Colorado: Infertility
- Indiana: Sexual dysfunction
- Nevada: Hormone replacement therapy

Louisiana residents: If your insurance is issued through the state of Louisiana and you pay a percent of the full drug cost, any discounts negotiated directly with a drug manufacturer may have been applied as an offset to your insurance premium instead of at the pharmacy counter. This is defined as an excess consumer cost burden by the state.

Colorado and Kentucky: If your insurance is issued through the state of Colorado or Kentucky, all covered substance use disorder medicines are available with no prior authorization or step therapy requirements.

To get more information around these state-mandated coverages, log in to MyHumana through **Humana.com** or call Customer Care at the number on the back of your Humana ID card.

Contraceptive coverage is subject to your employer's coverage selections. For more information, log in to MyHumana through **Humana.com** or call Customer Care at the number on the back of your Humana ID card.

Your employer's coverage selections may include preventive medicine coverage, available to you before your deductible is met. This preventive medication coverage is based upon guidance issued by the Internal Revenue Service (IRS) for preventive use and is not directly associated with Healthcare Reform (HCR) or Affordable Care Act (ACA) \$0 Preventive Medication Coverage. For more information, log in to MyHumana through **Humana.com** or call Customer Care at the number on the back of your Humana ID card.

Humana Plans are offered by Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc. - A Health Maintenance Organization, or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Humana Insurance of Puerto Rico, Inc. License #00187-0009, or administered by Humana Insurance Company or Humana Health Plan, Inc.

ASO products are administered by Humana Insurance Company or Humana Health Plan, Inc.

For Arizona Residents: Offered by Humana Health Plan, Inc. or insured by Humana Insurance Company.

Statements in languages other than English contained in the advertisement do not necessarily reflect the exact contents of the policy written in English, because of possible linguistic differences. In the event of a dispute, the policy as written in English is considered the controlling authority.

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information on the company providing your benefits.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.



[Humana.com](https://www.humana.com)

MAIL DELIVERY

CenterWell Pharmacy

More and more Humana members are finding CenterWell Pharmacy™ to be their choice for value, experience, safety, accuracy, convenience and service.



Why choose CenterWell Pharmacy?

Savings. Many Humana plans provide cost savings if you fill a 90-day supply of your maintenance medicine through a mail-delivery pharmacy instead of a retail pharmacy. Additionally, the pharmacy team works with you and your provider to find medicine that costs less.

Experienced pharmacy team. Pharmacists are available to answer questions about your medicine and our services.

Peace of mind. Two pharmacists check your new prescriptions to make sure they're safe to take with your other medications. The dispensing equipment and heat-sealed bottles with tamper-resistant foil help ensure quality and safety. Plus, your order comes in plain packaging for additional security.

Timely reminders. To help make sure you have the medicine and supplies you need when you need them, we can remind you when it's time to refill your medicine. Just set your preferences when you sign up at [CenterWellPharmacy.com](https://www.CenterWellPharmacy.com).

Time-saving mail delivery. Your medicine will be shipped safely and securely to the location of your choice. That means no more trips to the pharmacy. No more waiting in lines to pick up your medicine. No more hassle. You may be able to order just four times a year and have more time to do the things you enjoy.

Make CenterWell Pharmacy your one source

Maintenance medicine. Medicine you take all the time for conditions like high cholesterol, high blood pressure and asthma.

Specialty medicine. Specialized therapies to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

Visit [CenterWellPharmacy.com](https://www.CenterWellPharmacy.com)

After becoming a Humana member, you can sign in with your MyHumana identification number or register to get started. You can also sign up by calling **800-379-0092 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

Humana®



Your health is important to us. CenterWell Pharmacy can deliver the value and service you expect from your pharmacy.

Flexible ordering options

Online

CenterWellPharmacy.com. Start a new prescription, order refills, check on your order and get information about how to get started.

Provider

Let your provider know he or she can send prescriptions electronically through e-prescribe. Providers can also fill out the fax form by downloading it from **CenterWellPharmacy.com/forms** and faxing the prescription to CenterWell Pharmacy **800-379-7617** or CenterWell Specialty Pharmacy **877-405-7940**.

