Optum Rx®

IRON ROAD HEALTHCARE

Iron Road Healthcare Medicare Part D Prescription Drug Plan (PDP)

Your 2023 Abridged Formulary (partial list of covered drugs)

Sponsored by UPREHS, administered by Optum Rx®
Effective January 1, 2023 – December 31, 2023

Please read: this document contains information about the drugs we cover in this plan.

This abridged formulary was updated on February 1, 2023 and is not a complete list of drugs covered by our plan. For more recent information or if you have questions, please contact:

Optum Rx Member Services

Phone (toll-free): **1-866-443-1095**
TTY users: **711**
Hours of operation: 24 hours a day, 7 days a week
Website: **optumrx.com**

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

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Optum Rx. When it refers to “plan” or “our plan,” it means Iron Road Healthcare Medicare Part D Prescription Drug Plan.
In most instances, you must use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2024.

Formulary ID 23065
Version 8
S8841_23_MC-DS10_C_UNP

What is the Abridged Formulary?

A formulary is a list of covered drugs selected by Iron Road Healthcare in consultation with Optum Rx and a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. This plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Optum Rx network pharmacy, and other plan rules are followed.

This document is a partial formulary and includes only some of the drugs covered by this plan. For a complete listing of all prescription drugs covered, please visit our website or call us. Our contact information, along with the date we last updated the formulary, is shown on the front and back cover pages.

Can the formulary (drug list) change?

Yes. If you are taking a drug on our 2023 formulary that is covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except when a new, less-expensive generic drug becomes available, or when new adverse information about the safety or effectiveness of a drug is released.

If we make a negative change to our formulary (i.e. add prior authorization, quantity limit, and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, if applicable), we must notify affected members. Members will receive a notice regarding the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug. The member will receive a 60-day supply of the drug. If the Food and Drug Administration (FDA) deems a drug on our formulary to be unsafe, or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

The enclosed formulary is current as of March 1, 2023. To get updated information about covered drugs, please contact Optum Rx. You may also visit our website at optum.com where you will find the most up-to-date information about our list of covered drugs (formulary) by using the "Drug Information" tool (found under the "Member Tools" tab). Our contact information is shown on the front and back cover pages.

How do I use the formulary?

There are 2 ways to find your drug within the formulary:

- **<u>Medical Condition</u>**

  The formulary begins on page 7The drugs in this formulary are grouped into categories depending on the type of medical condition(s) they are used to treat. For example, drugs used to 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 7. Then, look under the category name for your drug.

- **<u>Alphabetical Listing</u>**

  If you are not sure what category to look under, you should look for your drug in the Index that begins on 28. The Index provides an alphabetical list of all drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index.

Formulary design

The formulary structure features preferred and non-preferred generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, and high-cost drugs.

Drug Tier	Helpful Tips
Tier 1	Preferred generic drugs are listed under Tier 1 and have the lowest copayments.
Tier 2	Drugs listed under Tier 2 include non-preferred generic drugs that have higher copayments than preferred generic drugs.
Tier 3	Drugs listed under Tier 3 include preferred brand-name drugs that have lower copayments than non-preferred brand-name drugs.
Tier 4	Drugs listed under Tier 4 include non-preferred brand-name drugs that higher copayments than preferred brand-name drugs.
Tier 5	Specialty or high-cost drugs listed under Tier 5 cost $830 or more for up to a 30-day maximum supply.

Covered Prescription Drugs	**Retail Pharmacy** (up to a 30-day supply)	**Retail Pharmacy** (up to a 90-day supply)	**Depot Drug Preferred Mail-Order Pharmacy** (up to a 90-day supply)	**Non-Preferred Home Delivery Pharmacy** (up to a 90-day supply)
Cost Sharing Tier 1 (Preferred Generic Drugs)	$15	$45	$9	$45
Cost Sharing Tier 2 (Non-Preferred Generic Drugs)	$20	$60	$30	$60
Cost Sharing Tier 3 (Preferred Brand Drugs)	$30	$90	$45	$90
Cost Sharing Tier 4 (Non-Preferred Brand Drugs)	Greater of: $90 or 33%	Greater of: $270 or 33%	Greater of: $225 or 33%	Greater of: $270 or 33%
Cost Sharing Tier 5 (High-Cost Drugs) *	33%	n/a	n/a	n/a

* High-Cost drugs are those that cost $830 or more for up to a 30-day maximum supply.

You must obtain a 90-day supply of Tier 1 Generics when using Depot Drug mail. If you need less than a 90-day supply of Tier 1 Generics, you must use a retail network pharmacy. You may obtain a 30, 60, or 90-day supply of Tier 2, 3, or 4 prescription drugs from Depot Drug mail. If you use a mail-order pharmacy outside of the plan's network, your prescription will not be covered.

Please refer to your *Evidence of Coverage* for more information.

What are generic drugs?

Our 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.

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)	You or your physician may need to get prior authorization for certain drugs. This means you will need to get approval from Optum Rx before you fill your prescriptions. If you do not get approval, the drug may not be covered.
Quantity Limits (QL)	For certain drugs, there is a limit on the amount of the drug we will cover.
Step Therapy (ST)	In some cases, it is required 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

To find out if your drug has any additional requirements or limits, look in the formulary that begins on page 7. You can also get more information about restrictions applied to specific covered drugs by visiting our website or by calling Optum Rx. Our contact information, along with the date we last updated the formulary, is shown on the front and back cover pages.

You can ask Optum Rx 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 formulary?" on page 4 for additional information.

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 Optum Rx and ask if your drug is covered. This document includes only a partial list of covered drugs, so we may cover your drug. Our contact information, along with the date we last updated the formulary, is shown on the front and back cover pages.

If your drug is not covered, you have 2 options:

- You can ask Optum Rx for a list of similar drugs that are covered. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.
- You can ask Optum Rx 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 formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, the drug will be covered at a predetermined cost-sharing level, and you will not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level if the drug is not in the high-cost drug tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we may limit 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.

Note: If we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the drug is included on the plan's formulary, or if additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact Optum Rx for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception, you must submit a statement from your doctor (or other prescriber) supporting your request.** Generally, we must make our decision within 72 hours of getting your doctor's (or other prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor (or other prescriber).

