2026

Prescription Drug Guide

NC State Health Plan Abbreviated Formulary

Partial List of covered drugs or "Drug List"

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

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Formulary 26800

This abridged formulary was updated on 09/03/2025 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the NC State Health Plan Humana Customer Care Team with any questions at 1-888-700-2263, or for TTY users, 711, or visit **your.humana.com/ncshp**.

Instructions for getting information about all covered drugs are inside.

Humana®

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Welcome to Humana Group Medicare Plan!

Note to existing members: This Formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (Formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan," it means Humana Group Medicare Plan.

This document includes a partial Drug List (formulary) for our plan which is current as of January 1, 2026. For a complete, updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

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

What is the Humana abridged formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is the entire list of covered drugs or medications selected by Humana. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. Humana Group Medicare Plan worked with a team of doctors and pharmacists to make a formulary that represents the prescription drugs we think you need for a quality treatment program. Humana Group Medicare Plan will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Humana Group Medicare Plan network pharmacy, and other plan rules are followed. For more information on how to fill your medications, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Humana Group Medicare Plan. For a complete listing of all prescription drugs covered by Humana, please visit **your.humana.com/ncshp** or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages

Can the formulary change?

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

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

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

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

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

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

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

- **Drugs removed from the market**. If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes**. We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

We will notify members who are affected by the following changes to the formulary:
- When a drug is removed from the formulary.
- When prior authorization, quantity limits, or step-therapy restrictions are added to a drug or made more restrictive.
- When a drug is moved to a higher cost sharing tier.

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

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

What if you are affected by a Drug List change?

We will notify you by mail at least 30 days before one of these changes happens or we will provide a 30-day refill of the affected medicine with notice of the change.

The enclosed formulary is current as of January 1, 2026. To get updated information about the drugs covered by Humana please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

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

Medical condition

The formulary begins on page 11. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 11. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 6 for more information on Utilization Management Requirements).

Alphabetical listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 32. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to each drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

What are generic drugs?

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

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

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

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

Prescription drugs are grouped into one of four tiers.
Humana Group Medicare Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

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

How much will I pay for covered drugs?

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

The amount of money you pay depends on:

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

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

Are there any restrictions on my coverage?

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

- **Prior Authorization (PA):** Humana Group Medicare Plan requires you to get prior authorization for certain drugs. This means that you will need to get approval from Humana Group Medicare Plan before you fill your prescriptions. If you do not get approval, Humana Group Medicare Plan may not cover the drug.

- **Quantity Limits (QL):** For certain drugs, the Humana Group Medicare Plan limits the amount of the drug that is covered. The Humana Group Medicare Plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Some drugs are limited to a 30-day supply regardless of tier placement.

- **Step Therapy (ST):** In some cases, the Humana Group Medicare Plan requires that you first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Group Medicare Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Group Medicare Plan will then cover Drug B.

- **Part B versus Part D (BvsD):** Some drugs may be covered under Medicare Part B or Part D, depending upon the circumstances. Information may need to be submitted to Humana that describes the use and the place where you receive and take the drug so a determination can be made.

For drugs that need prior authorization or step therapy, or drugs that fall outside of quantity limits, your health care provider can fax information about your condition and need for those drugs to Humana Group Medicare Plan at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m. (EST).

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 11. You can also get more information about the restrictions applied to specific covered drugs by visiting **your.humana.com/ncshp**. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Humana to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section "**How do I request an exception to the Humana Formulary?**" on page 7 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact NC State Health Plan Humana Customer Care and ask if your drug is covered. This document includes only a partial list of covered drugs, so Humana may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that Humana Group Medicare Plan does not cover your drug, you have two options:

- You can ask NC State Health Plan Humana Customer Care for a list of similar drugs that are covered by Humana Group Medicare Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Humana Group Medicare Plan.
- You can ask Humana Group Medicare Plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Humana Formulary?

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

- **Formulary exception:** You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- **Utilization restriction exception:** You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Humana Group Medicare Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

- **Tier exception:** You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

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

You or your prescriber should contact us to ask for a tiering, or formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception**.

Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

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

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

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

medication. If coverage is not approved, after your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug unless you have a prescription written for fewer days. (in which case we will allow multiple fills to provide up to a total of 31 days of a drug) while you pursue a formulary exception.

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes include:

- Members who are discharged from a hospital or skilled-nursing facility to a home setting
- Members who are admitted to a hospital or skilled-nursing facility from a home setting
- Members who transfer from one skilled-nursing facility to another and use a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- Members who give up Hospice Status and go back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

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

Transition extension

Humana Group Medicare Plan will consider on a case-by-case basis an extension of the transition period if your exception request or appeal has not been processed by the end of your initial transition period. We will continue to provide necessary drugs to you if your transition period is extended.

A Transition Policy is available on **your.humana.com/ncshp**, in the same area where the Prescription Drug Guides are displayed.

CenterWell Pharmacy™

You may fill your medicines at any network pharmacy. CenterWell Pharmacy – Humana's mail-delivery pharmacy is one option. To get started or learn more, visit **CenterWellPharmacy.com**. You can also call CenterWell Pharmacy at **1-844-222-2151** (**TTY: 711**) Monday – Friday, 8 a.m. to 11 p.m. (EST), and Saturday, 8 a.m. to 6:30 p.m. (EST).

Other pharmacies are available in our network.

For More Information

For more detailed information about your Humana Group Medicare Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

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

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

Humana Group Medicare Plan Formulary

The abridged formulary that begins on the next page provides coverage information about some of the drugs covered by Humana Group Medicare Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 32.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug is not listed in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Your plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D and are not subject to the Medicare appeals process. These drugs are listed separately on page 29.

How to read your formulary

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

$0 - Most vaccines and diabetic supplies covered 100% with no member cost.
DL - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
MO - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.
LA - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.
CI – Covered insulin products; Part D insulin products covered by your plan. For more information on cost sharing for your covered insulin products, please refer to your Evidence of Coverage.
PDS – Preferred Diabetic Supplies; BD and HTL-Droplet are the preferred diabetic syringe and pen needle brands for the plan.

