



City of Macedonia

Employee Benefits Enrollment Guide

Plan Year: 2021

Welcome to Open Enrollment for your Benefits!

Elections you make during open enrollment will become effective January 1, 2021.

Medical Mutual offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your your coverage for you and your family.

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Eligibility

Who is Eligible?

If you are a full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. The following family members are eligible for medical, dental and vision coverage: Spouse and dependent children. Under the Patient Protection and Affordable Care Act, coverage will be extended to adult dependents through age 26.

How to Enroll

If you do not request any changes for the new year, your current enrollments WILL automatically renew. Please review the new plan information closely. If there have been changes/additions/ deletions to your plan, you MUST make any changes if necessary. Please see HR to fill out necessary forms. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to Enroll

The open enrollment period is open until December 18, 2020. The benefits you elect during open enrollment will be effective from January 1, 2021 through December 31, 2021.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.

What's New for 2021



2021 Medical/Rx HRA

City of Macedonia

2021 Open Enrollment

The City of Macedonia's medical insurance carrier will be changing from Cigna to Medical Mutual of Ohio (MMO) effective January 1, 2021. MMO will administer both the medical plan and our Health Reimbursement Accounts (HRAs).

MMO HRA Fund for 2021: **Single:** \$3,500 **Family:** \$6,000

The HRA funds for both the Single and Family plans, may be used for applicable to the plan deductibles and copays. You will receive a Debit card for use at the pharmacy.

MMO Medical ID Cards

All cards will be mailed to your home address. If you need additional cards, contact Cigna's 24/7 Customer Service at **(800) 232-7400**. When you receive your ID card, we recommend you register on www.medmutual.com

Pharmacy

IMPORTANT: HRA Debit Cards will likely not arrive in the mail before January 1, 2021.

Be sure to fill any scripts prior to January 1st so you have a supply on hand.

If you spend money out of your pocket on pharmacy expenses before you receive your Debit card, keep the receipts so you can request reimbursement from your HRA fund.

All Mail Order and Specialty Mail Order medications will require a new script from your physician to fill through Medical Mutual's Mail Order pharmacy.

Tracking your HRA account balance: You can view your account balance at www.medmutual.com.

Telehealth - Telehealth (telemedicine) is available with your Medical Mutual plan through Express Care Online (refer to the guide for more information). We recommend registering *prior* to becoming ill. Nothing is worse than trying to register when you're sick!

MMO Member Services:

(800) 232-7400

www.medmutual.com

Claims Address: 2060 East Ninth Street, Cleveland, OH 44115

Be Well Wellness - There will be no changes to the Be Well Wellness program in 2021. If you have any questions, please contact Human Resources.

Medical Plans

Your Cost in 2020

The City of Macedonia is pleased to announce there will be no premium increase passed on to you for the new plan year. Bi-weekly payroll deductions will remain as shown.

Medical and Prescription Drug

Employee Contributions per Pay (26 Pays)

PLAN LEVEL	<u>No</u> Wellness Participation 12.5%	Wellness Participation 6.25%
Employee Only	\$39.51	\$19.75
Employee + Spouse	\$76.17	\$38.09
Employee + Child(ren)	\$64.23	\$32.11
Employee + Family	\$101.55	\$50.78



MEDICAL MUTUAL®

City of Macedonia - Benefit Summary

HRA – Single Plan

Effective: January 1, 2020

Group

Group Number	Group Name
160069	City of Macedonia

Medical

Subcategory	Variable	Network	Non-Network
Dependent Age		26	
Older Age Child		26	
Lifetime Maximum		Unlimited	
Overall Benefit Period Maximum		Unlimited	
Network and Non-Network Benefit Maximums		Integrated	
Claims Filing Limit		12 months	
Case Management		Yes	
Benefit Period		January 1st through December 31st	
Type of SuperMed Processing		Flat	
Coinsurance		100%	50%
Benefit Period Deductible - Single		\$2,000	\$7,500
Benefit Period Deductible - Family		\$2,000	\$7,500
Type of Deductible Accumulation		Separate - Deductible incurred for a non-network provider will only apply to the non-network deductible limits. Deductible incurred for a network provider will only apply to the network limits.	
Type of Deductible Processing		Aggregate Deductible	
Deductible - Common Accident		Yes	
Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Single		\$2,000	\$7,500

Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Family		\$2,000	\$7,500
Type of Coinsurance Out-of-Pocket Accumulation		Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits. Coinsurance incurred for a network provider will only apply to the network limits.	
Type of Coinsurance Out-of-Pocket Processing		Aggregate Coinsurance	
Maximum Out-of-Pocket Limits - Single (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	\$4,000	\$15,000
Maximum Out-of-Pocket Limits - Family (the sum of any	(includes medical and drug services)	\$4,000	\$15,000

Subcategory	Variable	Network	Non-Network
Applicable deductible, coinsurance and copays)			
Is MOOP sum of deductible plus coinsurance OOP?	(For SBC Processing Only)	Yes	
Type of Copay Processing		MOOP Accumulation Copay Processing(Medical/Drug)-Copays accumulate to the Maximum Out-of-Pocket (MOOP) Limits and they stop being taken once the MOOPs are met.	
Emergency - Medical/Accident - Emergency Room		\$250 copay, then 100% (copay is waived if admitted)	
Emergency - Medical/Accident - Ancillaries		100%	
Emergency - Medical/Accident - Physician		100%	
Non-Emergency - Emergency Room		\$250 copay, then 100% (copay is waived if admitted)	\$250 copay, then 100% (copay is waived if admitted)
Non-Emergency - Physician		100%	100%
Anesthesia		100% after deductible	50% after deductible
Consultations		100% after deductible	50% after deductible
Newborn Care		100% after deductible	50% after deductible
Institutional Services		100% after deductible	50% after deductible
Maternity		100% after deductible	50% after deductible