Mail

Download the “Registration & Prescription Order Form” from **CenterWellPharmacy.com/forms** and mail your paper prescriptions to:

CenterWell Pharmacy
P.O. Box 745099
Cincinnati, OH 45274-5099

The life of a prescription

1. CenterWell Pharmacy receives your prescription order. Your provider can send us your new prescriptions by fax, phone or electronically. Or you can send new prescriptions by mail with an order form. Order forms can be downloaded at **CenterWellPharmacy.com/forms**.
2. An associate checks your pharmacy benefit coverage, enters your order and creates a unique shipment number.
3. A pharmacist checks your prescription order for accuracy and possible drug, disease or allergy interactions.
4. Approved orders go through the payment process. If your plan doesn't cover the medicine, CenterWell Pharmacy will check the claim and fix the problem. If your prescription cannot be filled, Humana will contact you regarding the delay or return your prescription with an explanation.
5. An automated system fills your medicine and a pharmacist makes sure it matches the label before it's sealed.
6. CenterWell Pharmacy ships the order to you, along with an invoice for your records and the required medicine information and proper dosing directions. Standard shipping is free. Faster shipping is available for an additional cost.

You should get your new prescription by mail in 7–10 days after CenterWell Pharmacy has all the necessary information. Your refill should arrive within 5–7 days. It may take longer if they have to call you or your provider with questions about the order.

Humana®

Humana is a Medicare Advantage HMO, PPO organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

Other pharmacies may be available in our network. You can locate network pharmacies by visiting [Humana.com/finder/pharmacy](https://www.humana.com/finder/pharmacy).

Phone

Call CenterWell Pharmacy at **800-379-0092 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

For specialty medicine, call CenterWell Specialty Pharmacy® at **800-486-2668 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

CenterWell Pharmacy Mobile app

1. Go to **CenterWellPharmacy.com/about/mobile-apps.cmd**
2. Download our CenterWell Pharmacy app from the iTunes App Store® or Google Play™.
3. Sign in or select “Transfer Rx as guest” from the home screen.

Life

Insurance

Life Insurance:

Our Life Insurance offers financial protection in case of an employee's (main insured) death or if he/she suffers an important physical injury.



 **\$10,000***

Our Life Insurance insures the employees in case of death.

It also has available the coverage for accidental death or dismemberment with double benefits at the time of the accidental death or dismemberment as applicable.

Structure of Benefits:

Fixed amount: – The benefit amount is the same for all employees of the group. The benefit must be offered to all employees of the group.



*If at the time of the claim to the insurance, the employee is 65 years of age or over, the benefit is reduced to 65% or less, up to a 10%, subject to age.
Products and services offered by Humana Insurance of Puerto Rico, Inc. License # 00187-0009.
This is a summary of benefits. For more details, refer to the policy.



WHAT IS AN EAP?

The Employee Assistance Program (EAP) provides professional counseling to employees and their dependents to help them better manage difficult situations that impact their quality of life at home or their productivity at work.

SERVICE COORDINATION AND INFORMATION

CALL NOW!

787-522-4616

1-877-955-9554

(24/7 • TOLL FREE)

optimind@apspuertorico.com

apsoptimind.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

 **APS** OptiMind

 **APS**
OptiMind

THE EAP FROM APS OPTIMIND

Our **Employee Assistance Program (EAP)** has a preventive, proactive and confidential approach that has proven to be highly successful:

PREVENTIVE: we promote healthy lifestyles through education and prevention.

PROACTIVE: we empower individuals to deal with daily life situations in an optimal manner and identify potential issues on time to avoid major complications.

CONFIDENTIAL: we guarantee total confidentiality of the process, giving employees peace of mind to use the service when needed without being exposed.