The second column lists the tier of the drug. See page 5 for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. Humana Group Medicare Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL – 30 for 30 days" means you can only get 30 doses every 30 days). See page 6 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANALGESICS		
celecoxib 100 mg, 200 mg CAPSULE **MO**	1	
diclofenac sodium 75 mg TABLET, DR/EC **MO**	1	
hydrocodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET **DL**	1	QL(360 per 30 days)
ibuprofen 600 mg, 800 mg TABLET **MO**	1	
meloxicam 15 mg TABLET **MO**	1	QL(30 per 30 days)
meloxicam 7.5 mg TABLET **MO**	1	QL(60 per 30 days)
naproxen 500 mg TABLET **MO**	1	
oxycodone 10 mg, 5 mg TABLET **DL**	1	QL(360 per 30 days)
oxycodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET **DL**	1	QL(360 per 30 days)
tramadol 50 mg TABLET **DL**	1	QL(240 per 30 days)
ANESTHETICS		
lidocaine 5 % ADHESIVE PATCH, MEDICATED **MO**	1	PA,QL(90 per 30 days)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
KLOXXADO 8 MG/ACTUATION SPRAY, NON-AEROSOL **MO**	2	
OPVEE 2.7 MG/ACTUATION SPRAY, NON-AEROSOL **MO**	2	
ZUBSOLV 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG SUBLINGUAL TABLET **MO**	1	
ANTIBACTERIALS		
amoxicillin 500 mg CAPSULE **MO**	1	
amoxicillin 500 mg TABLET **MO**	1	
amoxicillin-pot clavulanate 875-125 mg TABLET **MO**	1	
azithromycin 250 mg TABLET **MO**	1	
cefdinir 300 mg CAPSULE **MO**	1	
cephalexin 500 mg CAPSULE **MO**	1	
ciprofloxacin hcl 500 mg TABLET **MO**	1	
DIFICID 200 MG TABLET **DL**	4	
DIFICID 40 MG/ML SUSPENSION FOR RECONSTITUTION **DL**	4	
doxycycline hyclate 100 mg CAPSULE **MO**	1	
doxycycline hyclate 100 mg TABLET **MO**	1	
levofloxacin 500 mg TABLET **MO**	1	
nitrofurantoin monohyd/m-cryst 100 mg CAPSULE **MO**	1	
sulfamethoxazole-trimethoprim 800-160 mg TABLET **MO**	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

BvsD – Part B vs Part D • CI – Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA – Prior Authorization • PDS – BD/HTL-Droplet are the Preferred Diabetic Supplies • QL – Quantity Limit • $0 – Vaccine/Diabetic • ST – Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANTICONVULSANTS		
EPIDIOLEX 100 MG/ML SOLUTION **DL**	4	PA
gabapentin 100 mg, 300 mg, 400 mg CAPSULE **MO**	1	QL(270 per 30 days)
gabapentin 600 mg, 800 mg TABLET **MO**	1	QL(180 per 30 days)
levetiracetam 500 mg TABLET **MO**	1	
NAYZILAM 5 MG/SPRAY (0.1 ML) SPRAY, NON-AEROSOL **DL**	3	QL(10 per 30 days)
ANTIDEMENTIA AGENTS		
donepezil 10 mg, 5 mg TABLET **MO**	1	
memantine 10 mg, 5 mg TABLET **MO**	1	PA
NAMZARIC 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG CAPSULE ER SPRINKLE 24 HR. **MO**	3	PA,QL(30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG CAPSULE ER SPRINKLE 24 HR. **MO**	3	PA,QL(28 per 28 days)
ANTIDEPRESSANTS		
amitriptyline 25 mg TABLET **MO**	1	
AUVELITY 45-105 MG TABLET, IR/ER, BIPHASIC **MO**	3	ST,QL(60 per 30 days)
bupropion hcl 150 mg TABLET, ER 24 HR. **MO**	1	QL(90 per 30 days)
bupropion hcl 300 mg TABLET, ER 24 HR. **MO**	1	QL(60 per 30 days)
citalopram 10 mg, 20 mg, 40 mg TABLET **MO**	1	
escitalopram oxalate 10 mg, 20 mg, 5 mg TABLET **MO**	1	
fluoxetine 20 mg CAPSULE **MO**	1	QL(120 per 30 days)
fluoxetine 40 mg CAPSULE **MO**	1	QL(60 per 30 days)
mirtazapine 15 mg, 30 mg, 7.5 mg TABLET **MO**	1	
sertraline 100 mg TABLET **MO**	1	QL(60 per 30 days)
sertraline 25 mg, 50 mg TABLET **MO**	1	QL(90 per 30 days)
trazodone 100 mg, 150 mg, 50 mg TABLET **MO**	1	
TRINTELLIX 10 MG, 20 MG, 5 MG TABLET **MO**	3	ST,QL(30 per 30 days)
venlafaxine 150 mg CAPSULE, ER 24 HR. **MO**	1	QL(60 per 30 days)
venlafaxine 75 mg CAPSULE, ER 24 HR. **MO**	1	QL(90 per 30 days)
ANTIEMETICS		
meclizine 25 mg TABLET **MO**	1	
ondansetron 4 mg, 8 mg TABLET, DISINTEGRATING **MO**	1	BvsD
ondansetron hcl 4 mg TABLET **MO**	1	BvsD
ANTIFUNGALS		
clotrimazole-betamethasone 1-0.05 % CREAM **MO**	1	QL(180 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