What do I do before I can talk to my doctor about changing or requesting an exception?

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 your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor (or other prescriber) to decide if you should switch to an appropriate drug that we cover or request a formulary exception. While you talk to your doctor (or other prescriber) to 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 not on our formulary, or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. 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, we will allow you to refill your prescription until we have provided you with 31-day transition supply, written for as many pills as necessary, unless you have a prescription written for fewer days. We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If 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 for fewer days) while you get a formulary exception.

If you are a current enrollee with a level-of-care change and you need a drug that is not on our formulary, or if your ability to get your drugs is limited, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days) while you seek a formulary exception. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.

For more information

For more detailed information about your prescription drug coverage, please review your other plan materials. If you have questions about the plan, please call Optum Rx. Our contact information, along with the date we last updated the formulary, is shown 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), TTY 1-877-486-2048, 24 hours a day, 7 days a week. You may also visit medicare.gov.

Formulary

The formulary below provides coverage information about some of your covered drugs. If you have trouble finding your drug in the list, turn to the Index that begins on 28.

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

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., COZAAR), and generic drugs are listed in lower-case italics (e.g., *atenolol*). The following abbreviations listed in the "Requirements/Limits" column let you know if there are any special requirements for coverage of your drug.

Requirements/Limits	Helpful Tips
B/D	This prescription drug has a Part B versus Part D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
NDS	Non-Extended Days' Supply. This prescription drug is not available for an extended days' supply.
PA	Prior Authorization. Our plan requires you or your physician to get prior authorization for certain drugs. This means you will need to get approval from Optum Rx before you fill your prescriptions. If you do not get approval, your drug may not be covered.
QL	Quantity Limit. For certain drugs, our plan limits the amount of the drug we will cover.
ST	Step Therapy. In some cases, our plan requires you to 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
celecoxib capsule	2	QL (60 EA per 30 days)
diclofenac sodium dr	2	
diclofenac sodium gel 1%	2	QL (1000 GM per 30 days)
ibuprofen tablet 400mg, 600mg, 800mg	1	
meloxicam tablet	1	
nabumetone tablet	2	
naproxen tablet 250mg, 375mg, 500mg	1	
Opioid Analgesics, Long-acting		
fentanyl patch 72 hour 100mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr	4	NDS
methadone hcl tablet	2	NDS
morphine sulfate er tablet extended release	3	NDS
XTAMPZA ER	3	NDS
Opioid Analgesics, Short-acting		
acetaminophen/codeine tablet	2	NDS
hydrocodone bitartrate/acetaminophen tablet 325mg; 10mg, 325mg; 5mg	2	NDS
hydrocodone/acetaminophen tablet 325mg; 7.5mg	2	NDS
hydromorphone hcl tablet 2mg, 4mg	2	NDS
hydromorphone hcl tablet 8mg	4	NDS
morphine sulfate tablet	3	NDS
oxycodone hydrochloride tablet 10mg, 15mg, 5mg	2	NDS
oxycodone hydrochloride tablet 20mg, 30mg	3	NDS
oxycodone/acetaminophen tablet 325mg; 5mg, 325mg; 7.5mg	2	NDS
oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg	3	NDS
tramadol hcl tablet	1	NDS
Anesthetics		
Local Anesthetics		
lidocaine ointment 5%	4	QL (150 GM per 30 days) PA
lidocaine patch 5%	4	PA
premium lidocaine	4	QL (150 GM per 30 days) PA
Antibacterials		
Antibacterials, Other		
clindamycin hcl capsule 300mg	2	
clindamycin hydrochloride capsule 150mg, 75mg	2	
methenamine hippurate	4	
metronidazole tablet 250mg, 500mg	1	
nitrofurantoin macrocrystals capsule 100mg, 50mg	4	
nitrofurantoin monohydrate/macrocrystals	2	

Drug Name	Drug Tier	Requirements/Limits
nitrofurantoin monohydrate capsule	2	
Beta-lactam, Cephalosporins		
cefadroxil capsule	2	
cefdinir capsule	2	
cefpodoxime proxetil tablet	4	
cefuroxime axetil tablet	2	
cephalexin capsule 250mg, 500mg	2	
Beta-lactam, Penicillins		
amoxicillin/clavulanate potassium tablet 500mg; 125mg, 875mg; 125mg	2	
amoxicillin/clavulanate potassium tablet 250mg; 125mg	4	
amoxicillin capsule, tablet	1	
penicillin v potassium tablet	2	
Macrolides		
azithromycin tablet 250mg	1	
azithromycin tablet 500mg, 600mg	3	
Quinolones		
ciprofloxacin hydrochloride tablet 250mg, 500mg	1	
levofloxacin tablet	2	
Sulfonamides		
sulfamethoxazole/trimethoprim ds	1	
Tetracyclines		
doxycycline hyclate capsule 100mg	2	
doxycycline hyclate capsule 50mg	3	
doxycycline hyclate tablet 100mg	2	
doxycycline monohydrate capsule 100mg	2	
doxycycline monohydrate capsule 50mg	3	
doxycycline monohydrate tablet 100mg	2	
doxycycline monohydrate tablet 50mg	3	
Anticonvulsants		
Anticonvulsants, Other		
BRIVIACT SOLUTION	5	PA
BRIVIACT TABLET 100MG, 25MG, 50MG, 75MG	5	PA
lamotrigine tablet	1	
levetiracetam tablet	2	
topiramate tablet	1	
XCOPRI TABLET	5	PA
XCOPRI TABLET THERAPY PACK 0	4	PA; (12.5mg-25mg)
XCOPRI TABLET THERAPY PACK 0	5	PA
XCOPRI TABLET THERAPY PACK 0	5	PA; (100mg-150mg)
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
clonazepam tablet 2mg	1	QL (300 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
clonazepam tablet 0.5mg, 1mg	1	QL (90 EA per 30 days)
divalproex sodium dr	2	
divalproex sodium er	2	
divalproex sodium capsule delayed release sprinkle	2	
gabapentin capsule 100mg, 300mg	1	QL (360 EA per 30 days)
gabapentin capsule 400mg	2	QL (270 EA per 30 days)
gabapentin tablet 800mg	2	QL (150 EA per 30 days)
gabapentin tablet 600mg	2	QL (180 EA per 30 days)
primidone tablet	2	
Sodium Channel Agents		
carbamazepine tablet	3	
oxcarbazepine tablet	2	
phenytoin sodium extended	2	
Antidementia Agents		
Antidementia Agents, Other		
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR	4	QL (30 EA per 30 days) ST
NAMZARIC CAPSULE ER 24 HOUR THERAPY PACK	4	QL (56 EA per 365 days) ST
Cholinesterase Inhibitors		
donepezil hcl tablet 10mg	1	
donepezil hcl tablet 23mg	4	
donepezil hydrochloride tablet 10mg, 5mg	1	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hydrochloride tablet	2	
Antidepressants		
Antidepressants, Other		
bupropion hcl tablet 100mg	2	
bupropion hydrochloride er (sr) tablet extended release 12 hour 150mg, 200mg	2	QL (60 EA per 30 days)
bupropion hydrochloride er (sr) tablet extended release 12 hour 100mg	2	QL (90 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 300mg	2	QL (30 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 150mg	2	QL (90 EA per 30 days)
bupropion hydrochloride tablet 75mg	2	
mirtazapine tablet	2	
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		
citalopram hydrobromide tablet	1	
desvenlafaxine er tablet extended release 24 hour 100mg	2	QL (120 EA per 30 days)
desvenlafaxine er tablet extended release 24 hour 25mg, 50mg	2	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document.