EMPLOYEE SERVICES

- Psychological therapy and counseling
- Appointment coordination
- Referrals (according to appropriate level of care)
- Legal counseling
- Financial advice
- Psycho-educational talks and workshops
- Crisis management
- Prevention and health promotion:
 - Educational newsletters
 - Health fairs
- VIP services

COMMON SITUATIONS

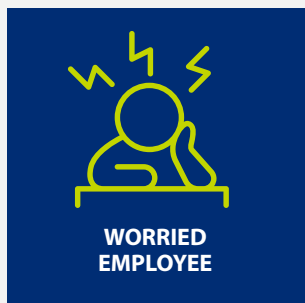
- Stress, anxiety or depression
- Relationships
- Family or marital conflicts
- Academic problems
- Use or abuse of drugs and alcohol
- Management of loss or mourning
- Legal and financial issues



ACCESS GUARANTEE

APS OPTIMIND is backed by the unequalled experience and strength of APS HEALTH, the leading mental health services group in Puerto Rico. This guarantees access to:

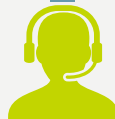
- The largest specialized providers network in Puerto Rico with over 360 certified professionals
- A 24/7 call center attended by licensed clinical personnel



WORRIED
EMPLOYEE



PSYCHOLOGICAL
THERAPY



SERVICE
COORDINATION



LEGAL
ADVICE



FINANCIAL
COUNSELING



HAPPY AND
PRODUCTIVE

Humana Total Wellness

Humana offers a variety of programs to help you improve your quality of life. Our aim is to guide you so you can reach an optimal level of health.

How do Humana's Total Wellness programs work?

Health professionals offer guidance and support to individuals or groups, providing health information and coordinating services according to your needs.



Calidad Humana

If you or any member of your family has any health condition such as asthma, congestive heart failure, arterial coronary disease, chronic obstructive pulmonary disease, diabetes, hyperlipidemia or obesity, this program is for you. A nursing professional will follow up with you over the phone to provide guidance and support. You can become more knowledgeable about your condition and start acting on the recommendations offered by a health professional. For more information, call **1-877-589-2819**.

Humana Beginnings

During pregnancy many questions come up about this very special period. The prenatal program is ideal to offer the mother support during and after her pregnancy. Humana Beginnings has professionals at hand, trained in prenatal education, breastfeeding and post-partum care. Call **1-866-488-5992** to participate in the program and enjoy its benefits. Ask about the delivery and breastfeeding workshops near your area!

Personal Nurse

With the Personal Nurse program you receive education and support from nursing professionals regarding the effective management of your health conditions and overall wellness. For further information, do not hesitate to call toll-free **1-866-488-5992**.

My Humana

If you need to get information about your health, your health plan and benefits; or you need a coverage certificate, access My Humana. On the spot, at any time of the day you can have access to our My Humana personalized web page (http://www.humana.com/resources/support_center/myhumana_benefits/register/).

Education and Prevention

Education and Prevention offers you the tools that provide support to prevent illness and/or manage effectively your health and wellbeing.

We invite you to participate in these free clinical programs. Visit your human resources department to find out more!

Humana®

PRHHH2DSP

Products and services offered by Humana Insurance of Puerto Rico, Inc. License # 00187-0009 and/or Humana Health Plans of Puerto Rico, Inc. License # 00235-0008. It is important that we treat you fairly. Discrimination is against the law. Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana complies with all Federal and State Civil Rights laws. Language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711). Español: Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística. 繁體中文：撥打上面的電話號碼即可獲得免費語言援助服務。

Professional care that's virtually there

REGISTER TODAY FOR
HUMANA VIRTUAL VISITS
POWERED BY MDLIVE®



You don't have to be at your doctor's office to receive quality professional healthcare. **Get nonemergency medical —anywhere, anytime.**

Simply use your phone, tablet or laptop to reach a U.S.-based, board-certified doctor with Puerto Rico license **24 hours a day, seven days a week.**

When your doctor is not available, use **virtual visits** to get help with things like allergies, skin irritation, flu-like symptoms, managing a chronic condition like high blood pressure or arthritis, and much more. Should a provider determine you need a prescription, it will be electronically prescribed to the pharmacy you choose.