BvsD – Part B vs Part D • CI – Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA – Prior Authorization • PDS – BD/HTL-Droplet are the Preferred Diabetic Supplies • QL – Quantity Limit • $0 – Vaccine/Diabetic • ST – Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
fluconazole 150 mg TABLET **MO**	1	
ketoconazole 2 % CREAM **MO**	1	QL(60 per 30 days)
ketoconazole 2 % SHAMPOO **MO**	1	QL(120 per 30 days)
ANTIGOUT AGENTS		
allopurinol 100 mg, 300 mg TABLET **MO**	1	
colchicine 0.6 mg TABLET **MO**	1	QL(120 per 30 days)
ANTIMIGRAINE AGENTS		
EMGALITY PEN 120 MG/ML PEN INJECTOR **MO**	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 120 MG/ML SYRINGE **MO**	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 300 MG/3 ML (100 MG/ML X 3) SYRINGE **MO**	3	PA,QL(3 per 30 days)
QULIPTA 10 MG, 30 MG, 60 MG TABLET **MO**	3	PA,QL(30 per 30 days)
UBRELVY 100 MG, 50 MG TABLET **MO**	2	PA,QL(16 per 30 days)
ANTIMYASTHENIC AGENTS		
VYVGART 20 MG/ML SOLUTION **DL**	4	PA
VYVGART HYTRULO 1,000 MG-10,000 UNIT/5 ML SYRINGE **DL**	4	PA,QL(20 per 28 days)
VYVGART HYTRULO 1,008 MG-11,200 UNIT/5.6 ML SOLUTION **DL**	4	PA,QL(22.4 per 28 days)
ANTINEOPLASTICS		
ALECENSA 150 MG CAPSULE **DL**	4	PA,QL(240 per 30 days)
ALUNBRIG 180 MG, 90 MG TABLET **DL**	4	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET **DL**	4	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK **DL**	4	PA,QL(30 per 30 days)
anastrozole 1 mg TABLET **MO**	1	QL(30 per 30 days)
BRUKINSA 80 MG CAPSULE **DL**	4	PA,QL(120 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG TABLET **DL**	4	PA,QL(30 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) 100 MG TABLET **DL**	4	PA,QL(60 per 30 days)
ERIVEDGE 150 MG CAPSULE **DL**	4	PA,QL(28 per 28 days)
ERLEADA 240 MG TABLET **DL**	4	PA,QL(30 per 30 days)
ERLEADA 60 MG TABLET **DL**	4	PA,QL(120 per 30 days)
IBRANCE 100 MG, 125 MG, 75 MG CAPSULE **DL**	4	PA,QL(21 per 28 days)
IBRANCE 100 MG, 125 MG, 75 MG TABLET **DL**	4	PA,QL(21 per 28 days)
IMBRUVICA 140 MG CAPSULE **DL**	4	PA,QL(120 per 30 days)
IMBRUVICA 140 MG, 280 MG TABLET **DL**	4	PA
IMBRUVICA 420 MG TABLET **DL**	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE **DL**	4	PA,QL(28 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
IMBRUVICA 70 MG/ML SUSPENSION DL	4	PA
KISQALI 200 MG/DAY (200 MG X 1) TABLET DL	4	PA,QL(21 per 28 days)
KISQALI 400 MG/DAY (200 MG X 2) TABLET DL	4	PA,QL(42 per 28 days)
KISQALI 600 MG/DAY (200 MG X 3) TABLET DL	4	PA,QL(63 per 28 days)
KISQALI FEMARA CO-PACK 200 MG/DAY(200 MG X 1)-2.5 MG TABLET DL	4	PA,QL(49 per 28 days)
KISQALI FEMARA CO-PACK 400 MG/DAY(200 MG X 2)-2.5 MG TABLET DL	4	PA,QL(70 per 28 days)
KISQALI FEMARA CO-PACK 600 MG/DAY(200 MG X 3)-2.5 MG TABLET DL	4	PA,QL(91 per 28 days)
LUMAKRAS 120 MG TABLET DL	4	PA,QL(240 per 30 days)
LUMAKRAS 240 MG TABLET DL	4	PA,QL(120 per 30 days)
LUMAKRAS 320 MG TABLET DL	4	PA,QL(90 per 30 days)
LYNPARZA 100 MG, 150 MG TABLET DL	4	PA,QL(120 per 30 days)
NUBEQA 300 MG TABLET DL	4	PA,QL(120 per 30 days)
ORGOVYX 120 MG TABLET DL	4	PA,QL(32 per 30 days)
RUXIENCE 10 MG/ML SOLUTION DL	4	PA
TRAZIMERA 150 MG, 420 MG RECON SOLUTION DL	4	PA
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET DL	4	PA,QL(60 per 30 days)
XTANDI 40 MG CAPSULE DL	4	PA,QL(120 per 30 days)
XTANDI 40 MG TABLET DL	4	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET DL	4	PA,QL(60 per 30 days)
ZEJULA 100 MG, 200 MG, 300 MG TABLET DL	4	PA,QL(30 per 30 days)
ZIRABEV 25 MG/ML SOLUTION DL	4	PA
ANTIPARASITICS		
hydroxychloroquine 200 mg TABLET MO	1	
ANTIPARKINSON AGENTS		
carbidopa-levodopa 25-100 mg TABLET MO	1	
CREXONT 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG CAPSULE, IR/ER, BIPHASIC MO	3	ST,QL(180 per 30 days)
RYTARY 23.75-95 MG, 48.75-195 MG CAPSULE, ER MO	3	ST,QL(360 per 30 days)
RYTARY 36.25-145 MG CAPSULE, ER MO	3	ST,QL(270 per 30 days)
RYTARY 61.25-245 MG CAPSULE, ER MO	3	ST,QL(300 per 30 days)
ANTIPSYCHOTICS		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET MO	3	PA
ABILIFY ASIMTUFII 720 MG/2.4 ML SUSPENSION, ER, SYRINGE	4	QL(2.4 per 56 days)
ABILIFY ASIMTUFII 960 MG/3.2 ML SUSPENSION, ER, SYRINGE	4	QL(3.2 per 56 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON DL	4	QL(1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE DL	4	QL(1 per 28 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE	4	QL(3.9 per 56 days)
ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE	4	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE	4	QL(2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, ER, SYRINGE	4	QL(3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, ER, SYRINGE	4	QL(2.4 per 42 days)
INVEGA 3 MG, 9 MG TABLET, ER 24 HR. MO	3	PA,QL(30 per 30 days)
INVEGA 6 MG TABLET, ER 24 HR. MO	3	PA,QL(60 per 30 days)
INVEGA HAFYERA 1,092 MG/3.5 ML SYRINGE	4	QL(3.5 per 180 days)
INVEGA HAFYERA 1,560 MG/5 ML SYRINGE	4	QL(5 per 180 days)
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML SYRINGE DL	4	QL(1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML SYRINGE DL	4	QL(1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML SYRINGE MO	3	QL(1.5 per 28 days)
INVEGA TRINZA 273 MG/0.88 ML SYRINGE	4	QL(0.88 per 90 days)
INVEGA TRINZA 410 MG/1.32 ML SYRINGE	4	QL(1.32 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML SYRINGE	4	QL(1.75 per 90 days)
INVEGA TRINZA 819 MG/2.63 ML SYRINGE	4	QL(2.63 per 90 days)
LYBALVI 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG TABLET DL	4	PA,QL(30 per 30 days)
quetiapine 100 mg TABLET MO	1	QL(90 per 30 days)
quetiapine 25 mg, 50 mg TABLET MO	1	QL(120 per 30 days)
REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG TABLET DL	4	PA,QL(30 per 30 days)
RISPERDAL 0.5 MG TABLET MO	3	QL(120 per 30 days)
RISPERDAL 1 MG, 2 MG, 3 MG, 4 MG TABLET MO	3	QL(60 per 30 days)
RISPERDAL 1 MG/ML SOLUTION MO	3	
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML SUSPENSION, ER, RECON MO	3	QL(2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML SUSPENSION, ER, RECON DL	4	QL(2 per 28 days)
ANTISPASTICITY AGENTS		
baclofen 10 mg TABLET MO	1	
tizanidine 4 mg TABLET MO	1	
ANTIVIRALS		
BIKTARVY 30-120-15 MG, 50-200-25 MG TABLET DL	4	QL(30 per 30 days)
DESCOVY 120-15 MG, 200-25 MG TABLET DL	4	QL(30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
EPCLUSA 150-37.5 MG PELLETS IN PACKET **DL**	4	PA,QL(28 per 28 days)
EPCLUSA 200-50 MG PELLETS IN PACKET **DL**	4	PA,QL(56 per 28 days)
EPCLUSA 200-50 MG, 400-100 MG TABLET **DL**	4	PA,QL(28 per 28 days)
GENVOYA 150-150-200-10 MG TABLET **DL**	4	QL(30 per 30 days)
ODEFSEY 200-25-25 MG TABLET **DL**	4	QL(30 per 30 days)
oseltamivir 75 mg CAPSULE **MO**	1	QL(112 per 365 days)
PAXLOVID 150 MG (10)- 100 MG (10) TABLET, DOSE PACK **MO**	2	QL(40 per 10 days)
PAXLOVID 150 MG (6)- 100 MG (5) TABLET, DOSE PACK **MO**	2	QL(22 per 10 days)
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLET, DOSE PACK **MO**	2	QL(60 per 10 days)
valacyclovir 1 gram, 500 mg TABLET **MO**	1	
VEMLIDY 25 MG TABLET **DL**	4	QL(30 per 30 days)
VOSEVI 400-100-100 MG TABLET **DL**	4	PA,QL(28 per 28 days)
ANXIOLYTICS		
alprazolam 0.25 mg, 0.5 mg, 1 mg TABLET **DL**	1	QL(120 per 30 days)
buspirone 10 mg, 5 mg TABLET **MO**	1	
clonazepam 0.5 mg, 1 mg TABLET **DL**	1	
diazepam 5 mg TABLET **DL**	1	QL(90 per 30 days)
hydroxyzine hcl 25 mg TABLET **MO**	1	
lorazepam 0.5 mg, 1 mg TABLET **DL**	1	QL(90 per 30 days)
BLOOD GLUCOSE REGULATORS		
BAQSIMI 3 MG/ACTUATION SPRAY, NON-AEROSOL **MO**	2	
FARXIGA 10 MG, 5 MG TABLET **MO**	2	QL(30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE **CI,MO**	2	
FIASP U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
glimepiride 2 mg, 4 mg TABLET **MO**	1	
glipizide 10 mg, 5 mg TABLET **MO**	1	
GLYXAMBI 10-5 MG, 25-5 MG TABLET **MO**	2	QL(30 per 30 days)
HUMALOG JUNIOR KWIKPEN U-100 100 UNIT/ML INSULIN PEN, HALF-UNIT **CI,MO**	3	ST
HUMALOG KWIKPEN INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	ST
HUMALOG MIX 50-50 KWIKPEN 100 UNIT/ML (50-50) INSULIN PEN **CI,MO**	3	ST
HUMALOG MIX 75-25 KWIKPEN 100 UNIT/ML (75-25) INSULIN PEN **CI,MO**	3	ST