Physical Medicine and Rehabilitation	(limited to 60 days per benefit period when rendered in a Freestanding Rehabilitation Hospital)	100% after deductible	50% after deductible
Professional Services		100% after deductible	50% after deductible
Skilled Nursing Facility(SNF)	(60 days per benefit period)	100% after deductible	50% after deductible
Inpatient Alcoholism Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Inpatient Drug Abuse Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Inpatient Mental Health Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Outpatient Alcoholism Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	

Subcategory	Variable	Network	Non-Network
Abuse Services	developmental delay)		
Outpatient Mental Health Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Parity - Mental Health/Residential		Yes	
Health Care Reform - Mental Health/Substance Abuse Benefits		100%	Benefits paid based on services rendered
Medically Necessary Office Visits/Consultations/ Telemedicine - PCP		\$25 copay, then 100%	50% after deductible
On Demand Virtual Telemedicine		\$25 copay, then 100%	50% after deductible
Medically Necessary Office Visits/Consultations/ Telemedicine - Specialist		\$50 copay, then 100%	50% after deductible
Urgent Care Provider Office Visits		\$75 copay, then 100%	50% after deductible
Allergy Testing		100% after deductible	50% after deductible
Allergy Treatment		100% after deductible	50% after deductible
Diagnostic Imaging		100% after deductible	50% after deductible
Diagnostic Lab		100% after deductible	50% after deductible
Diagnostic Medical Tests		100% after deductible	50% after deductible
Diagnostic X-ray		100% after deductible	50% after deductible

Education and Training	(excludes Diabetic Education and Training)	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits
Education and Training/Diabetic		Not Covered, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits
Home Health Care	(60 visits per benefit period)	100% after deductible	50% after deductible
Immunizations	(All Immunizations)	100%	50% after deductible
Maternity	(Prenatal Visits are covered at no charge with in-network providers)	100% after deductible	50% after deductible

Subcategory	Variable	Network	Non-Network
Surgical Services - Anesthesia	(except for excision or elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)	100% after deductible	50% after deductible
Surgical Services - Assistant Surgeon	(except for excision or elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)	100% after deductible	50% after deductible
Surgical Services - Surgery Professional	(except for excision or elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)	\$25 copay, then 100% (PCP - Physician Office); \$50 copay, then 100% (Specialist - Physician Office); \$75 copay, then 100% (Urgent Care); 100% after deductible (All other Places of Service)	50% after deductible
Surgical Services - Surgery Facility	(except for excision or elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)	100% after deductible	50% after deductible

Surgical Services - Diagnostic Endoscopic Services		\$25 copay, then 100% (PCP - Physician Office); \$50 copay, then 100% (Specialist - Physician Office); \$75 copay, then 100% (Urgent Care); 100% after deductible (All other Places of Service)	50% after deductible
Cardiac Rehabilitation		100% after deductible	50% after deductible
Chemotherapy		100% after deductible	50% after deductible
Chiropractic	(20 visits per benefit period)	\$25 copay, then 100%	50% after deductible
Dialysis Treatment		100% after deductible	50% after deductible
Hyperbaric Therapy		100% after deductible	50% after deductible
Occupational Therapy	(60 visits per benefit period combined with Physical Therapy, Speech Therapy)	\$25 copay, then 100%	50% after deductible
Physical Therapy	(60 visits per benefit	\$25 copay, then 100%	50% after deductible

Subcategory	Variable	Network	Non-Network
	period combined with Occupational Therapy, Speech Therapy)		
Pulmonary Therapy		100% after deductible	50% after deductible
Radiation Therapy		100% after deductible	50% after deductible
Respiratory Therapy		100% after deductible	50% after deductible
Speech Therapy	(60 visits per benefit period combined with Physical Therapy, Occupational Therapy)	\$25 copay, then 100%	50% after deductible
Health Care Reform Preventive Benefits		100%	50% after deductible
Health Care Reform Preventive Benefits for Women		100%	50% after deductible
Family Planning Exam		100% after deductible	50% after deductible
Hearing Exam	(age 21 and over)	100% after deductible	50% after deductible
Immunizations	(All Immunizations)	100%	50% after deductible
Physical Exam	(age 21 and over)	100%	50% after deductible
Bone Density Tests		100%	50% after deductible
Endoscopic Services		100%	50% after deductible
Lab		100%	50% after deductible
Mammogram	(1 per benefit period)	100%	50% after deductible
Medical Tests		100%	50% after deductible
Pap Test	(1 per benefit period)	100%	50% after deductible
PSA Tests		100%	50% after deductible
X-rays		100%	50% after deductible
Covered up to the age of		21	

Exams		100%	50% after deductible
Hearing Exams		100%	50% after deductible
Immunizations	(All Immunizations)	100%	50% after deductible
Labs		100%	50% after deductible
Vision Exams		100%	50% after deductible
Abortions - Elective		100% after deductible	50% after deductible
Abortions - Therapeutic		100% after deductible	50% after deductible
Acupuncture		Not Covered	Not Covered
Ambulance		100% after deductible	50% after deductible
Approved Clinical Trial		Benefits paid based on services rendered	
Autism Spectrum Disorders (other than	Only the following services are covered:	Benefits paid based on services rendered	

Subcategory	Variable	Network	Non-Network
ABA)	OP Therapies subject to limits on corresponding benefits for all ages (including unlimited OP Mental Health); Except Unlimited OP PT and separate OP OT & Speech Therapy visits are covered (20 visits each))		
Applied Behavior Analysis(ABA)	Unlimited (all ages)	Benefits paid based on services rendered	
Blood, Blood Typing and Administration		100% after deductible	50% after deductible
Diabetes Disease Management (DM) Program	Materials covered under the DM program are not listed in certificate	Limited Supplies - no cost share (includes syringes, pen needles, glucose strips, control solution, lancing device, glucose lancets and a glucose meter)	
Durable Medical Equipment	(except for Orthopedic Shoes and Foot Orthotics, which are not covered)	100% after deductible	50% after deductible
DME - Breast Pumps	(1 per birth as ordered or prescribed by a physician)(includes related supplies)	100% after deductible	50% after deductible
Gender Transition Treatment		Not Covered	Not Covered
Hospice		100% after deductible	50% after deductible
Medical Supplies		100% after deductible	50% after deductible
Non-emergency care when traveling outside the United States		Not Covered	Not Covered
Oral Accident		100% after deductible	50% after deductible