Virtual visits are a convenient way to **access care** when you are **at home** or **on the go**.

Humana®

MDLIVE®

Products and services offered by Humana Insurance of Puerto Rico, Inc. License # 00187-0009 and/or Humana Health Plans of Puerto Rico, Inc. License # 00235-0008.

* Fees apply for messages and data. Answer STOP to cancel, HELP for additional help. Limitations on virtual visit healthcare and prescription services delivered via remote access technology and communications vary by plan. Virtual visit services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.



Get started in one of these ways:

1. Download the **MDLIVE mobile** app from the App Store® or Google Play®
2. Visit the following website: **MDLIVE.com/Humanapr**
3. Call **1-888-921-0314 (TTY: 711)**
4. Send* text message "**Humanapr**" to **635483** (MDLive).

When should you use virtual doctor visits?

An MDLIVE virtual doctor visit is a great way to treat routine medical conditions. Fast, easy and convenient.



- You're not feeling up to leaving home 
- You want to avoid the high cost of Urgent Care or the ER 
- Your doctor isn't available 
- It's after hours, the weekend or a holiday 
- You need a short-term refill on a prescription 
- It's hard to get to the doctor's office 
- You don't want to take time off work 

Medical Visits Copay

No deductible is required. Cost per visit will be \$0*.



Registering for MDLIVE just got easier!

Meet Sophie, your personal assistant.
Text "humanapr" to 635483.

MDLIVE.com/humanapr
888-921-0314

Download our free app today!



*\$0 copayment during the COVID-19 emergency period. After that, copay may apply depending on your plan.

Humana

MDLIVE®

Stay in network to avoid extra costs



Choosing doctors, hospitals and other providers out of Humana's network can cost you more money. Using providers in the Humana network whenever possible can help keep your healthcare costs lower. When you use an out-of-network provider, they may charge you more and they could bill you (where permitted) for the difference your Humana plan doesn't cover. That's called balance billing.

What is balance billing?

Balance billing is when an out-of-network provider bills you for the difference between their charge and what your Humana health plan will allow. For example, let's say an out-of-network doctor charges \$100 to review your MRI, but your plan will only cover and pay for \$70. The doctor may bill you for the remaining \$30 in addition to what you may owe for your deductible or coinsurance.

The **No Surprises Act** does not allow an out-of-network provider to balance bill you for the following:

- Emergency services
- Physician services in an in-network facility (like a radiologist or an anesthesiologist)
- Air ambulance

Note: Any balance bill you may pay will not apply to your deductible or maximum out-of-pocket limit for the plan year.

What is an out-of-network provider?

An out-of-network provider is a doctor or care professional (like a nurse practitioner or anesthesiologist) or facility (such as a hospital, lab processing facility or ambulatory surgery center) that isn't part of your health plan's network.

Humana negotiates with healthcare providers and facilities to provide services at lower rates, and that's how doctors and hospitals become part of the network. Out-of-network providers do not have contracts with Humana.

What happens when I use an out-of-network hospital or provider?

Your out-of-pocket costs (like copayments, coinsurance and deductibles) may be higher. That's because you're charged the full price for a service and not the lower, negotiated rate you'd pay through the Humana network.

I've gone to an in-network hospital. All of the providers there are in network, right?

Not necessarily. For example, if you go to a network hospital to get an MRI, the doctor reading the MRI may not be in the network. That doctor may charge the full price for the service, not the lower negotiated rate allowed for a network provider. The **No Surprises Act** protects you from being balance billed the difference between what the provider charged and what your Humana plan allows.

What if I have an emergency?

You should visit the nearest emergency room. If you receive emergency services from an out-of-network doctor or hospital, your costs may be more than they would be from a network provider. The **No Surprises Act** protects you from being balance billed the difference between what the provider charged and what your Humana plan allows.

What is an allowable charge?

An allowable charge (sometimes called the allowed amount) is the amount Humana pays for a covered healthcare service.