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMALOG MIX 75-25(U-100)INSULN 100 UNIT/ML (75-25) SUSPENSION CI,MO	3	ST
HUMALOG TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR CI,MO	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML CARTRIDGE CI,MO	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	ST
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION CI,MO	3	ST
HUMULIN 70/30 U-100 KWIKPEN 100 UNIT/ML (70-30) INSULIN PEN CI,MO	3	ST
HUMULIN N NPH INSULIN KWIKPEN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	ST
HUMULIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION CI,MO	3	ST
HUMULIN R REGULAR U-100 INSULN 100 UNIT/ML SOLUTION CI,MO	3	ST
HUMULIN R U-500 (CONC) KWIKPEN 500 UNIT/ML (3 ML) INSULIN PEN CI	4	
INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET MO	3	PA,QL(60 per 30 days)
INVOKAMET XR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET, IR/ER 24 HR., BIPHASIC MO	3	PA,QL(60 per 30 days)
INVOKANA 100 MG, 300 MG TABLET MO	3	PA,QL(30 per 30 days)
JANUMET 50-1,000 MG, 50-500 MG TABLET MO	2	QL(60 per 30 days)
JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	2	QL(30 per 30 days)
JANUMET XR 50-1,000 MG, 50-500 MG TABLET, ER 24 HR., MULTIPHASE MO	2	QL(60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG TABLET MO	2	QL(30 per 30 days)
JARDIANCE 10 MG, 25 MG TABLET MO	2	QL(30 per 30 days)
JENTADUETO 2.5-1,000 MG, 2.5-500 MG TABLET MO	2	QL(60 per 30 days)
JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	2	
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML INSULIN PEN CI,MO	3	ST
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	ST
LYUMJEV TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR CI,MO	3	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	ST
metformin 1,000 mg, 500 mg TABLET MO	1	
metformin 500 mg TABLET, ER 24 HR. MO	1	QL(120 per 30 days)
MOUNJARO 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML PEN INJECTOR MO	2	PA,QL(2 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **CI,MO**	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **CI,MO**	2	
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLIN R REGULAR U100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLOG MIX 70-30 U-100 INSULN 100 UNIT/ML (70-30) SOLUTION **CI,MO**	2	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE **CI,MO**	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION **CI,MO**	2	
OZEMPIC 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR **MO**	2	PA,QL(3 per 28 days)
pioglitazone 30 mg TABLET **MO**	1	QL(30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG TABLET **MO**	2	PA,QL(30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML INSULIN PEN **CI,MO**	2	QL(15 per 24 days)
SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET **MO**	2	QL(60 per 30 days)
SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	2	QL(30 per 30 days)
SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	2	QL(60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN **CI,MO**	2	
TRADJENTA 5 MG TABLET **MO**	2	QL(30 per 30 days)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
TRESIBA FLEXTOUCH U-200 200 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	2	QL(30 per 30 days)
TRIJARDY XR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	2	QL(60 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML PEN INJECTOR **MO**	2	PA,QL(2 per 28 days)
XIGDUO XR 10-1,000 MG, 10-500 MG, 5-500 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	2	QL(30 per 30 days)