Organ Transplant		100% after deductible	50% after deductible
Private Duty Nursing		100% after deductible	50% after deductible
Routine Foot Care for Diabetes		100% after deductible	50% after deductible
Routine Foot Care for Peripheral Vascular Disease		100% after deductible	50% after deductible
TMJ		Benefits paid based on services rendered	
Weight Loss Surgical Services (Bariatric Surgery)		Not Covered	Not Covered

Subcategory	Variable	Network	Non-Network
Limit	(includes Hearing Aids, Hearing Aid Evaluation, Conformity Evaluation, Fitting and Repairs)	\$2,500 per benefit period	
Conformity Evaluation		100% after deductible	50% after deductible
Standard Hearing Aid	(1 per benefit period)	100% after deductible	50% after deductible
Hearing Aid Evaluation Test		100% after deductible	50% after deductible
Hearing Aid Fitting and Repair		100% after deductible	50% after deductible
Acupuncture		Not Covered	Not Covered
Bariatric Surgery		Not Covered	Not Covered
Chiropractic Care		Covered	Covered
Cosmetic Surgery		Not Covered	Not Covered
Dental Care (Adult)		Not Covered	Not Covered
Hearing Aids		Covered	Covered
Infertility Treatment		Not Covered	Not Covered
Long-term Care		Not Covered	Not Covered
Non-emergency care when traveling outside the U.S.		Not Covered	Not Covered
Private-duty Nursing		Covered	Covered
Routine eye care (adult)		Not Covered	Not Covered
Routine Foot Care		Not Covered	Not Covered
Weight Loss Programs		Not Covered	Not Covered

Drug

Subcategory	Variable		Note Id
General Information			
Product		Major Medical Drug - Realtime Processing - Next Gen	
Formulary with Integrated Coverage Management Programs		Basic Plus	
Coverage Management with 90 day waiver member notification		Yes	
Pharmacy Network		National Plus Maintenance	
Specialty Drug Solution Pharmacy Network		Applies	
True Payment Processing(TPP)		Applies	
How Claims are Paid			
Benefit Period		January 1st through December 31st	
HCR Preventive Benefits - Drug		100%	
Contraceptive Coverage and HCR Preventive Benefits for Women - Drug		100%	
Benefit Period Deductible - Single	(combined with medical)	\$2,000	
Benefit Period Deductible - Family	(combined with medical)	\$2,000	
Maximum Out-of-Pocket Limits - Single (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	\$4,000	
Maximum Out-of-Pocket	(includes medical and drug	\$4,000	
Subcategory			
Limits - Family (the sum of any applicable deductible, coinsurance and copays)	services)		
Major Medical Drug Coverage	Covers up to a 30 day supply (specialty drugs); 90 day supply (all other drugs)	100% after deductible	
Commonly Covered or Excluded Drugs and Programs			
Asthmatic Supplies		Not Covered	
Compound Drug Management		Participates	
Diabetic Supplies (over-the-counter)	(includes over-the-counter items, except for glucose monitors and meters)	Covered	
Fertility Drugs		Not Covered	
Growth Hormones		Covered	
Immunizations/Vaccines		Covered	
Injectables		Covered	

Sexual Dysfunction Drugs		Not Covered	
Smoking Cessation Drugs (non-OTC)		Covered	
Smoking Cessation Drugs (over-the-counter)		Not Covered, unless the service is covered under HCR Preventive Benefits - Drugs	
Weight Loss Drugs		Not Covered	



Group

Group Number	Group Name
160069	City of Macedonia

Medical

Subcategory	Variable	Network	Non-Network
Dependent Age		26	
Older Age Child		26	
Lifetime Maximum		Unlimited	
Overall Benefit Period Maximum		Unlimited	
Network and Non-Network Benefit Maximums		Integrated	
Claims Filing Limit		12 months	
Case Management		Yes	

Subcategory	Variable	Network	Non-Network
Benefit Period		January 1st through December 31st	
Type of SuperMed Processing		Flat	
Coinsurance		100%	50%
Benefit Period Deductible - Single		\$6,000	\$15,000
Benefit Period Deductible - Family		\$6,000	\$15,000
Type of Deductible Accumulation		Separate - Deductible incurred for a non-network provider will only apply to the non-network deductible limits. Deductible incurred for a network provider will only apply to the network limits.	
Type of Deductible Processing		Aggregate Deductible	
Deductible - Common Accident		Yes	
Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Single		\$850	\$15,000

Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Family		\$850	\$15,000
Type of Coinsurance Out-of-Pocket Accumulation		Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits. Coinsurance incurred for a network provider will only apply to the network limits.	
Type of Coinsurance Out-of-Pocket Processing		Aggregate Coinsurance	
Maximum Out-of-Pocket Limits - Single (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	\$6,850	\$30,000
Maximum Out-of-Pocket Limits - Family	(includes medical and drug services)	\$6,850	\$30,000

Subcategory	Variable	Network	Non-Network
(the sum of any applicable deductible, coinsurance and copays)			
Is MOOP sum of deductible plus coinsurance OOP?	(For SBC Processing Only)	Yes	
Type of Copay Processing		MOOP Accumulation Copay Processing(Medical/Drug)-Copays accumulate to the Maximum Out-of-Pocket (MOOP) Limits and they stop being taken once the MOOPs are met.	
Emergency - Medical/Accident - Emergency Room		\$250 copay, then 100% (copay is waived if admitted)	
Emergency - Medical/Accident - Ancillaries		100%	
Emergency - Medical/Accident - Physician		100%	
Non-Emergency - Emergency Room		\$250 copay, then 100% (copay is waived if admitted)	\$250 copay, then 100% (copay is waived if admitted)
Non-Emergency - Physician		100%	100%
Anesthesia		100% after deductible	50% after deductible
Consultations		100% after deductible	50% after deductible
Newborn Care		100% after deductible	50% after deductible
Institutional Services		100% after deductible	50% after deductible
Maternity		100% after deductible	50% after deductible