For services not covered under the **No Surprises Act**: The amount Humana allows an out-of-network provider to charge Humana for a covered service is called a maximum allowable fee.*

For services covered under the **No Surprises Act**: The amount Humana allows is the qualified payment amount.

**Referred to as “usual and customary” amount in some products.*

Use network doctors and facilities

You can access “Find a doctor or pharmacy” by signing in to **MyHumana**, your secure online account at **Humana.com**. You can also call the number on the back of your Humana member ID card to check if a provider is in network.

.....

This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional. If you are in a life-threatening or emergency medical situation, please dial 9-1-1 and seek medical attention immediately.

This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

Humana group medical plans are offered by Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, Humana Health Plan of Texas, Inc., insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Humana Insurance of Puerto Rico, Inc. License # 00187-0009, or administered by Humana Insurance Company or Humana Health Plan, Inc.

Statements in languages other than English contained in the advertisement do not necessarily reflect the exact contents of the policy written in English because of possible linguistic differences. In the event of a dispute, the policy as written in English is considered the controlling authority. For Arizona residents: offered by Humana Health Plan, Inc., or insured by Humana Insurance Company. Administered by Humana Insurance Company.



How can I avoid extra costs?



Talk to your doctor

Before you have a healthcare screening or procedure, be sure to talk to your doctor. Ask him or her about the facility and any other specialists who may be involved so that you can make sure they participate in the network before you receive care.



What if I receive a balance bill from an out-of-network doctor or facility?

If you believe you have been wrongly billed for services covered under the **No Surprises Act**, you may contact the No Surprises Help Desk (NSHD) at: **1-800-985-3059** or visit cms.gov/nosurprises.

Understand your benefits



You should review your Summary Plan Description to make sure you fully understand your health plan benefits.

Here's how you can access it:

1. **Sign in** – MyHumana at **Humana.com**
2. **Select** the Coverage tab under “Plan Benefits”
3. **Scroll down** – click “Coverage Details”
4. **Download** – your “Summary Plan Description”

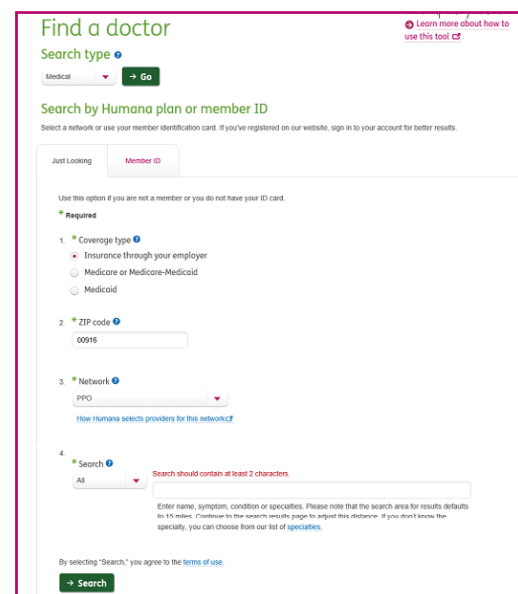
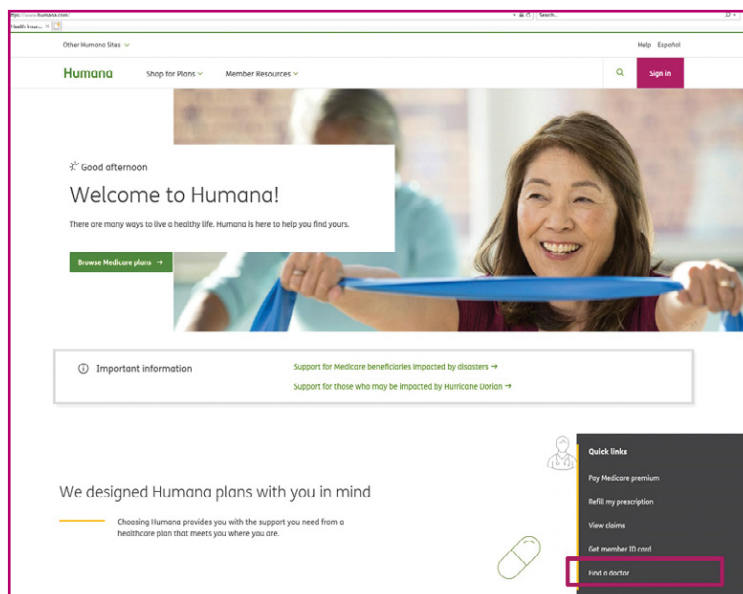
Find a doctor with Physician Finder Plus[®]