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XIGDUO XR 2.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	2	QL(60 per 30 days)
ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR **MO**	2	
ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE **MO**	2	
BLOOD PRODUCTS AND MODIFIERS		
clopidogrel 75 mg TABLET **MO**	1	QL(30 per 30 days)
ELIQUIS 2.5 MG TABLET **MO**	2	QL(60 per 30 days)
ELIQUIS 5 MG TABLET **MO**	2	QL(74 per 30 days)
ELIQUIS DVT-PE TREAT 30D START 5 MG (74 TABS) TABLET, DOSE PACK **MO**	2	QL(74 per 30 days)
NIVESTYM 300 MCG/0.5 ML, 480 MCG/0.8 ML SYRINGE **DL**	4	PA
NIVESTYM 300 MCG/ML, 480 MCG/1.6 ML SOLUTION **DL**	4	PA
PROMACTA 12.5 MG POWDER IN PACKET **DL**	4	PA,QL(360 per 30 days)
PROMACTA 12.5 MG, 25 MG TABLET **DL**	4	PA,QL(30 per 30 days)
PROMACTA 25 MG POWDER IN PACKET **DL**	4	PA,QL(180 per 30 days)
PROMACTA 50 MG TABLET **DL**	4	PA,QL(90 per 30 days)
PROMACTA 75 MG TABLET **DL**	4	PA,QL(60 per 30 days)
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML SOLUTION **MO**	3	PA,QL(14 per 30 days)
RETACRIT 40,000 UNIT/ML SOLUTION **DL**	4	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE **DL**	4	PA,QL(1.2 per 28 days)
UDENYCA AUTOINJECTOR 6 MG/0.6 ML AUTO-INJECTOR **DL**	4	PA,QL(1.2 per 28 days)
warfarin 5 mg TABLET **MO**	1	
XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION **MO**	2	ST,QL(600 per 30 days)
XARELTO 10 MG, 20 MG TABLET **MO**	2	QL(30 per 30 days)
XARELTO 15 MG, 2.5 MG TABLET **MO**	2	QL(60 per 30 days)
XARELTO DVT-PE TREAT 30D START 15 MG (42)- 20 MG (9) TABLET, DOSE PACK **MO**	2	QL(51 per 30 days)
ZARXIO 300 MCG/0.5 ML, 480 MCG/0.8 ML SYRINGE **DL**	4	PA
CARDIOVASCULAR AGENTS		
amiodarone 200 mg TABLET **MO**	1	
amlodipine 10 mg, 2.5 mg, 5 mg TABLET **MO**	1	
atenolol 25 mg, 50 mg TABLET **MO**	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET **MO**	1	
bumetanide 1 mg TABLET **MO**	1	
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg TABLET **MO**	1	
chlorthalidone 25 mg TABLET **MO**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
clonidine hcl 0.1 mg TABLET **MO**	1	
diltiazem hcl 120 mg CAPSULE, ER 24 HR. **MO**	1	
ENTRESTO 24-26 MG, 49-51 MG, 97-103 MG TABLET **MO**	2	QL(60 per 30 days)
ENTRESTO SPRINKLE 15-16 MG, 6-6 MG PELLET **MO**	2	QL(240 per 30 days)
ezetimibe 10 mg TABLET **MO**	1	QL(30 per 30 days)
fenofibrate 160 mg TABLET **MO**	1	QL(30 per 30 days)
fenofibrate nanocrystallized 145 mg TABLET **MO**	1	QL(30 per 30 days)
furosemide 20 mg, 40 mg TABLET **MO**	1	
hydralazine 25 mg, 50 mg TABLET **MO**	1	
hydrochlorothiazide 12.5 mg CAPSULE **MO**	1	
hydrochlorothiazide 12.5 mg, 25 mg TABLET **MO**	1	
isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR. **MO**	1	
KERENDIA 10 MG, 20 MG TABLET **MO**	2	PA,QL(30 per 30 days)
lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET **MO**	1	
lisinopril-hydrochlorothiazide 20-12.5 mg, 20-25 mg TABLET **MO**	1	
losartan 100 mg, 25 mg, 50 mg TABLET **MO**	1	QL(60 per 30 days)
losartan-hydrochlorothiazide 100-12.5 mg, 100-25 mg, 50-12.5 mg TABLET **MO**	1	QL(60 per 30 days)
metoprolol succinate 100 mg, 25 mg, 50 mg TABLET, ER 24 HR. **MO**	1	
metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET **MO**	1	
MULTAQ 400 MG TABLET **MO**	2	QL(60 per 30 days)
nitroglycerin 0.4 mg SUBLINGUAL TABLET **MO**	1	
olmesartan 20 mg, 40 mg TABLET **MO**	1	QL(30 per 30 days)
pravastatin 20 mg, 40 mg TABLET **MO**	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML WEARABLE INJECTOR **MO**	2	PA,QL(3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML PEN INJECTOR **MO**	2	PA,QL(3 per 28 days)
REPATHA SYRINGE 140 MG/ML SYRINGE **MO**	2	PA,QL(3 per 28 days)
rosuvastatin 10 mg, 20 mg, 40 mg, 5 mg TABLET **MO**	1	
simvastatin 10 mg, 20 mg, 40 mg TABLET **MO**	1	
spironolactone 25 mg, 50 mg TABLET **MO**	1	
torsemide 20 mg TABLET **MO**	1	
triamterene-hydrochlorothiazid 37.5-25 mg TABLET **MO**	1	
valsartan 160 mg, 320 mg TABLET **MO**	1	QL(60 per 30 days)
VASCEPA 0.5 GRAM CAPSULE **MO**	2	QL(240 per 30 days)
VASCEPA 1 GRAM CAPSULE **MO**	2	QL(120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
VERQUVO 10 MG, 2.5 MG, 5 MG TABLET **MO**	2	PA,QL(30 per 30 days)
ZYPITAMAG 2 MG, 4 MG TABLET **MO**	2	ST,QL(30 per 30 days)
CENTRAL NERVOUS SYSTEM AGENTS		
AUSTEDO 12 MG, 9 MG TABLET **DL**	4	PA,QL(120 per 30 days)
AUSTEDO 6 MG TABLET **DL**	4	PA,QL(60 per 30 days)
AUSTEDO XR 12 MG, 6 MG TABLET, ER 24 HR. **DL**	4	PA,QL(90 per 30 days)
AUSTEDO XR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG TABLET, ER 24 HR. **DL**	4	PA,QL(30 per 30 days)
AUSTEDO XR 24 MG TABLET, ER 24 HR. **DL**	4	PA,QL(60 per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) 12-18-24-30 MG TABLET, ER 24 HR., DOSE PACK **DL**	4	PA,QL(28 per 28 days)
AUSTEDO XR TITRATION KT(WK1-4) 6 MG (14)-12 MG (14)-24 MG (14) TABLET, ER 24 HR., DOSE PACK **DL**	4	PA,QL(42 per 28 days)
BETASERON 0.3 MG KIT **DL**	4	PA,QL(15 per 30 days)
COPAXONE 20 MG/ML SYRINGE **DL**	4	PA,QL(30 per 30 days)
COPAXONE 40 MG/ML SYRINGE **DL**	4	PA,QL(12 per 28 days)
duloxetine 20 mg CAPSULE, DR/EC **MO**	1	QL(120 per 30 days)
duloxetine 30 mg CAPSULE, DR/EC **MO**	1	QL(90 per 30 days)
duloxetine 60 mg CAPSULE, DR/EC **MO**	1	QL(60 per 30 days)
KESIMPTA PEN 20 MG/0.4 ML PEN INJECTOR **DL**	4	PA,QL(1.2 per 28 days)
pregabalin 100 mg, 150 mg, 50 mg, 75 mg CAPSULE **MO**	1	QL(90 per 30 days)
RADICAVA ORS STARTER KIT SUSP 105 MG/5 ML SUSPENSION **DL**	4	PA,QL(70 per 28 days)
VUMERITY 231 MG CAPSULE, DR/EC **DL**	4	PA,QL(120 per 30 days)
DENTAL & ORAL AGENTS		
chlorhexidine gluconate 0.12 % MOUTHWASH **MO**	1	
DERMATOLOGICAL AGENTS		
mupirocin 2 % OINTMENT **MO**	1	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
CARBAGLU 200 MG TABLET, DISPERSIBLE **DL**	4	PA
LOKELMA 10 GRAM, 5 GRAM POWDER IN PACKET **MO**	2	QL(30 per 30 days)
potassium chloride 10 meq CAPSULE, ER **MO**	1	
potassium chloride 10 meq, 20 meq TABLET ER **MO**	1	
potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS **MO**	1	
GASTROINTESTINAL AGENTS		
dicyclomine 10 mg CAPSULE **MO**	1	
esomeprazole magnesium 40 mg CAPSULE, DR/EC **MO**	1	QL(60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
famotidine 20 mg, 40 mg TABLET **MO**	1	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE **MO**	2	QL(30 per 30 days)
MOVANTIK 12.5 MG, 25 MG TABLET **MO**	2	QL(30 per 30 days)
omeprazole 20 mg, 40 mg CAPSULE, DR/EC **MO**	1	
pantoprazole 20 mg, 40 mg TABLET, DR/EC **MO**	1	QL(60 per 30 days)
sucralfate 1 gram TABLET **MO**	1	
SUFLAVE 178.7-7.3-0.5 GRAM RECON SOLUTION **MO**	3	
SUTAB 1.479-0.188- 0.225 GRAM TABLET **MO**	2	
TALICIA 10-250-12.5 MG CAPSULE, IR/DR, BIPHASIC **MO**	3	
VOWST CAPSULE **DL**	4	PA
XIFAXAN 200 MG TABLET **MO**	3	PA,QL(9 per 30 days)
XIFAXAN 550 MG TABLET	4	PA,QL(84 per 28 days)
GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
AMVUTTRA 25 MG/0.5 ML SYRINGE **DL**	4	PA,QL(0.5 per 90 days)
ATTRUBY 356 MG TABLET **DL**	4	PA,QL(120 per 30 days)
CREON 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT CAPSULE, DR/EC **MO**	2	
ELELYSO 200 UNIT RECON SOLUTION **DL**	4	PA
ONPATTRO 2 MG/ML SOLUTION **DL**	4	PA
STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML SOLUTION **DL**	4	PA
VYNDAMAX 61 MG CAPSULE **DL**	4	PA,QL(30 per 30 days)
ZEMAIRA 1,000 MG RECON SOLUTION **DL**	4	PA
ZENPEP 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT CAPSULE, DR/EC **MO**	3	
GENITOURINARY AGENTS		