Drug Name	Drug Tier	Requirements/Limits
duloxetine hydrochloride capsule delayed release particles 20mg, 60mg	2	QL (60 EA per 30 days)
duloxetine hydrochloride capsule delayed release particles 30mg	2	QL (90 EA per 30 days)
escitalopram oxalate tablet	1	
fluoxetine hcl capsule 20mg	1	
fluoxetine hydrochloride capsule 10mg, 40mg	1	
paroxetine hcl tablet 30mg, 40mg	2	
paroxetine hydrochloride tablet 10mg, 20mg	2	
sertraline hcl tablet 25mg, 50mg	1	
sertraline hydrochloride tablet 100mg	1	
trazodone hydrochloride tablet 100mg, 150mg, 50mg	2	
venlafaxine hcl er capsule extended release 24 hour 150mg, 37.5mg	2	
venlafaxine hydrochloride	2	
venlafaxine hydrochloride er capsule extended release 24 hour 75mg	2	
Tricyclics		
amitriptyline hcl tablet 100mg, 150mg, 25mg, 75mg	3	
amitriptyline hydrochloride tablet 10mg, 50mg	3	
nortriptyline hcl capsule 25mg, 75mg	2	
nortriptyline hydrochloride capsule 10mg, 50mg	2	
Antiemetics		
Antiemetics, Other		
meclizine hcl tablet	4	
prochlorperazine maleate tablet	2	
promethazine hcl tablet 12.5mg	4	
promethazine hydrochloride tablet 25mg	4	
Emetogenic Therapy Adjuncts		
ondansetron hydrochloride tablet	1	B/D
ondansetron odt	2	B/D
Antifungals		
Antifungals		
fluconazole tablet	2	
ketoconazole shampoo	2	
ketoconazole cream	2	QL (90 GM per 30 days)
nystatin cream, suspension	2	
nystatin powder	2	QL (120 GM per 30 days)
nystop	2	QL (120 GM per 30 days)
terbinafine hcl tablet	2	QL (84 EA per 180 days)
Antigout Agents		
Antigout Agents		

Drug Name	Drug Tier	Requirements/Limits
allopurinol tablet 100mg, 300mg	1	
COLCHICINE TABLET 0.6MG	3	
febuxostat	4	
Antimigraine Agents		
Prophylactic		
AIMOVIG INJECTION 140MG/ML	4	QL (1 ML per 30 days) PA
AIMOVIG INJECTION 70MG/ML	4	QL (2 ML per 30 days) PA
EMGALITY INJECTION 120MG/ML	4	QL (1 ML per 30 days) PA
EMGALITY INJECTION 100MG/ML	4	QL (3 ML per 30 days) PA
UBRELVY	5	QL (16 EA per 30 days) PA
Serotonin (5-HT) Receptor Agonist		
rizatriptan benzoate odt	3	QL (18 EA per 30 days)
sumatriptan succinate tablet	2	QL (9 EA per 30 days)
Antineoplastics		
Antiandrogens		
abiraterone acetate	5	PA
NUBEQA	5	PA
XTANDI	5	PA
Antiangiogenic Agents		
REVLIMID	5	PA
Antiestrogens/Modifiers		
tamoxifen citrate tablet	2	
Antimetabolites		
hydroxyurea capsule	2	
Aromatase Inhibitors, 3rd Generation		
anastrozole tablet	1	
letrozole	2	
Molecular Target Inhibitors		
ALECENSA	5	PA
BRUKINSA	5	PA
CALQUENCE CAPSULE	5	PA
IMBRUVICA CAPSULE, TABLET	5	PA
ODOMZO	5	PA
SPRYCEL	5	PA
TASIGNA	5	PA
Monoclonal Antibody/Antibody-Drug Conjugate		
MVASI INJECTION 100MG/4ML	5	PA
RUXIENCE INJECTION 500MG/50ML	5	PA
TRAZIMERA INJECTION 150MG	5	PA
ZIRABEV INJECTION 100MG/4ML	5	PA
Antiparasitics		
Antiprotozoals		