Physician Finder Plus is Humana's online provider look-up tool. It's your guide to the latest information about providers in Humana's network.

The tool provides the names, addresses and phone numbers of in-network providers. You can choose to sort your results by specialty or distance from your home or office.

To find a participating provider, visit [Humana.com](https://www.humana.com) and select **Find a doctor**. Using the **"Just Looking"** Tab, you will need your ZIP code and plan type to help narrow your search. This service is also available on MyHumana and the MyHumana Mobile app for your smart phone.

If you need more assistance finding an in-network provider, call the Customer Care number on the back of your Humana member ID card.



To find a participating provider, select the **Search Type** (Medical, Dental, or Pharmacy) and use the **Just Looking** tab and then enter the following:

- Coverage type: **Insurance through your employer**
- Your Zip Code
- Network: **PPO**
- Search: Specialty, condition or name of provider.
- Press Search.





Receive an EyeMed Vision Discount

As a Humana member, you receive the EyeMed Vision Discount program at no cost to you. EyeMed offers access to 35,000 providers including optometrists, ophthalmologists, opticians, and optical retailers such as LensCrafters®, Pearle Vision®, and JCPenney Optical.

To find an EyeMed provider

- Click on “EyeMed Vision Care” under the “Provider Search” area in the member section of Humana.com, or call EyeMed’s toll-free locator service at 1-866-995-9316
- To find a LASIK or PRK vision-correction provider, call 1-877-5LASER6

It’s easy to obtain your discount from an EyeMed provider

- Present your vision discount card below or
- Present your Humana member identification card or
- Print your vision discount card by logging into MyHumana, your member page on Humana.com, and clicking on “EyeMed Discount” in “Savings Center” under the Health and Wellness tab

See the other side of this flyer for a list of vision care services

Humana®

eye
Med

GN50720HD 1012

Humana®

EyeMed Vision Discount

For a location nearest you call 1-866-995-9316.

This vision discount program is not part of your insurance.

Vision discount program

(retail prices may vary by location)

Exams

Routine exam	\$5 off
Contact lens exam	\$10 off

Standard plastic lenses

Single vision	\$50
Bifocal	\$70
Trifocal	\$105

Frames

Discount available – 35 percent off retail prices – on all frames except when prohibited by the manufacturer.

Lens options

Lens options	Member pays
UV coating	\$15
Tint (solid and gradient)	\$15
Standard scratch-resistant	\$15
Standard polycarbonate	\$40
Standard progressive* (add-on to bifocal) ..	\$65
Standard anti-reflective coating	\$45
Other add-ons and services	20% discount

* The cost for Premium Progressive lenses equals the Basic Progressive lens retail price plus a 20 percent discount on the balance over this price.

Contact lenses

Conventional lenses are 15 percent off retail price. Discount applied to materials only (excludes disposable).

Laser vision correction*

LASIK or PRK from U.S. Laser Network is 15 percent off retail price or 5 percent off promotional price.

* Because LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization, please call 1-877-5LASER6.

Service

Frequency

Examination	unlimited
Frames	unlimited
Lenses	unlimited
Contact lenses	unlimited



THIS IS NOT INSURANCE. These discount programs are not part of your insurance product. Discounts are only available at participating providers. Service providers are solely responsible for the provision of products and services. Humana and its affiliates are not liable for product defects, provider negligence or other errors in the delivery of discount products or services.

Member will receive a 20% discount on items purchased at participating providers that are not specifically covered by this discount design. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses. Retail prices may vary by location.