finasteride 5 mg TABLET **MO**	1	QL(30 per 30 days)
GEMTESA 75 MG TABLET **MO**	3	QL(30 per 30 days)
MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. **MO**	2	QL(30 per 30 days)
MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON **MO**	2	QL(300 per 30 days)
oxybutynin chloride 10 mg TABLET, ER 24 HR. **MO**	1	QL(60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
oxybutynin chloride 5 mg TABLET **MO**	1	
tamsulosin 0.4 mg CAPSULE **MO**	1	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
ACTHAR 80 UNIT/ML GEL **DL**	4	PA,QL(30 per 30 days)
ACTHAR SELFJECT 40 UNIT/0.5 ML, 80 UNIT/ML PEN INJECTOR **DL**	4	PA,QL(45 per 30 days)
methylprednisolone 4 mg TABLET, DOSE PACK **MO**	1	
prednisone 10 mg, 20 mg, 5 mg TABLET **MO**	1	BvsD
triamcinolone acetonide 0.1 % CREAM **MO**	1	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) CARTRIDGE **DL**	4	PA
OMNITROPE 5.8 MG RECON SOLUTION **DL**	4	PA
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
estradiol 0.01 % (0.1 mg/gram) CREAM **MO**	1	
OSPHENA 60 MG TABLET **MO**	2	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET **MO**	3	
PREMARIN 0.625 MG/GRAM CREAM **MO**	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg TABLET **MO**	1	
TIROSINT 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG CAPSULE **MO**	3	
TIROSINT-SOL 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML SOLUTION **MO**	3	PA
HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
SOMATULINE DEPOT 90 MG/0.3 ML SYRINGE **DL**	4	PA,QL(0.3 per 28 days)
IMMUNOLOGICAL AGENTS		
ACTHIB (PF) 10 MCG/0.5 ML RECON SOLUTION **DL**	1	
ADALIMUMAB-ADAZ 10 MG/0.1 ML SYRINGE **DL**	4	PA,QL(0.2 per 28 days)
ADALIMUMAB-ADAZ 20 MG/0.2 ML SYRINGE **DL**	4	PA,QL(1.2 per 28 days)
ADALIMUMAB-ADAZ 40 MG/0.4 ML PEN INJECTOR **DL**	4	PA,QL(2.4 per 28 days)
ADALIMUMAB-ADAZ 40 MG/0.4 ML SYRINGE **DL**	4	PA,QL(2.4 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ADALIMUMAB-ADAZ 80 MG/0.8 ML PEN INJECTOR **DL**	4	PA,QL(4.8 per 28 days)
ADALIMUMAB-ADBM 10 MG/0.2 ML, 20 MG/0.4 ML SYRINGE KIT **DL**	4	PA,QL(2 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML SYRINGE KIT **DL**	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
COSENTYX 75 MG/0.5 ML SYRINGE **DL**	4	PA,QL(2 per 28 days)
COSENTYX (2 SYRINGES) 150 MG/ML SYRINGE **DL**	4	PA,QL(8 per 28 days)
COSENTYX PEN (2 PENS) 150 MG/ML PEN INJECTOR **DL**	4	PA,QL(8 per 28 days)
COSENTYX UNOREADY PEN 300 MG/2 ML PEN INJECTOR **DL**	4	PA,QL(8 per 28 days)
DUPIXENT PEN 200 MG/1.14 ML PEN INJECTOR **DL**	4	PA,QL(3.42 per 28 days)
DUPIXENT PEN 300 MG/2 ML PEN INJECTOR **DL**	4	PA,QL(8 per 28 days)
DUPIXENT SYRINGE 100 MG/0.67 ML SYRINGE **DL**	4	PA,QL(1.34 per 28 days)
DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE **DL**	4	PA,QL(3.42 per 28 days)
DUPIXENT SYRINGE 300 MG/2 ML SYRINGE **DL**	4	PA,QL(8 per 28 days)
ENTYVIO PEN 108 MG/0.68 ML PEN INJECTOR **DL**	4	PA,QL(1.36 per 28 days)
ENVARSUS XR 0.75 MG, 1 MG, 4 MG TABLET, ER 24 HR. **MO**	3	PA
GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION **DL**	4	PA
HAEGARDA 2,000 UNIT, 3,000 UNIT RECON SOLUTION **DL**	4	PA,QL(24 per 28 days)
HUMIRA 40 MG/0.8 ML SYRINGE KIT **DL**	4	PA,QL(6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML SYRINGE KIT **DL**	4	PA,QL(2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SYRINGE KIT **DL**	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SYRINGE KIT **DL**	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS 80 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC 80 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS 80 MG/0.8 ML-40 MG/0.4 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
methotrexate sodium 2.5 mg TABLET **MO**	1	BvsD
OTULFI 45 MG/0.5 ML SYRINGE **MO**	2	PA,QL(1.5 per 84 days)
OTULFI 90 MG/ML SYRINGE **DL**	4	PA,QL(3 per 84 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RINVOQ 15 MG, 30 MG TABLET, ER 24 HR. **DL**	4	PA,QL(30 per 30 days)
RINVOQ 45 MG TABLET, ER 24 HR. **DL**	4	PA,QL(168 per 365 days)
RINVOQ LQ 1 MG/ML SOLUTION **DL**	4	PA,QL(360 per 30 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION **$0,DL**	1	
SKYRIZI 150 MG/ML PEN INJECTOR	4	PA,QL(2 per 84 days)
SKYRIZI 150 MG/ML SYRINGE	4	PA,QL(2 per 84 days)
SKYRIZI 180 MG/1.2 ML (150 MG/ML) WEARABLE INJECTOR **DL**	4	PA,QL(8.4 per 365 days)
SKYRIZI 360 MG/2.4 ML (150 MG/ML) WEARABLE INJECTOR **DL**	4	PA,QL(16.8 per 365 days)
STELARA 45 MG/0.5 ML SOLUTION **DL**	4	PA,QL(1.5 per 84 days)
STELARA 45 MG/0.5 ML SYRINGE **DL**	4	PA,QL(1.5 per 84 days)
STELARA 90 MG/ML SYRINGE **DL**	4	PA,QL(3 per 84 days)
TREMFYA 100 MG/ML AUTO-INJECTOR	4	PA,QL(3 per 84 days)
TREMFYA 100 MG/ML SYRINGE	4	PA,QL(3 per 84 days)
TREMFYA 200 MG/2 ML SYRINGE **DL**	4	PA,QL(4 per 28 days)
TREMFYA PEN 200 MG/2 ML PEN INJECTOR **DL**	4	PA,QL(4 per 28 days)
YESINTEK 45 MG/0.5 ML SOLUTION **MO**	2	PA,QL(1.5 per 84 days)
YESINTEK 45 MG/0.5 ML SYRINGE **MO**	2	PA,QL(1.5 per 84 days)
YESINTEK 90 MG/ML SYRINGE **DL**	4	PA,QL(3 per 84 days)
METABOLIC BONE DISEASE AGENTS		
alendronate 70 mg TABLET **MO**	1	QL(4 per 28 days)
FORTEO 20 MCG/DOSE (560MCG/2.24ML) PEN INJECTOR **DL**	4	PA,QL(2.24 per 28 days)
PROLIA 60 MG/ML SYRINGE **MO**	3	QL(1 per 180 days)
TYMLOS 80 MCG (3,120 MCG/1.56 ML) PEN INJECTOR **DL**	4	PA,QL(1.56 per 30 days)
MISCELLANEOUS THERAPEUTIC AGENTS		
BD ALCOHOL SWABS PADS, MEDICATED **$0,MO**	1	
BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16" NEEDLE **$0,PDS,MO**	1	
BD INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" SYRINGE **$0,PDS,MO**	1	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64" SYRINGE **$0,PDS,MO**	1	
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 SYRINGE **$0,PDS,MO**	1	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **$0,PDS,MO**	1	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" NEEDLE **$0,PDS,MO**	1	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" NEEDLE **$0,PDS,MO**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **$0,PDS,MO**	1	
BD ULTRA-FINE ORIG PEN NEEDLE 29 GAUGE X 1/2" NEEDLE **$0,PDS,MO**	1	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" NEEDLE **$0,PDS,MO**	1	
BD VEO INSULIN SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE **$0,PDS,MO**	1	
BD VEO INSULIN SYRINGE UF 0.3 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 15/64", 1/2 ML 31 GAUGE X 15/64" SYRINGE **$0,PDS,MO**	1	
CEQUR SIMPLICITY INSERTER MISCELLANEOUS **MO**	2	
DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 SYRINGE **$0,PDS,MO**	1	
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" NEEDLE **$0,PDS,MO**	1	
DROPSAFE ALCOHOL PREP PADS PADS, MEDICATED **$0,MO**	1	
GIVLAARI 189 MG/ML SOLUTION **DL**	4	PA
OXLUMO 94.5 MG/0.5 ML SOLUTION	4	PA
XDEMVY 0.25 % DROPS **MO**	3	PA,QL(10 per 42 days)
OPHTHALMIC AGENTS		
brimonidine 0.2 % DROPS **MO**	1	
CEQUA 0.09 % DROPPERETTE **MO**	3	PA,QL(60 per 30 days)
COMBIGAN 0.2-0.5 % DROPS **MO**	2	
dorzolamide-timolol 22.3-6.8 mg/ml DROPS **MO**	1	
EYSUVIS 0.25 % DROPS, SUSPENSION **MO**	2	QL(16.6 per 30 days)
ILEVRO 0.3 % DROPS, SUSPENSION **MO**	2	QL(3 per 30 days)
latanoprost 0.005 % DROPS **MO**	1	QL(5 per 25 days)
LOTEMAX 0.5 % DROPS, GEL **MO**	3	ST
LOTEMAX 0.5 % DROPS, SUSPENSION **MO**	3	ST
LOTEMAX 0.5 % OINTMENT **MO**	3	ST
LOTEMAX SM 0.38 % DROPS, GEL **MO**	3	
LUMIGAN 0.01 % DROPS **MO**	2	QL(2.5 per 25 days)
prednisolone acetate 1 % DROPS, SUSPENSION **MO**	1	
RHOPRESSA 0.02 % DROPS **MO**	2	ST,QL(2.5 per 25 days)