Drug Name	Drug Tier	Requirements/Limits
hydroxychloroquine sulfate tablet 100mg, 200mg	2	
Antiparkinson Agents		
Anticholinergics		
benztropine mesylate tablet	2	
Dopamine Agonists		
NEUPRO	4	ST
pramipexole dihydrochloride	2	
ropinirole hcl tablet 0.5mg, 1mg, 2mg, 4mg, 5mg	2	
ropinirole hydrochloride tablet 0.25mg, 3mg	2	
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa	2	
carbidopa/levodopa er	3	
INBRIJA	5	PA
RYTARY	4	ST
Antipsychotics		
2nd Generation/Atypical		
ABILIFY MAINTENA	5	
aripiprazole tablet	2	QL (30 EA per 30 days)
ARISTADA	5	
INVEGA HAFYERA INJECTION 1560MG/5ML	5	ST
INVEGA SUSTENNA INJECTION 39MG/0.25ML	4	
INVEGA SUSTENNA INJECTION 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML	5	
INVEGA TRINZA	5	
LATUDA TABLET 120MG, 20MG, 40MG, 60MG	5	QL (30 EA per 30 days)
LATUDA TABLET 80MG	5	QL (60 EA per 30 days)
olanzapine tablet	2	QL (30 EA per 30 days)
PERSERIS	5	
quetiapine fumarate tablet 300mg, 400mg	2	QL (60 EA per 30 days)
quetiapine fumarate tablet 100mg, 200mg, 25mg, 50mg	2	QL (90 EA per 30 days)
REXULTI	5	QL (30 EA per 30 days)
risperidone tablet	1	QL (60 EA per 30 days)
Treatment-Resistant		
clozapine tablet 25mg	2	QL (270 EA per 30 days)
clozapine tablet 50mg	3	QL (180 EA per 30 days)
clozapine tablet 200mg	4	QL (120 EA per 30 days)
clozapine tablet 100mg	4	QL (270 EA per 30 days)
Antispasticity Agents		
Antispasticity Agents		
baclofen tablet 10mg, 20mg	2	
baclofen tablet 5mg	3	

Drug Name	Drug Tier	Requirements/Limits
tizanidine hcl tablet 2mg	2	
tizanidine hydrochloride tablet 4mg	2	
Antivirals		
Anti-hepatitis C (HCV) Agents		
MAVYRET TABLET	5	QL (336 EA per 365 days) PA
SOFOSBUVIR/VELPATASVIR	5	QL (84 EA per 365 days) PA
VOSEVI	5	QL (84 EA per 365 days) PA
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	4	QL (20 EA per 5 days)
Anti-influenza Agents		
XOFLUZA TABLET THERAPY PACK 80MG	3	QL (2 EA per 365 days)
XOFLUZA TABLET THERAPY PACK 20MG, 40MG	3	QL (4 EA per 365 days)
Antiherpetic Agents		
acyclovir tablet	2	
valacyclovir hcl tablet 1gm	3	QL (120 EA per 30 days)
valacyclovir hydrochloride tablet 500mg	3	QL (120 EA per 30 days)
Anxiolytics		
Anxiolytics, Other		
buspirone hcl tablet 15mg	1	
buspirone hcl tablet 30mg	4	
buspirone hydrochloride tablet 10mg, 5mg	1	
buspirone hydrochloride tablet 7.5mg	4	
hydroxyzine pamoate capsule	4	
Benzodiazepines		
alprazolam tablet 0.25mg, 0.5mg, 1mg	1	QL (120 EA per 30 days)
alprazolam tablet 2mg	1	QL (150 EA per 30 days)
diazepam tablet 10mg	1	QL (120 EA per 30 days)
diazepam tablet 5mg	1	QL (240 EA per 30 days)
diazepam tablet 2mg	1	QL (300 EA per 30 days)
lorazepam tablet 2mg	1	QL (150 EA per 30 days)
lorazepam tablet 0.5mg, 1mg	1	QL (90 EA per 30 days)
Blood Glucose Regulators		
Antidiabetic Agents		
FARXIGA	3	
glimepiride	1	
glipizide er	1	
glipizide tablet	1	
INVOKAMET XR	4	ST
INVOKANA	4	ST
JANUMET	3	
JANUMET XR	3	

Drug Name	Drug Tier	Requirements/Limits
JANUVIA	3	QL (30 EA per 30 days)
JARDIANCE	3	
JENTADUETO	3	
JENTADUETO XR	3	
metformin hydrochloride er tablet extended release 24 hour 500mg, 750mg	1	
metformin hydrochloride tablet 1000mg, 500mg, 850mg	1	
MOUNJARO INJECTION 2.5MG/0.5ML, 5MG/0.5ML	5	QL (2 ML per 28 days) ST
OZEMPIC INJECTION 2MG/1.5ML	3	QL (1.5 ML per 28 days) ST
OZEMPIC INJECTION 2MG/1.5ML, 4MG/3ML, 5.5MG/ML; 14MG/ML; 8MG/3ML	3	QL (3 ML per 28 days) ST
pioglitazone hcl tablet 45mg	1	
pioglitazone hydrochloride tablet 15mg, 30mg	1	
RYBELSUS TABLET 14MG, 7MG	3	QL (30 EA per 30 days) ST
RYBELSUS TABLET 3MG	3	QL (60 EA per 365 days) ST
SOLIQUA 100/33	3	ST
SYNJARDY	3	
SYNJARDY XR	3	
TRADJENTA	3	QL (30 EA per 30 days)
TRIJARDY XR	3	
TRULICITY	3	QL (2 ML per 28 days) ST
VICTOZA	3	QL (9 ML per 30 days) ST
XIGDUO XR	3	
Glycemic Agents		
BAQSIMI ONE PACK	3	
BAQSIMI TWO PACK	3	
GLUCAGON EMERGENCY KIT FOR LOW BLOOD SUGAR INJECTION 1MG/ML	3	
GVOKE HYPOPEN 1-PACK INJECTION 1MG/0.2ML	3	
GVOKE HYPOPEN 2-PACK	3	
GVOKE PFS	3	
Insulins		
HUMALOG	3	
HUMALOG JUNIOR KWIKPEN	3	
HUMALOG KWIKPEN	3	
HUMALOG MIX 50/50	3	
HUMALOG MIX 50/50 KWIKPEN	3	
HUMALOG MIX 75/25	3	
HUMALOG MIX 75/25 KWIKPEN	3	
HUMULIN 70/30	3	
HUMULIN 70/30 KWIKPEN	3	
HUMULIN N	3	