Physical Medicine and Rehabilitation	(limited to 60 days per benefit period when rendered in a Freestanding Rehabilitation Hospital)	100% after deductible	50% after deductible
Professional Services		100% after deductible	50% after deductible
Skilled Nursing Facility(SNF)	(60 days per benefit period)	100% after deductible	50% after deductible
Inpatient Alcoholism Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Inpatient Drug Abuse Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Inpatient Mental Health Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Outpatient Alcoholism Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	

Subcategory	Variable	Network	Non-Network
Outpatient Drug Abuse Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Outpatient Mental Health Services	(includes coverage for developmental delay)	Benefits paid based on corresponding medical benefits	
Parity - Mental Health/Residential		Yes	
Health Care Reform - Mental Health/Substance Abuse Benefits		100%	Benefits paid based on services rendered
Medically Necessary Office Visits/Consultations/ Telemedicine - PCP		\$25 copay, then 100%	50% after deductible
On Demand Virtual Telemedicine		\$25 copay, then 100%	50% after deductible
Medically Necessary Office Visits/Consultations/ Telemedicine - Specialist		\$50 copay, then 100%	50% after deductible
Urgent Care Provider Office Visits		\$75 copay, then 100%	50% after deductible
Allergy Testing		100% after deductible	50% after deductible
Allergy Treatment		100% after deductible	50% after deductible
Diagnostic Imaging		100% after deductible	50% after deductible
Diagnostic Lab		100% after deductible	50% after deductible
Diagnostic Medical Tests		100% after deductible	50% after deductible
Diagnostic X-ray		100% after deductible	50% after deductible

Education and Training	(excludes Diabetic Education and Training)	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits
Education and Training/Diabetic		Not Covered, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits
Home Health Care	(60 visits per benefit period)	100% after deductible	50% after deductible
Immunizations	(All Immunizations)	100%	50% after deductible
Maternity	(Prenatal Visits are covered at no charge with in-network providers)	100% after deductible	50% after deductible
Surgical Services -	(except for excision or	100% after deductible	50% after deductible

Subcategory	Variable	Network	Non-Network
Anesthesia	elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)		
Surgical Services - Assistant Surgeon	(except for excision or elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)	100% after deductible	50% after deductible
Surgical Services - Surgery Professional	(except for excision or elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)	\$25 copay, then 100% (PCP - Physician Office); \$50 copay, then 100% (Specialist - Physician Office); \$75 copay, then 100% (Urgent Care); 100% after deductible (All other Places of Service)	50% after deductible
Surgical Services - Surgery Facility	(except for excision or elimination of hanging skin, which is not covered for all places of service)(except for penile implants which are not covered for all places of service)	100% after deductible	50% after deductible

Surgical Services - Diagnostic Endoscopic Services		\$25 copay, then 100% (PCP - Physician Office); \$50 copay, then 100% (Specialist - Physician Office); \$75 copay, then 100% (Urgent Care); 100% after deductible (All other Places of Service)	50% after deductible
Cardiac Rehabilitation		100% after deductible	50% after deductible
Chemotherapy		100% after deductible	50% after deductible
Chiropractic	(20 visits per benefit period)	\$25 copay, then 100%	50% after deductible
Dialysis Treatment		100% after deductible	50% after deductible
Hyperbaric Therapy		100% after deductible	50% after deductible
Occupational Therapy	(60 visits per benefit period combined with Physical Therapy, Speech Therapy)	\$25 copay, then 100%	50% after deductible

Subcategory	Variable	Network	Non-Network
Physical Therapy	(60 visits per benefit period combined with Occupational Therapy, Speech Therapy)	\$25 copay, then 100%	50% after deductible
Pulmonary Therapy		100% after deductible	50% after deductible
Radiation Therapy		100% after deductible	50% after deductible
Respiratory Therapy		100% after deductible	50% after deductible
Speech Therapy	(60 visits per benefit period combined with Physical Therapy, Occupational Therapy)	\$25 copay, then 100%	50% after deductible
Health Care Reform Preventive Benefits		100%	50% after deductible
Health Care Reform Preventive Benefits for Women		100%	50% after deductible
Family Planning Exam		100% after deductible	50% after deductible
Hearing Exam	(age 21 and over)	100% after deductible	50% after deductible
Immunizations	(All Immunizations)	100%	50% after deductible
Physical Exam	(age 21 and over)	100%	50% after deductible
Bone Density Tests		100%	50% after deductible
Endoscopic Services		100%	50% after deductible
Lab		100%	50% after deductible
Mammogram	(1 per benefit period)	100%	50% after deductible
Medical Tests		100%	50% after deductible
Pap Test	(1 per benefit period)	100%	50% after deductible
PSA Tests		100%	50% after deductible
X-rays		100%	50% after deductible
Covered up to the age of		21	

Exams		100%	50% after deductible
Hearing Exams		100%	50% after deductible
Immunizations	(All Immunizations)	100%	50% after deductible
Labs		100%	50% after deductible
Vision Exams		100%	50% after deductible
Abortions - Elective		100% after deductible	50% after deductible
Abortions - Therapeutic		100% after deductible	50% after deductible
Acupuncture		Not Covered	Not Covered
Ambulance		100% after deductible	50% after deductible
Approved Clinical Trial		Benefits paid based on services rendered	
Autism Spectrum	Only the following	Benefits paid based on services rendered	