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ROCKLATAN 0.02-0.005 % DROPS MO	2	ST
SIMBRINZA 1-0.2 % DROPS, SUSPENSION MO	3	
timolol maleate 0.5 % DROPS MO	1	
VYZULTA 0.024 % DROPS MO	3	QL(2.5 per 25 days)
ZERVIATE 0.24 % DROPPERETTE MO	3	ST,QL(60 per 30 days)
RESPIRATORY TRACT/PULMONARY AGENTS		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL	4	PA,QL(90 per 30 days)
ADVAIR HFA 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(12 per 30 days)
AIRSUPRA 90-80 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(32.1 per 30 days)
albuterol sulfate 2.5 mg /3 ml (0.083 %) SOLUTION FOR NEBULIZATION MO	1	BvsD
albuterol sulfate 90 mcg/actuation HFA AEROSOL INHALER MO	1	QL(36 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE MO	2	QL(30 per 30 days)
AUVI-Q 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML AUTO-INJECTOR MO	2	QL(4 per 30 days)
azelastine 137 mcg (0.1 %) SPRAY, NON-AEROSOL MO	1	QL(30 per 25 days)
BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE, 50-25 MCG/DOSE BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(10.7 per 30 days)
COMBIVENT RESPIMAT 20-100 MCG/ACTUATION MIST MO	3	QL(4 per 20 days)
FASENRA 10 MG/0.5 ML SYRINGE DL	4	PA,QL(0.5 per 28 days)
FASENRA 30 MG/ML SYRINGE DL	4	PA,QL(1 per 28 days)
FASENRA PEN 30 MG/ML AUTO-INJECTOR DL	4	PA,QL(1 per 28 days)
fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION MO	1	QL(16 per 30 days)
ipratropium bromide 42 mcg (0.06 %) SPRAY, NON-AEROSOL MO	1	QL(45 per 30 days)
ipratropium-albuterol 0.5 mg-3 mg(2.5 mg base)/3 ml SOLUTION FOR NEBULIZATION MO	1	BvsD
levocetirizine 5 mg TABLET MO	1	QL(30 per 30 days)
montelukast 10 mg TABLET MO	1	QL(30 per 30 days)
NUCALA 100 MG RECON SOLUTION DL	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML AUTO-INJECTOR DL	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML SYRINGE DL	4	PA,QL(3 per 28 days)
NUCALA 40 MG/0.4 ML SYRINGE DL	4	PA,QL(0.4 per 28 days)
OFEV 100 MG, 150 MG CAPSULE DL,LA	4	PA,QL(60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPSUMIT 10 MG TABLET DL	4	PA,QL(30 per 30 days)
OPSYNVI 10-20 MG, 10-40 MG TABLET DL	4	PA,QL(30 per 30 days)
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION MIST MO	2	QL(4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG CAPSULE, W/INHALATION DEVICE MO	2	QL(30 per 30 days)
STIOLTO RESPIMAT 2.5-2.5 MCG/ACTUATION MIST MO	2	QL(4 per 28 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION MIST MO	2	QL(4 per 30 days)
SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(30.6 per 30 days)
TRELEGY ELLIPTA 100-62.5-25 MCG, 200-62.5-25 MCG BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
TYVASO DPI 16 MCG, 32 MCG, 48 MCG, 64 MCG CARTRIDGE WITH INHALER DL	4	PA,QL(112 per 28 days)
TYVASO DPI 16(112)-32(112) -48(28) MCG CARTRIDGE WITH INHALER DL	4	PA,QL(252 per 28 days)
UPTRAVI 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG TABLET DL	4	PA,QL(60 per 30 days)
UPTRAVI 200 MCG (140)- 800 MCG (60) TABLET, DOSE PACK DL	4	PA,QL(200 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(36 per 30 days)
SKELETAL MUSCLE RELAXANTS		
cyclobenzaprine 10 mg, 5 mg TABLET MO	1	
methocarbamol 500 mg, 750 mg TABLET MO	1	
SLEEP DISORDER AGENTS		
BELSOMRA 10 MG TABLET MO	2	QL(60 per 30 days)
BELSOMRA 15 MG, 20 MG TABLET MO	2	QL(30 per 30 days)
BELSOMRA 5 MG TABLET MO	2	QL(120 per 30 days)
sodium oxybate 500 mg/ml SOLUTION DL	4	PA,QL(540 per 30 days)
temazepam 30 mg CAPSULE DL	1	QL(30 per 30 days)
zolpidem 10 mg, 5 mg TABLET MO	1	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