Drug Name	Drug Tier	Requirements/Limits
HUMULIN N KWIKPEN	3	
HUMULIN R	3	
HUMULIN R U-500 (CONCENTRATED)	3	
HUMULIN R U-500 KWIKPEN	3	
LANTUS	3	
LANTUS SOLOSTAR	3	
LEVEMIR	3	
LEVEMIR FLEXTOUCH	3	
LYUMJEV	3	
LYUMJEV KWIKPEN	3	
NOVOLIN 70/30	3	
NOVOLIN 70/30 FLEXPEN	3	
NOVOLIN N	3	
NOVOLIN N FLEXPEN	3	
NOVOLIN R	3	
NOVOLIN R FLEXPEN	3	
NOVOLOG	3	
NOVOLOG MIX 70/30	3	
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	3	
NOVOLOG PENFILL	3	
TOUJEO MAX SOLOSTAR	3	
TOUJEO SOLOSTAR	3	
TRESIBA	3	
TRESIBA FLEXTOUCH	3	
Blood Products and Modifiers		
Anticoagulants		
ELIQUIS STARTER PACK	3	QL (148 EA per 365 days)
ELIQUIS TABLET 2.5MG	3	QL (60 EA per 30 days)
ELIQUIS TABLET 5MG	3	QL (90 EA per 30 days)
warfarin sodium tablet	1	
XARELTO STARTER PACK	3	QL (102 EA per 365 days)
XARELTO TABLET 10MG, 20MG	3	QL (30 EA per 30 days)
XARELTO TABLET 15MG, 2.5MG	3	QL (60 EA per 30 days)
Blood Products and Modifiers, Other		
NEULASTA	5	PA
NEULASTA ONPRO KIT	5	PA
PROCRIT INJECTION 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	PA
PROCRIT INJECTION 40000UNIT/ML	5	PA
RETACRIT INJECTION 10000UNIT/ML, 20000UNIT/2ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	PA

Drug Name	Drug Tier	Requirements/Limits
RETACRIT INJECTION 40000UNIT/ML	5	PA
UDENYCA	5	PA
ZARXIO	5	
Platelet Modifying Agents		
BRILINTA	3	
clopidogrel tablet 75mg	1	
clopidogrel tablet 300mg	2	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine hcl patch weekly	4	
clonidine hydrochloride tablet	1	
midodrine hcl	2	
Alpha-adrenergic Blocking Agents		
terazosin hcl capsule 10mg, 1mg, 5mg	1	
terazosin hydrochloride capsule 2mg	1	
Angiotensin II Receptor Antagonists		
candesartan cilexetil	1	
EDARBI	4	
irbesartan	1	
losartan potassium tablet	1	
olmesartan medoxomil tablet	1	
telmisartan	1	
valsartan tablet	1	
Angiotensin-converting Enzyme (ACE) Inhibitors		
benazepril hcl tablet 10mg, 40mg, 5mg	1	
benazepril hydrochloride tablet 20mg	1	
enalapril maleate tablet	1	
lisinopril tablet	1	
quinapril hcl tablet 20mg, 40mg	1	
ramipril	1	
Antiarrhythmics		
amiodarone hydrochloride tablet 200mg	1	
amiodarone hydrochloride tablet 100mg, 400mg	3	
digoxin tablet 125mcg, 250mcg, 62.5mcg	2	
flecainide acetate	2	
MULTAQ	3	
sotalol hcl	2	
sotalol hydrochloride tablet 120mg	2	
Beta-adrenergic Blocking Agents		
atenolol tablet	1	
bisoprolol fumarate	2	
carvedilol	1	

Drug Name	Drug Tier	Requirements/Limits
labetalol hydrochloride tablet	2	
metoprolol succinate er	2	
metoprolol tartrate tablet 100mg, 25mg, 37.5mg, 50mg	1	
metoprolol tartrate tablet 75mg	2	
nebivolol hydrochloride tablet 10mg, 5mg	3	
nebivolol tablet 5mg	3	
propranolol hcl tablet 40mg	2	
propranolol hydrochloride er capsule extended release 24 hour 60mg, 80mg	2	
propranolol hydrochloride tablet 10mg, 20mg, 60mg, 80mg	2	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate tablet	1	
felodipine er	2	
nifedipine er	2	
Calcium Channel Blocking Agents, Nondihydropyridines		
cartia xt	2	
diltiazem hcl tablet	2	
diltiazem hydrochloride er capsule extended release 24 hour	2	
verapamil hcl er tablet extended release 120mg, 240mg	2	
verapamil hydrochloride er tablet extended release 180mg	2	
Cardiovascular Agents, Other		
amlodipine besylate/benazepril hydrochloride	1	
bisoprolol fumarate/hydrochlorothiazide	2	
CORLANOR TABLET	4	QL (60 EA per 30 days) PA
EDARBYCLOR	4	
ENTRESTO	3	QL (60 EA per 30 days)
lisinopril/hydrochlorothiazide	1	
losartan potassium/hydrochlorothiazide	1	
olmesartan medoxomil/hydrochlorothiazide	1	
ranolazine er	2	
triamterene/hydrochlorothiazide capsule 25mg; 37.5mg	2	
triamterene/hydrochlorothiazide tablet	1	
valsartan/hydrochlorothiazide	1	
Diuretics, Loop		
bumetanide tablet	2	
furosemide tablet	1	
torsemide tablet	1	
Diuretics, Potassium-sparing		
spironolactone tablet	1	
Diuretics, Thiazide		
chlorthalidone tablet 25mg, 50mg	2	
hydrochlorothiazide capsule, tablet	1	

Drug Name	Drug Tier	Requirements/Limits
metolazone	2	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate tablet 145mg, 160mg, 48mg, 54mg	2	
gemfibrozil tablet	2	
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium	1	
LIVALO	4	ST
lovastatin tablet	1	
pravastatin sodium	1	
rosuvastatin calcium	1	
simvastatin tablet	1	
Dyslipidemics, Other		
ezetimibe	2	
ezetimibe/simvastatin	2	
NEXLETOL	4	QL (30 EA per 30 days) PA
NEXLIZET	4	QL (30 EA per 30 days) PA
omega-3-acid ethyl esters	3	
PRALUENT	3	QL (2 ML per 28 days) PA
REPATHA PUSHTRONEX SYSTEM	3	QL (7 ML per 28 days) PA
REPATHA SURECLICK	3	QL (3 ML per 28 days) PA
Vasodilators, Direct-acting Arterial/Venous		
isosorbide mononitrate er tablet extended release 24 hour 30mg, 60mg	1	
isosorbide mononitrate er tablet extended release 24 hour 120mg	2	
nitroglycerin tablet sublingual 0.3mg, 0.4mg, 0.6mg	2	
Vasodilators, Direct-acting Arterial		
hydralazine hcl tablet 10mg	1	
hydralazine hydrochloride tablet 25mg, 50mg	1	
hydralazine hydrochloride tablet 100mg	2	
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine/dextroamphetamine capsule extended release 24 hour 3.75mg; 3.75mg; 3.75mg; 3.75mg	3	QL (60 EA per 30 days); Extended-release capsule 15mg
amphetamine/dextroamphetamine capsule extended release 24 hour 5mg; 5mg; 5mg; 5mg	3	QL (60 EA per 30 days); Extended-release capsule 20mg
amphetamine/dextroamphetamine capsule extended release 24 hour 7.5mg; 7.5mg; 7.5mg; 7.5mg	3	QL (60 EA per 30 days); Extended-release capsule 30mg
amphetamine/dextroamphetamine capsule extended release 24 hour 2.5mg; 2.5mg; 2.5mg; 2.5mg	4	QL (60 EA per 30 days); Extended-release capsule 10mg
amphetamine/dextroamphetamine capsule extended release 24 hour 6.25mg; 6.25mg; 6.25mg; 6.25mg	4	QL (60 EA per 30 days); Extended-release capsule 25mg