Subcategory	Variable	Network	Non-Network
Disorders (other than ABA)	services are covered: OP Therapies subject to limits on corresponding benefits for all ages (including unlimited OP Mental Health); Except Unlimited OP PT and separate OP OT & Speech Therapy		
Applied Behavior Analysis(ABA)	Unlimited (all ages)	Benefits paid based on services rendered	
Blood, Blood Typing and Administration		100% after deductible	50% after deductible
Diabetes Disease Management (DM) Program	Materials covered under the DM program are not listed in certificate	Limited Supplies - no cost share (includes syringes, pen needles, glucose strips, control solution, lancing device, glucose lancets and a glucose meter)	
Durable Medical Equipment	(except for Orthopedic Shoes and Foot Orthotics, which are not covered)	100% after deductible	50% after deductible
DME - Breast Pumps	(1 per birth as ordered or prescribed by a physician)(includes related supplies)	100% after deductible	50% after deductible
Gender Transition Treatment		Not Covered	Not Covered
Hospice		100% after deductible	50% after deductible
Medical Supplies		100% after deductible	50% after deductible
Non-emergency care when traveling outside the United States		Not Covered	Not Covered
Oral Accident		100% after deductible	50% after deductible
Organ Transplant		100% after deductible	50% after deductible
Private Duty Nursing		100% after deductible	50% after deductible

Routine Foot Care for Diabetes		100% after deductible	50% after deductible
Routine Foot Care for Peripheral Vascular Disease		100% after deductible	50% after deductible
TMJ		Benefits paid based on services rendered	
Weight Loss Surgical Services (Bariatric Surgery)		Not Covered	Not Covered
Limit	(includes Hearing	\$2,500 per benefit period	

Subcategory	Variable	Network	Non-Network
	Aids, Hearing Aid Evaluation, Conformity Evaluation, Fitting and Repairs)		
Conformity Evaluation		100% after deductible	50% after deductible
Standard Hearing Aid	(1 per benefit period)	100% after deductible	50% after deductible
Hearing Aid Evaluation Test		100% after deductible	50% after deductible
Hearing Aid Fitting and Repair		100% after deductible	50% after deductible
Acupuncture		Not Covered	Not Covered
Bariatric Surgery		Not Covered	Not Covered
Chiropractic Care		Covered	Covered
Cosmetic Surgery		Not Covered	Not Covered
Dental Care (Adult)		Not Covered	Not Covered
Hearing Aids		Covered	Covered
Infertility Treatment		Not Covered	Not Covered
Long-term Care		Not Covered	Not Covered
Non-emergency care when traveling outside the U.S.		Not Covered	Not Covered
Private-duty Nursing		Covered	Covered
Routine eye care (adult)		Not Covered	Not Covered
Routine Foot Care		Not Covered	Not Covered
Weight Loss Programs		Not Covered	Not Covered

Drug

Subcategory	Variable	
Product		Major Medical Drug - Realtime Processing - Next Gen
Formulary with Integrated Coverage Management Programs		Basic Plus
Coverage Management with 90 day waiver member notification		Yes
Pharmacy Network		National Plus Maintenance
Specialty Drug Solution Pharmacy Network		Applies
True Payment Processing(TPP)		Applies
Benefit Period		January 1st through December 31st
HCR Preventive Benefits - Drug		100%
Contraceptive Coverage and HCR Preventive Benefits for Women - Drug		100%
Benefit Period Deductible - Single	(combined with medical)	\$6,000
Benefit Period Deductible - Family	(combined with medical)	\$6,000
Maximum Out-of-Pocket Limits - Single (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	\$6,850
Maximum Out-of-Pocket	(includes medical and drug)	\$6,850

Subcategory	Variable	
Limits - Family (the sum of any applicable deductible, coinsurance and copays)	services)	
Major Medical Drug Coverage	Covers up to a 30 day supply (specialty drugs); 90 day supply (all other drugs)	100% after deductible
Asthmatic Supplies		Not Covered
Compound Drug Management		Participates
Diabetic Supplies (over-the-counter)	(includes over-the-counter items, except for glucose monitors and meters)	Covered
Fertility Drugs		Not Covered
Growth Hormones		Covered
Immunizations/Vaccines		Covered
Injectables		Covered

Sexual Dysfunction Drugs		Not Covered
Smoking Cessation Drugs (non-OTC)		Covered
Smoking Cessation Drugs (over-the-counter)		Not Covered, unless the service is covered under HCR Preventive Benefits - Drugs
Weight Loss Drugs		Not Covered

Dental Insurance

City of Macedonia
FUSION Highlight Sheet



Effective Date: 3/1/2019

FUSION: THE ULTIMATE CHOICESM combines dental and eye care benefits in one easy-to-administer plan. This plan combines the annual maximum between the dental and eye care plans.

For the maximum:

- The member can use up to \$1,750 Non PPO - \$1,750 PPO toward any covered dental expense.
- The member can use up to \$150 towards any covered eye care expense.
- Total benefits paid between the two coverages will not exceed \$1,750.

Dental Plan Summary *subject to FUSION plan design listed above*

Plan Benefit	In Network	Out of Network
Type 1	100%	100%
Type 2	90%	80%
Type 3	80%	50%
Deductible	\$50/Calendar Year Type 2 & 3 Waived Type 1 \$150/family	\$50/Calendar Year Type 2 & 3 Waived Type 1 \$150/family
Maximum (per person)	\$1,750 per calendar year	\$1,750 per calendar year
Allowance	Discounted Fee	Discounted Fee
Dental Rewards®	Included	Included
Waiting Period	None	None
LASIK Advantage®	Included	Included
SoundCare SM	Included	Included
Annual Open Enrollment	Included	Included

Orthodontia Summary - Child Only Coverage

	In Network	Out of Network
Allowance	Discounted Fee	U&C
Plan Benefit	50%	50%
Lifetime Maximum (per person)	\$1,000*	\$1,000*
Waiting Period	None	None

*Maximum not reduced by prior carrier payment.