BvsD – Part B vs Part D • CI – Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA – Prior Authorization • PDS – BD/HTL-Droplet are the Preferred Diabetic Supplies • QL – Quantity Limit • $0 – Vaccine/Diabetic • ST – Step Therapy

Humana Group Medicare Plan Coverage of Additional Prescription Drugs

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cough/Cold - Mail Order Available		
benzonatate 100 mg, 150 mg, 200 mg CAPSULE	1	
bromfed dm 2-30-10 mg/5 ml SYRUP	1	
brompheniramine-pseudoeph-dm 2-30-10 mg/5 ml SYRUP	1	
HYCODAN 5-1.5 MG/5 ML (5 ML) SOLUTION	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG TABLET	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG/5 ML SOLUTION	1	
hydrocodone-chlorpheniramine 10-8 mg/5 ml SUSPENSION, ER 12 HR.	1	
hydrocodone-homatropine 5-1.5 mg TABLET	1	
hydrocodone-homatropine 5-1.5 mg/5 ml, 5-1.5 mg/5 ml (5 ml) SOLUTION	1	
hydromet 5-1.5 mg/5 ml SOLUTION	1	
promethazine vc-codeine 6.25-5-10 mg/5 ml SYRUP	1	
promethazine-codeine 6.25-10 mg/5 ml SYRUP	1	
promethazine-dm 6.25-15 mg/5 ml SYRUP	1	
RESPA-AR 8-90-0.24 MG TABLET, ER 12 HR.	3	
TUXARIN ER 8-54.3 MG TABLET, ER 12 HR.	3	
TUZISTRA XR 14.7-2.8 MG/5 ML SUSPENSION, ER 12 HR.	3	
Fertility - Mail Order Available		
cetrorelix 0.25 mg KIT	1	
CETROTIDE 0.25 MG KIT	3	
clomid 50 mg TABLET	1	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • $0 – Vaccine/Diabetic • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Fertility - Mail Order Available		
clomiphene citrate 50 mg TABLET	1	
FOLLISTIM AQ 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML CARTRIDGE	3	
fyremadel 250 mcg/0.5 ml SYRINGE	1	
GANIRELIX 250 MCG/0.5 ML SYRINGE	3	
ganirelix 250 mcg/0.5 ml SYRINGE	3	
GONAL-F 1,050 UNIT, 450 UNIT RECON SOLUTION	3	
GONAL-F RFF 75 UNIT RECON SOLUTION	3	
MENOPUR 75 UNIT RECON SOLUTION	3	
OVIDREL 250 MCG/0.5 ML SYRINGE	3	
Vitamins/Minerals - Mail Order Available		
ascorbic acid (vitamin c) 500 mg/ml SOLUTION	1	
b complex 100 100-2-100-2-2 mg/ml SOLUTION	1	
b-complex injection 100-2-100-2-2 mg/ml SOLUTION	1	
cyanocobalamin (vitamin b-12) 1,000 mcg/ml SOLUTION	1	
cyanocobalamin (vitamin b-12) 500 mcg/spray SPRAY, NON-AEROSOL	1	
dodex 1,000 mcg/ml SOLUTION	1	
DRISDOL 1,250 MCG (50,000 UNIT) CAPSULE	3	
ergocalciferol (vitamin d2) 1,250 mcg (50,000 unit) CAPSULE	1	
folic acid 1 mg TABLET	1	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Vitamins/Minerals - Mail Order Available		
folic acid 5 mg/ml SOLUTION	1	
hydroxocobalamin 1,000 mcg/ml SOLUTION	1	
INFUVITE ADULT 3,300 UNIT- 150 MCG/10 ML SOLUTION	3	
INFUVITE PEDIATRIC 80 MG-400 UNIT- 200 MCG/5 ML SOLUTION	3	
MEPHYTON 5 MG TABLET	3	
NASCOBAL 500 MCG/SPRAY SPRAY, NON-AEROSOL	3	
phytonadione (vitamin k1) 1 mg/0.5 ml SYRINGE	1	
phytonadione (vitamin k1) 1 mg/0.5 ml, 10 mg/ml SOLUTION	1	
phytonadione (vitamin k1) 5 mg TABLET	1	
pyridoxine (vitamin b6) 100 mg/ml SOLUTION	1	
thiamine hcl (vitamin b1) 100 mg/ml SOLUTION	1	
vitamin d2 1,250 mcg (50,000 unit) CAPSULE	1	
vitamin k 1 mg/0.5 ml SOLUTION	1	
vitamin k1 10 mg/ml SOLUTION	1	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • $0 – Vaccine/Diabetic • ST - Step Therapy

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עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिन्दी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। 877-320-1235 (TTY: 711) पर कॉल करें।

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This notice is available at **https://www.humana.com/legal/multi-language-support**.

GHHNOA2025HUM_0425

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ 877-320-1235 (TTY: 711)។

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Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahólǫ. Kohjį' hodíilnih **877-320-1235 (TTY: 711)**.

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አማርኛ [Amharic]፦ ቋንቋ፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ 877-320-1235 (TTY: 711) ላይ ይደውሉ።

Bǎsɔ́ [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, Hwòdǒ-fɔńɔ-ńnyɔ,́ kè nyɔ-bɔǔn-po-kà bě bé nyuɛɛ se wídí péè-péè dò kɔ.̀ **877-320-1235 (TTY: 711)** dá.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó. Pe **877-320-1235 (TTY: 711).**

नेपाली [Nepali]: भाषासम्बन्धी नि:शुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । 877-320-1235 (TTY: 711) मा कल गर्नुहोस् ।

Notes

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Notes

This abridged formulary was updated on 09/03/2025 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the NC State Health Plan Humana Customer Care Team with any questions at 1-888-700-2263 or, for TTY users, 711, or visit **your.humana.com/ncshp**.

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