Drug Name	Drug Tier	Requirements/Limits
amphetamine/dextroamphetamine capsule extended release 24 hour 1.25mg; 1.25mg; 1.25mg; 1.25mg	4	QL (60 EA per 30 days); Extended-release capsule 5mg
amphetamine/dextroamphetamine tablet	3	QL (90 EA per 30 days)
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
methylphenidate hydrochloride tablet	2	QL (90 EA per 30 days)
Central Nervous System, Other		
AUSTEDO	5	QL (120 EA per 30 days) PA
butalbital/acetaminophen/caffeine tablet 325mg; 50mg; 40mg	3	
INGREZZA CAPSULE 60MG, 80MG	5	QL (30 EA per 30 days) PA
INGREZZA CAPSULE 40MG	5	QL (60 EA per 30 days) PA
Fibromyalgia Agents		
pregabalin capsule 300mg	2	QL (60 EA per 30 days)
pregabalin capsule 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg	2	QL (90 EA per 30 days)
SAVELLA	3	QL (60 EA per 30 days)
Multiple Sclerosis Agents		
AVONEX PEN	5	QL (4 EA per 28 days) PA
AVONEX INJECTION 30MCG/0.5ML	5	QL (4 EA per 28 days) PA
BETASERON	5	QL (15 EA per 30 days) PA
GILENYA CAPSULE 0.5MG	5	QL (30 EA per 30 days) PA
MAYZENT TABLET 0.25MG	5	QL (120 EA per 30 days) PA
MAYZENT TABLET 2MG	5	QL (30 EA per 30 days) PA
PLEGRIDY	5	QL (1 ML per 28 days) PA
PLEGRIDY STARTER PACK	5	QL (2 ML per 365 days) PA
REBIF	5	QL (6 ML per 28 days) PA
REBIF REBIDOSE	5	QL (6 ML per 28 days) PA
REBIF REBIDOSE TITRATION PACK	5	QL (8.4 ML per 365 days) PA
REBIF TITRATION PACK	5	QL (8.4 ML per 365 days) PA
VUMERITY	5	QL (120 EA per 30 days) PA
ZEPOSIA	5	QL (30 EA per 30 days) PA
ZEPOSIA 7-DAY STARTER PACK	5	QL (14 EA per 365 days) PA
Dental and Oral Agents		
Dental and Oral Agents		
chlorhexidine gluconate solution	1	
doxycycline hyclate tablet 20mg	2	
Dermatological Agents		
Acne and Rosacea Agents		
metronidazole cream 0.75%	3	
metronidazole gel 0.75%	3	
metronidazole gel 1%	4	
Dermatitis and Pruitus Agents		

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document.

Drug Name	Drug Tier	Requirements/Limits
betamethasone dipropionate augmented cream	2	
betamethasone dipropionate augmented ointment	3	
CIBINQO TABLET 100MG	5	QL (30 EA per 30 days) PA
clobetasol propionate cream, ointment	2	
clobetasol propionate solution	3	
fluocinonide cream 0.05%	3	
fluocinonide cream 0.1%	3	QL (120 GM per 30 days)
fluocinonide ointment, solution	3	
hydrocortisone cream 2.5%	2	
hydrocortisone ointment 2.5%	2	
tacrolimus	4	
triamcinolone acetonide cream	2	
triamcinolone acetonide ointment 0.025%, 0.1%, 0.5%	2	
Dermatological Agents, Other		
clotrimazole/betamethasone dipropionate cream	2	
fluorouracil cream 5%	2	QL (40 GM per 30 days)
SANTYL	4	
Topical Anti-infectives		
ciclopirox nail lacquer	2	PA
clindamycin phosphate solution	2	QL (60 ML per 30 days)
mupirocin ointment	2	QL (110 GM per 30 days)
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
klor-con 8	2	
klor-con m20	2	
potassium chloride er capsule extended release	2	
potassium chloride er tablet extended release 20meq	2	
potassium chloride er tablet extended release 10meq, 20meq, 8meq	2	
potassium citrate er	4	
Phosphate Binders		
AURYXIA	5	PA
sevelamer carbonate tablet	4	
VELPHORO	5	
Potassium Binders		
veltassa	5	
Gastrointestinal Agents		
Anti-Constipation Agents		
lactulose solution	2	
LINZESS	3	QL (30 EA per 30 days)
MOTEGRITY	3	QL (30 EA per 30 days)
Anti-Diarrheal Agents		