Eye Care Summary *subject to FUSION plan design listed above*

Allowances		Frequencies <i>Based on date of service</i>	
Exam	Subject to maximum	Exam	None
Lenses (per pair)		Lenses	None
Single	Subject to maximum	Frames	None
Bifocal	Subject to maximum		
Trifocal	Subject to maximum	Maximum	\$150
Lenticular	Subject to maximum	Deductibles (None)	\$0*
Progressive	Subject to maximum		
Contacts			
Elective/Medically Necessary	Subject to maximum		
Frames	Subject to maximum		

*Deductible applies to the first service received

Dental Insurance

Dental Procedure Summary

Type 1	In Network Type 2	Type 3
<ul style="list-style-type: none"> Routine Exam (2 per benefit period) Biteewing X-rays (2 per benefit period) Full Mouth/P anoramic X-rays (1 in 3 years) Periapical X-rays Cleaning (2 per benefit period) Fluoride for Children 18 and under (1 per benefit period) Sealants (age 16 and under) Space Maintainers 	<ul style="list-style-type: none"> Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Endodontics (surgical) Periodontics (nonsurgical) Periodontics (surgical) Denture Repair Simple Extractions Complex Extractions Anesthesia 	<ul style="list-style-type: none"> Onlays Crowns (1 in 5 years per tooth) Crown Repair Implants Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
Type 1	Out of Network Type 2	Type 3
<ul style="list-style-type: none"> Routine Exam (2 per benefit period) Biteewing X-rays (2 per benefit period) Full Mouth/P anoramic X-rays (1 in 3 years) Periapical X-rays Cleaning (2 per benefit period) Fluoride for Children 18 and under (1 per benefit period) Sealants (age 16 and under) Space Maintainers 	<ul style="list-style-type: none"> Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Endodontics (surgical) Periodontics (nonsurgical) Periodontics (surgical) Denture Repair Simple Extractions Complex Extractions Anesthesia 	<ul style="list-style-type: none"> Onlays Crowns (1 in 5 years per tooth) Crown Repair Implants Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Current Dental Terminology © American Dental Association.

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of **City of Macedonia**. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com.



Vision Insurance

City of Macedonia
Eye Care Highlight Sheet



ViewPointe® Plan H Summary

	EyeMed Access Network	Out of Network
Deductibles		No deductible
Annual Eye Exam	\$10 Exam \$10 Eye Glass Lenses Covered in full	Up to \$35
Lenses (per pair)		
Single Vision	Covered in full	Up to \$25
Bifocal	Covered in full	Up to \$40
Trifocal	Covered in full	Up to \$55
Lenticular	20% discount	No benefit
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams		
Standard	Standard: Member cost up to \$55	No benefit
Premium (Allowance)	Premium: 10% off of retail	No benefit
Elective	Up to \$150	Up to \$120
Medically Necessary	Covered in full	Up to \$200
Frames	\$150	Up to \$75
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

Lens Options (member cost)

	EyeMed Access Network	Out of Network
Progressive Lenses		No benefit
Standard	Standard: \$65 + lens deductible	
Premium	Premium: lens cost - 20% discount - \$120 allowance + Standard Progressive cost	
Std. Polycarbonate	\$40	No benefit
Tint (solid and gradient)	\$15	No benefit
Scratch Resistant Coating	\$15	No benefit
Anti-Reflective Coating	\$45	No benefit
Ultraviolet Coating	\$15	No benefit
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	No benefit

Vision Insurance

Additional ViewPointe® H Features

EyeMed In-Network Discounts	15% discount off the remaining balance in excess of the conventional contact lens allowance. 20% discount off the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.
EyeMed In-Network Secondary Purchase Plan	Members receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Members receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit EyeMedvisioncare.com for details.

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed network provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866-289-0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com

View plan benefit information at: eyemedvisioncare.com

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.



Life Insurance

Basic Life and AD&D (Accidental Death and Dismemberment) Employer Paid Benefit

All Eligible Full-Time Employees	\$50,000
Age Reduction Schedule	To 35% @ Age 65; To 50% @ Age 70

Voluntary Life and AD&D (Accidental Death and Dismemberment)

FEATURE	DESCRIPTION
Employee Benefit:	In increments of \$10,000 to a maximum of the lesser of \$250,000 or 5 X annual earnings. For employees age 70 or over, maximum coverage is \$50,000.
Spouse Benefit:	Increments of \$5,000 up to a maximum of the lesser of 2.5 times the employee's annual salary or \$50,000
Child(ren) Benefit:	Age: 14 days to 6 months: \$250 Age: 6 months to Age 19 (or 25 if a Full-time student): \$10,000
Guaranteed Issue Limit:	Employee: \$50,000 • Spouse: \$25,000 • Child(ren): \$10,000
Age Reduction:	Benefit reduces to 65% at age 65, 50% at 70

Special One-Time Enrollment Effective 1/1/2021 - During this year's annual open enrollment, Symetra is allowing us a one-time enrollment for employees to elect Optional Life and AD&D up to the Guarantee Issue Limits (meaning you will not need to answer a health questionnaire to prove Evidence of Insurability (EOI)).



***As a new hire, you have the opportunity to elect Optional Life and AD&D on yourself and your dependents up to the Guarantee Issue Limits without providing Evidence of Insurability (EOI). If you decide to enroll at a later time, you must complete an EOI form.**

If you had Voluntary Life insurance with our prior policy with the Hartford, your coverage will transfer to Symetra effective 1/1/2021—you will not need to complete EOI documents or enrollment forms to keep your coverage the same.

Life Insurance

Voluntary Rate Schedule

Voluntary Life and AD&D – Monthly Premium Rates	
Employee Age	Per Adult Rates
	Monthly Premium Rate per \$1,000
Under 24	\$0.06
25 - 29	\$0.06
30 – 34	\$0.07
35 – 39	\$0.10
40 – 44	\$0.16
45 – 49	\$0.26
50 – 54	\$0.46
55 – 59	\$0.75
60 – 64	\$1.00
65 – 69	\$1.56
70— 74	\$2.74
79 and up	\$4.49
\$ 2 per month for \$1,000 for all children	



Sample Calculations

Calculations Based on the Rate Chart Above				
Age	Coverage Amount	Divide by 1,000	Multiplied by Rate	Total Cost
Employee: 45	\$75,000	/ 1,000 = \$75.00	x \$0.26	\$19.50 Monthly
Employee: 55	\$20,000	/ 1,000 = \$20.00	x \$0.75	\$15.00 Monthly
Spouse: 45	\$30,000	/ 1,000 = \$30.00	x \$0.26	\$7.80 Monthly
Spouse: 55	\$10,000	/ 1,000 = \$10.00	x \$0.75	\$7.50 Monthly



City of Macedonia Incentive Program



To: All Eligible Employees

From: Human Resources

Date: January 1, 2021

Re: Get Ready!! Get Set!! Go Wellness!!!!