Products and services offered by Humana Insurance of Puerto Rico, Inc. License # 00187-0009 and/or Humana Health Plans of Puerto Rico, Inc. License # 00235-0008.

GN50720HD 1012

Limitations/ Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Services provided as a result of any worker's compensation law
- Discount is not available on frames when the manufacturer prohibits a discount

Plan Code: 9236860

REIMBURSEMENT CLAIM FORM

1. Contract or MPI Number: _____
2. Group Number: _____
3. Patient's Name: _____ subscriber ___ spouse ___ dependent ___
4. Postal Address: If you wish to notify change of address other than the one in our records please add here:

5. Home Phone No.: _____ - _____ - _____
6. Work Phone No.: _____ - _____ - _____ Ext. _____
7. Name of provider of services: _____
(If the Physician is part of a Group, include the name of the Physician)
8. Provider's specialty: _____ Phone No. : _____ - _____ - _____
9. Date of service: (Month) ___ (Day) ___ (Year) _____
10. Condition or diagnosis: _____ CPT Code: _____
11. Any other health plan? ___ No ___ Yes - Company: _____ Policy / Contract No.: _____
12. Is this service related to an accident? ___ No ___ Yes - Please answer the questions:
Where? _____ When? _____ How? _____
- | 13. Services Provided | Charges | Services Provided | Charges |
|---|---------|---|---------|
| <input type="checkbox"/> Office Visit &/or Consultation | _____ | <input type="checkbox"/> Laboratory | _____ |
| <input type="checkbox"/> Radiology | _____ | <input type="checkbox"/> Surgery | _____ |
| <input type="checkbox"/> Anesthesia | _____ | <input type="checkbox"/> Pharmacy | _____ |
| <input type="checkbox"/> Procedures | _____ | <input type="checkbox"/> Durable Medical Equip. | _____ |
| <input type="checkbox"/> Hospital Services | _____ | <input type="checkbox"/> Mental Health | _____ |
| <input type="checkbox"/> Emergency Room Services | _____ | <input type="checkbox"/> Other | _____ |
14. Did you contact Humana before service was rendered? ___ No ___ Yes, with whom? _____
15. Please explain why you had to pay for the services:

16. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

Name

Signature

Date

INSTRUCTIONS REIMBURSEMENT CLAIM FORM

The reimbursement claim form must be submitted for all reimbursements.

Must be sure that the information included is correct. (Example: Contract number, date of service, etc.)

The following are the requirements to receive the reimbursement:

1. Original receipt from provider.
2. Name and telephone number of the provider.
3. The form must be completed.
4. Must request the provider to include procedure code and diagnosis, using the corresponding code (ICD -9, CPT-4) and description.
5. Medical order for the services that requires it (purchase or lease of durable medical equipment, diagnostic tests, etc.) The reimbursements for the purchase or lease of durable medical equipment require pre-authorization from Humana.
6. Copy of the referral from PCP, when applicable (only for HMO).
7. In case of Coordination of Benefits, please include the Explanation of Benefits of the Primary Plan
8. Copy of the Rx prescription covered under medical coverage.

If you have other medical plan and your claim is for deductibles or copayments, you must submit copy of the charges paid by the other plan.

Please keep copy of the documents included in this claim.

ANTI-FRAUD LAW

The Article 27.250 of the Insurance Code of Puerto Rico, 26 L.P.R.A. sec. 2725, of August 9, 2008) mentioned that Any person who, knowingly and with the intend to defraud, presents false information in an insurance request form, or who presents a fraudulent claim for the payment of a loss, will incur a felony, and upon a conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed establishment imprisonment may be increase to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

The non-compliance of the dispositions of this Article will include the imposition of an administrative fine no less than one thousand (1,000) dollars nor more than five thousand (5,000) dollars.

If this notice is not included in the indicated formularies it will not constitute a defense for the insured or third claimant to comply with the dispositions of this Chapter. The breach of the regulations of this Article will entail the imposition of an administrative fine as required by the Article 27.260 of the Insurance Code of Puerto Rico.