Drug Name	Drug Tier	Requirements/Limits
diphenoxylate hydrochloride/atropine sulfate	3	
loperamide hcl capsule	2	
Antispasmodics, Gastrointestinal		
dicyclomine hydrochloride capsule, tablet	2	
Gastrointestinal Agents, Other		
CLENPIQ	3	
gavilyte-c	2	
peg-3350/electrolytes	2	
SUPREP BOWEL PREP KIT	3	
Histamine2 (H2) Receptor Antagonists		
famotidine tablet 20mg, 40mg	2	
Protectants		
sucralfate tablet	2	
Proton Pump Inhibitors		
DEXILANT	4	QL (30 EA per 30 days)
esomeprazole magnesium capsule delayed release	2	QL (60 EA per 30 days)
lansoprazole capsule delayed release	2	QL (60 EA per 30 days)
omeprazole capsule delayed release 20mg, 40mg	1	QL (60 EA per 30 days)
pantoprazole sodium tablet delayed release	1	QL (60 EA per 30 days)
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
CREON CAPSULE DELAYED RELEASE PARTICLES 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	3	
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 105000UNIT; 25000UNIT; 79000UNIT, 14000UNIT; 3000UNIT; 10000UNIT, 168000UNIT; 40000UNIT; 126000UNIT, 24000UNIT; 5000UNIT; 17000UNIT, 42000UNIT; 10000UNIT; 32000UNIT, 63000UNIT; 15000UNIT; 47000UNIT, 84000UNIT; 20000UNIT; 63000UNIT	3	
Genitourinary Agents		
Antispasmodics, Urinary		
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR	3	
oxybutynin chloride er	2	
oxybutynin chloride tablet	2	
solifenacin succinate	2	
tolterodine tartrate er	3	

Drug Name	Drug Tier	Requirements/Limits
trospium chloride	3	
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er	2	
doxazosin mesylate	2	
dutasteride capsule	2	
finasteride tablet	1	
tadalafil tablet 2.5mg, 5mg	3	QL (30 EA per 30 days) PA
tamsulosin hydrochloride	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
dexamethasone tablet 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg	2	
fludrocortisone acetate tablet	2	
methylprednisolone dose pack tablet therapy pack	2	
prednisone tablet therapy pack	2	
prednisone tablet 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
GENOTROPIN	5	PA
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
Androgens		
ANDRODERM PATCH 24 HOUR 2MG/24HR, 4MG/24HR	3	PA
testosterone cypionate injection 100mg/ml, 200mg/ml	2	PA
testosterone pump gel 1.62%	3	PA
TESTOSTERONE GEL 25MG/2.5GM, 50MG/5GM	3	PA
testosterone gel 20.25mg/1.25gm, 40.5mg/2.5gm	3	PA
Estrogens		
estradiol cream, oral tablet	2	
estradiol vaginal tablet	4	
ESTRING	4	QL (1 EA per 90 days)
PREMARIN CREAM	4	
PREMARIN TABLET 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG	4	
PREMPHASE	4	
PREMPRO	4	
yuvafem	4	
Progestins		
progesterone capsule	2	
Selective Estrogen Receptor Modifying Agents		
raloxifene hydrochloride	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document.

Drug Name	Drug Tier	Requirements/Limits
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
EUTHYROX TABLET 100MCG, 112MCG, 125MCG, 137MCG, 150MCG, 175MCG, 200MCG, 25MCG, 50MCG, 75MCG, 88MCG	3	
levothyroxine sodium tablet	2	
liothyronine sodium tablet	2	
SYNTHROID TABLET	3	
Hormonal Agents, Suppressant (Pituitary)		
Hormonal Agents, Suppressant (Pituitary)		
LUPRON DEPOT (1-MONTH) INJECTION 7.5MG	5	QL (1 EA per 28 days) PA
LUPRON DEPOT (3-MONTH)	5	QL (1 EA per 84 days) PA
LUPRON DEPOT (6-MONTH)	5	QL (1 EA per 168 days) PA
ORGOVYX	5	PA
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
methimazole tablet 10mg, 5mg	2	
Immunological Agents		
Immunological Agents, Other		
COSENTYX SENSOREADY PEN	5	PA
COSENTYX INJECTION 150MG/ML	5	PA
RINVOQ	5	QL (30 EA per 30 days) PA
SKYRIZI PEN	5	PA
SKYRIZI INJECTION 150MG/ML, 75MG/0.83ML	5	PA
STELARA INJECTION 130MG/26ML	5	PA
STELARA INJECTION 45MG/0.5ML, 90MG/ML	5	QL (3 ML per 84 days) PA
XELJANZ XR	5	QL (30 EA per 30 days) PA
XELJANZ TABLET	5	QL (60 EA per 30 days) PA
Immunosuppressants		
azathioprine tablet 50mg	2	B/D
azathioprine tablet 100mg, 75mg	4	B/D
CIMZIA INJECTION 200MG/ML	5	PA
ENBREL	5	PA
ENBREL MINI	5	PA
ENBREL SURECLICK	5	PA
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 80MG/0.8ML	5	PA
HUMIRA PEN	5	PA
HUMIRA PEN-CD/UC/HS STARTER	5	PA
HUMIRA PEN-PS/UV STARTER	5	PA
HUMIRA INJECTION 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML	5	PA
leflunomide	2	

Drug Name	Drug Tier	Requirements/Limits
methotrexate sodium tablet	2	
Vaccines		
ADACEL	3	
SHINGRIX	3	
Inflammatory Bowel Disease Agents		
Aminosalicylates		
sulfasalazine tablet	2	
Glucocorticoids		
budesonide capsule delayed release particles	4	
proctozone-hc	2	
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
alendronate sodium tablet 10mg, 35mg	1	
alendronate sodium tablet 70mg	1	QL (4 EA per 28 days)
calcitriol capsule	2	
ibandronate sodium tablet	2	QL (1 EA per 28 days)
PROLIA	4	QL (2 ML per 365 days)
RAYALDEE	5	
risedronate sodium tablet 30mg, 5mg	4	
risedronate sodium tablet 150mg	4	QL (1 EA per 28 days)
risedronate sodium tablet 35mg	4	QL (4 EA per 28 days)
TERIPARATIDE	5	PA
Miscellaneous Therapeutic Agents		
Miscellaneous Therapeutic Agents		
bd veo insulin syringe ultra-fine/0.3ml/31g x 6mm	2	QL (200 EA per 30 days)
OMNIPOD DASH PDM KIT (GEN 4)	3	QL (1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	3	QL (30 EA per 30 days)
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	4	QL (30 EA per 5 days)
V-GO 20	3	
V-GO 30	3	
V-GO 40	3	
Ophthalmic Agents		
Ophthalmic Agents, Other		
COMBIGAN	3	
dorzolamide hcl/timolol maleate	2	
neomycin/polymyxin/dexamethasone	2	
polymyxin b sulfate/trimethoprim sulfate	1	
RESTASIS	3	
RESTASIS MULTIDOSE	3	
ROCKLATAN	3	QL (2.5 ML per 25 days)
SIMBRINZA	3	
TOBRADEX ST	4	