Our Employee Wellness Program is ramped up and ready to hit the ground running! It is HR's goal to give you some health tools that can help you and your family become the healthiest you can and want to be!

Read on and take advantage as we begin to roll out the City of Macedonia's wellness red carpet for each of you! Get ready! You should have already registered, but if not, no worries, see the steps below:

Visit portal.bewelldata.com on your computer, tablet, or smartphone and enter your login credentials.

- Employee Username: Your Macedonia email address (example: JSmith@macedonia.oh.us)
- Employee Password: First 3 letters of birth month in CAPS + Last 4 of SSN (example: JAN1234)

Spouses whom are on the company medical plan are welcome to participate in the onsite biometric screening. If your spouse wishes to participate, their health portal credentials are:

- Spouse Username: COM-Spouse First Name.Spouse Last Name-SP (example: COM-John.Smith-SP)
- Spouse Password: Employee's first 3 letters of birth month in CAPS + Last 4 of SSN + SP (same as the employee's password + SP; example: JAN1234SP)

Participation in the wellness program is a healthy option that YOU can choose to be active in or not. Participation in completing the activities is completely optional. With that said, we hope you will choose to become more active and more aware of your health! We have an exciting year ahead of us and hopefully many more years to come!

Your input, ideas, and suggestions are always welcome as I continue to work with our Wellness provider to build our program and make the Employee Wellness Program awesome!

Send comments/questions to asmith@macedonia.oh.us and include "Wellness" in subject line or call me at 330-468-8353. I look forward to an energizing and exciting year in wellness and in working with each and every one of you!



City of Macedonia Incentive Program



Be Well Solutions is pleased to present the 2021 Wellness Incentive Program for The City of Macedonia. Employees on the medical plan can earn PTO hours and a reduction on their co-insurance depending on their Wellness Status level (see below). Wellness status is determined by the number of points that you and your eligible spouse earn based on the activities in which you partake. 10% of points from the 2020 wellness program will be applied to your account.

Bronze	Silver	Gold	Platinum*	
2,000 points	5,000 points	8,000 points	10,000 points	One Adult
Health Risk Assessment & Biometric Screening	8,000 points	12,000 points	15,000 points	Two Adults
4 hours off	4 hours off	4 hours off	4 hours off	
		Employee pays 6.25% toward co-insurance	Employee pays 6.25% toward Co-Insurance	

**The maximum incentive a participant can earn by participating in the wellness program and reaching platinum status is 16 hours paid time off and employees will only pay 6.25% of their co-insurance.*

If you were unable to attend the onsite screening, you may go to your doctor for the required tests. To do so:

1. Download the Physician Screening Form from the Be Well portal located under [My Wellness —> Program Forms & Information](#)
2. Sign the Release of Information section and take the form to your doctor. Your doctor will need to enter the results from your screening and sign the form.
3. Follow the submission instructions on the form to send results to Be Well Solutions.

**Only biometrics collected between January 1, 2021 and December 1, 2021 will be accepted.*



Please review the following pages for a list of 2021 Wellness Points Offerings. If you have any questions, contact Be Well Solutions at 888-WEL.SERV or info@bewellsolutions.com



City of Macedonia Incentive Program



Prevention			
Activity	Description	Points per Activity	Max Points
Health Risk Assessment (HRA)	Complete online/paper questionnaire that asks information on demographics, health status, diet and exercise, sleep habits and financial wellbeing.	1,000	1,000
Biometric Screening	Participate in the onsite biometric screening or visit your doctor and complete the off-site Physician Screening Form.	1,000	1,000
Health Fair Attendance	Visit required number of health fair vendors.	500	500
Healthy Numbers - Fasting Glucose	National Institutes of Health (NIH) Standard: <100 mg/dL	250	250
Healthy Numbers - LDL Cholesterol	NIH Standard: <100 mg/dL	250	250
Healthy Numbers - Blood Pressure	NIH Standard: <120/80	250	250
Breast Cancer Screening (Mammogram)*	Breast Cancer screening options were reviewed and the patient should be considered current.	500	500
Cervical Cancer Screening (Pap Test)*	Cervical Cancer screening options reviewed and the patient is currently up to date.	500	500
Prostate Cancer Screening Exam (PSA or Physical Exam)*	Prostate Cancer screening options were discussed and patient is up to date.	500	500
Colon Cancer Screening (Colonoscopy or other)*	Colon Cancer screening and prevention strategies reviewed and up to date.	500	500
Dental Exam*	Complete routine/preventive dental exam and cleaning. (2 times per year)	500	1,000
Vision Exam*	Complete routine/preventive annual vision exam.	500	500
Flu Vaccine*	Submit verification of flu vaccination.	500	500
Smoke & Tobacco Free Declaration*	Complete the declaration statement if you have been smoke & tobacco free for a minimum of 90 days.	250	250

*Activities with asterisks can be uploaded via the portal.