Must be submitted on or before one (1) year after services rendered to the following address:

**HUMANA
CLAIMS DEPARTMENT
P O BOX 192059
SAN JUAN, PR 00919-2059**

For questions or further information, please call our Customer Service Department at:

**(787) 282-7900
or our toll free number
1-800-314-3121**

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, or demographic information. The term "information" in this notice includes any personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we protect your information?

We have a responsibility to protect the privacy of your information in all formats including electronic, written and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

We don't destroy your PHI even when you end your coverage with us. We may need to use and share it even after your coverage terminates. (We describe the reasons for using or sharing in this Notice). We will continue to protect your information against inappropriate use or disclosure.

How do we use and disclose your information?

We use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.

- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission or your plan sponsor has to certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out as described below, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.

Notice of Privacy Practices

(continued)

- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.

The following uses and disclosures will require your written permission:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and health information

What do we do with your information when you are no longer a member?

Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

We are committed to responding to your rights request in a timely manner

- Access – You have the right to review and obtain an electronic copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision – If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. In the event that we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment

of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*

- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice – You have the right to request and receive a written copy of this notice any time.
- Restriction – You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

What types of communications can I opt out of that are made to me?

- Appointment reminders
- Treatment alternatives or other health-related benefits or services

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762
- Accessing our Website at Humana.com and going to the Privacy Practices link
- Send completed request form to:
Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

If I believe that my privacy has been violated, what should I do?

If you believe that your privacy has been violated you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also email your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

*This right applies only to our Massachusetts residents in accordance with state regulations.

Notice of Privacy Practices

(continued)

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time, let us know in writing if you change your mind.
- We can change the terms of this notice, and the changes will apply to all information we have about you.
- The new notice will be available upon request, in our office, and on our web site.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

We and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will we disclose your information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can also prevent us and or affiliated companies from marketing products offered by non-affiliated third parties by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your identification number or member account. Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell us not to share any of your personal information with affiliated companies that provide offers for products or services of non-affiliated third parties. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your member identification number. The opt-out request shall not prohibit our affiliated companies from marketing our products or services.

- Call us at 1-866-861-2762
- Send your opt-out request to us in writing:
Humana Inc. Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, we follow the law, rule, or regulation which provides greater protection.

We are required by law to abide by the terms of this notice currently in effect.

Notice of Privacy Practices (continued)

The following affiliates and subsidiaries also adhere to our privacy policies and procedures:

Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan Inc.
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
DentiCare, Inc.
Emphesys Insurance Company
Humana Dental Insurance Company
Humana Benefit Plan of Illinois, Inc.
Humana Benefit Plan of South Carolina, Inc.
Humana Benefit Plan of Texas, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Independent Care Health Plan
Managed Care Indemnity, Inc.
The Dental Concern, Inc.

Effective 9/2013



Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:

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

If you need help filing a grievance, call the number on your ID card 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 their Complaint Portal, available at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**,

200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**,

800-537-7697 (TDD). Complaint forms are available at **<https://www.hhs.gov/ocr/office/file/index.html>**.

- **California residents:** You may also call the California Department of Insurance toll-free hotline number:

800-927-HELP (4357), to file a grievance.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

Humana provides 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.

Language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (**TTY: 711**)... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (**TTY: 711**)... 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (**TTY: 711**)... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (**TTY: 711**)... 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 적혀 있는 번호로 전화해 주십시오 (**TTY: 711**)... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (**TTY: 711**)... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (**телетайп: 711**)... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (**TTY: 711**)... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (**ATS: 711**)... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (**TTY: 711**)... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (**TTY: 711**)... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (**TTY: 711**)... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (**TTY: 711**)... 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。お手持ちの ID カードに記載されている電話番号までご連絡ください (**TTY: 711**)...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید (**TTY: 711**)...

Díí baa akó nínizín: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq, námboo ninaaltsoos yézhí, bee nées ho'dółzin bikáá'ígíí bee hólne' (**TTY: 711**)...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (**TTY: 711**).

GCHK42UEN 0222