Drug Name	Drug Tier	Requirements/Limits
XIIDRA	4	QL (60 EA per 30 days)
Ophthalmic Anti-allergy Agents		
olopatadine hcl	3	
olopatadine hydrochloride solution 0.2%	3	
Ophthalmic Anti-Infectives		
BESIVANCE	4	
erythromycin	2	
moxifloxacin hydrochloride solution	3	
ofloxacin	2	
Ophthalmic Anti-inflammatories		
diclofenac sodium solution 0.1%	2	
FLAREX	3	
fluorometholone	3	
ILEVRO	3	QL (4 ML per 30 days)
ketorolac tromethamine solution 0.5%	2	
ketorolac tromethamine solution 0.4%	3	
LOTEMAX SM	4	QL (20 GM per 365 days)
prednisolone acetate	2	
PROLENSA	4	QL (12 ML per 365 days)
Ophthalmic Beta-Adrenergic Blocking Agents		
timolol maleate solution	1	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
brimonidine tartrate solution 0.2%	2	
dorzolamide hydrochloride	2	
RHOPRESSA	3	QL (2.5 ML per 25 days)
Ophthalmic Prostaglandin and Prostamide Analogs		
latanoprost solution	1	
LUMIGAN	3	QL (2.5 ML per 25 days)
Respiratory Tract/Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA	3	QL (30 EA per 30 days)
ASMANEX HFA	4	QL (13 GM per 30 days)
ASMANEX TWISTHALER 120 METERED DOSES	4	QL (1 EA per 30 days)
ASMANEX TWISTHALER 14 METERED DOSES	4	QL (1 EA per 30 days)
ASMANEX TWISTHALER 30 METERED DOSES	4	QL (1 EA per 30 days)
ASMANEX TWISTHALER 60 METERED DOSES	4	QL (1 EA per 30 days)
BREZTRI AEROSPHERE	3	QL (23.6 GM per 28 days)
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 250MCG/BLIST	3	QL (240 EA per 30 days)
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 100MCG/BLIST, 50MCG/BLIST	3	QL (60 EA per 30 days)
FLOVENT HFA AEROSOL 44MCG/ACT	3	QL (21.2 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FLOVENT HFA AEROSOL 110MCG/ACT, 220MCG/ACT	3	QL (24 GM per 30 days)
fluticasone propionate	1	
mometasone furoate	4	QL (34 GM per 30 days)
QVAR REDIHALER	4	QL (21.2 GM per 30 days) ST
Antihistamines		
azelastine hydrochloride solution 0.1%	2	QL (60 ML per 30 days)
hydroxyzine hydrochloride tablet 10mg, 25mg	3	
levocetirizine dihydrochloride tablet	2	
Antileukotrienes		
montelukast sodium tablet	1	
Bronchodilators, Anticholinergic		
ATROVENT HFA	4	QL (25.8 GM per 30 days)
INCRUSE ELLIPTA	3	QL (30 EA per 30 days)
ipratropium bromide solution	2	
LONHALA MAGNAIR REFILL KIT	5	QL (60 ML per 30 days)
SPIRIVA HANDIHALER	3	QL (30 EA per 30 days)
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5MCG/ACT	3	
SPIRIVA RESPIMAT AEROSOL SOLUTION 1.25MCG/ACT	3	QL (8 GM per 30 days)
YUPELRI	5	QL (90 ML per 30 days) B/D
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa aerosol solution 108mcg/act	2	QL (13.4 GM per 30 days)
albuterol sulfate hfa aerosol solution 108mcg/act	2	QL (17 GM per 30 days)
albuterol sulfate hfa aerosol solution 108mcg/act	2	QL (48 GM per 30 days)
EPINEPHRINE INJECTION 0.15MG/0.3ML, 0.3MG/0.3ML	3	
epinephrine injection 0.15mg/0.15ml, 0.3mg/0.3ml	3	
PROAIR HFA	3	QL (17 GM per 30 days)
PROAIR RESPICLICK	3	QL (2 EA per 30 days)
SEREVENT DISKUS	3	QL (60 EA per 30 days)
Cystic Fibrosis Agents		
TOBI PODHALER	5	QL (224 EA per 56 days)
Pulmonary Antihypertensives		
OPSUMIT	5	QL (30 EA per 30 days) PA
ORENITRAM TABLET EXTENDED RELEASE 0.25MG, 1MG, 2.5MG, 5MG	5	PA
Pulmonary Fibrosis Agents		
ESBRIET CAPSULE	5	PA
OFEV	5	PA
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ANORO ELLIPTA	3	QL (60 EA per 30 days)
BREO ELLIPTA	3	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
FASENRA	5	PA
FASENRA PEN	5	PA
fluticasone propionate/salmeterol diskus	2	QL (60 EA per 30 days)
NUCALA INJECTION 100MG	5	QL (3 EA per 28 days) PA
NUCALA INJECTION 100MG/ML	5	QL (3 ML per 28 days) PA
STIOLTO RESPIMAT	3	QL (24 GM per 30 days)
SYMBICORT AEROSOL 160MCG/ACT; 4.5MCG/ACT	3	QL (12 GM per 30 days)
SYMBICORT AEROSOL 80MCG/ACT; 4.5MCG/ACT	3	QL (13.8 GM per 30 days)
TRELEGY ELLIPTA	3	QL (60 EA per 30 days)
wixela inhub	2	QL (60 EA per 30 days)
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Skeletal Muscle Relaxants		
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Sleep Promoting Agents		
BELSOMRA	3	QL (30 EA per 30 days)
eszopiclone	4	QL (30 EA per 30 days)
temazepam capsule 15mg, 30mg	2	QL (30 EA per 30 days)
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Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

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請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

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UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍៖ បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka›anída›awo›ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'déé› t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíílnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

This formulary was updated on February 1, 2023 and is a partial listing of drugs covered by our plan.

For a complete listing or if you have questions, please contact:

Optum Rx Member Services

Phone (toll-free)**:**	**1-866-443-1095**
TTY users:	**711**
Hours of operation:	24 hours a day, 7 days a week
Website:	**optumrx.com**

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UPREHS
Abridged Formulary