City of Macedonia Incentive Program



BWS Activity			
Activity	Description	Points per Activity	Max Points
28-Day Wellness Challenges	Complete a 28-day wellness challenge. The wellness challenges are offered once per quarter. (4 opportunities)	500	2,000
Health Coaching	Set your personal health goals and receive support along the way by participating in telephonic health coaching with a certified health and wellness coach. (10 sessions)	250	2,500
Nutrition Counseling	Work with a registered, licensed dietitian. These sessions may be done telephonically or via email through Be Well Solutions or another dietitian of your choosing. (10 sessions)	250	2,500
BWS Educational Videos	Watch online video and pass the corresponding quizzes. Videos refreshed quarterly, 3 videos per quarter. Each video has 2-3 corresponding quizzes. (max point value 10/12 videos)	200	2,000
BWS Scavenger Hunt*	Complete the BWS Scavenger Hunt and get to know more about your health partner and how they can support your personal wellness journey.	250	250

**Activities with asterisks can be uploaded via the portal.*



City of Macedonia Incentive Program



Self-Directed			
Activity	Description	Points per Activity	Max Points
Mindfulness*	Participate in a structured yoga or meditation session for at least 30 minutes and take care of your mind, body and spirit. Days do not have to be consecutive. (25 sessions max)	100	2,500
Physical Activity*	Exercise for at least 30 minutes a day. Days do not have to be consecutive. (25 days max)	100	2,500
Wellness Promoter*	Describe how you promote wellness at the City of Macedonia in such a way that supports or encourages the participation of your fellow employees in wellness programming with the city. (2 opportunities)	250	500
What is Your Why?*	Complete the "What is Your Why" exercise to identify why wellness is important to you.	250	250
Wellness Your Way*	Describe your own, self-directed or chosen wellness activity. (2 opportunities)	250	500
Step Challenge*	Track at least 10,000 steps/day for a max of 50 days. Days do not need to be consecutive.	50	2,500
Move for a Cause*	Participate in a walk/run/ride event. This includes 5k/10k/half/full marathons. (4 opportunities)	250	1,000
Community Wellness*	Volunteer for a charitable organization or community event of your choice. Must be a 2-hour or more commitment. (4 opportunities)	250	1,000
First Aid/CPR Certification*	Submit proof of First Aid or CPR Certification.	250	250
City of Macedonia "Pop-Up" Challenges	Participate in challenges run by the City of Macedonia. List of employees who complete challenges will be sent over by HR. (4 events per year).	500	2000

*Activities with asterisks can be uploaded via the portal.

2021 Prescription Drug Formulary

Basic/Basic Plus



PLEASE READ:

This document contains information about the drugs we cover in your plan. This formulary was updated 12/31/2020 and is subject to change.

Coverage is subject to the definitions, limitations, exclusions and parameters set forth in your official plan benefit documents. Please refer to your Certificate or Benefit Book for more information.

Multi-Language Interpreter Services & Nondiscrimination Notice



This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíłnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711)まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html

Basic/Basic Plus Formulary

What is the Basic/Basic Plus formulary?

The Basic/Basic Plus formulary is a list of medications covered by your plan. The formulary includes five tiers:

1. Generic (lowest out-of-pocket cost)
2. Preferred brand
3. Non-preferred brand
4. Specialty (highest out-of-pocket cost)
5. Preventive (\$0 out-of-pocket cost)

Refer to your Certificate or Benefit Book for information about your cost share, including copays, coinsurance and/or deductibles. Not all tiers apply to all plans.

If you are a member of a plan that includes a preferred pharmacy network (e.g., CLE-Care), those preferred pharmacies may offer lower cost sharing to help you save money. Check your benefit materials for more details.

Your plan may exclude certain medications. Please refer to your Certificate or Benefit Book for more information.

How do I use the Basic/Basic Plus formulary?

Covered medications are organized two ways in the Basic/Basic Plus formulary:

1. By condition
2. By name

If you know what your medication is used to treat, you can look it up by condition in the front of the document. If you don't know what condition it is used to treat, you can look for it in the alphabetical Index at the back of the document.

What do I do if my medication requires prior authorization or step therapy, or has a quantity limit?

You, your doctor or your pharmacist can call Express Scripts at 1-800-753-2851 to begin the review process for medications that require prior authorization or step therapy, or that have a quantity limit. After contacting Express Scripts, your doctor will receive a form to fill out and fax back to Express Scripts. Express Scripts will send you and your doctor a letter confirming if coverage has been approved (usually within three business days of receiving the necessary information).

- If you ordered your prescription through mail order, Express Scripts will automatically send it to you once coverage is approved.
- If you tried to fill your prescription at a retail pharmacy, you will need to return to the pharmacy to pick up your medication.

Does the Basic/Basic Plus formulary include generic and brand medications?

Yes. The Basic/Basic Plus formulary includes a variety of generic and brand medications to help you pay less out of pocket.

Generic medications are shown in this document in *lower-case italic letters*. Generics are approved by the U.S. Food and Drug Administration (FDA) as having the same active ingredient as their brand-name counterparts. In addition, the FDA requires generics to be just as safe and strong as their brand-name counterparts so you get the same medical benefit.

Brand medications are shown in this document in ALL CAPITAL LETTERS.

Does the Basic/Basic Plus formulary include specialty medications?

Yes. Specialty medications are used to treat certain complex medical conditions and may require special handling, instruction, or monitoring. Many plans limit you to a 30-day supply for most specialty medications and/or require you to fill prescriptions for these medications through one of Medical Mutual's contracted specialty pharmacies, Accredo or Gentry.

If you are a member of a plan that includes a preferred pharmacy network (e.g., CLE-Care), you may be required to use specific preferred pharmacies for specialty drugs.

Please check your Certificate or Benefit Book for more details about ordering specialty drugs.

Are there other limitations or coverage rules in addition to what are listed in this guide?

Yes. Medications listed as covered may be subject to additional coverage rules and to your plan's benefits. In addition, Medical Mutual may limit the dose and/or overall quantity of medications you are able to receive to protect your safety. These limits are developed from evidence-based clinical best practices and both national and state prescribing guidelines. If you require a dose or quantity beyond the limits allowed, your doctor or your pharmacist can call Express Scripts at 1-800-753-2851 to begin the review process.

How can I save money on my prescriptions?

Depending on your plan, you may have lower copays for drugs listed as Tier 1 and Tier 2. Even if you pay 100 percent of the cost of your drugs (until you meet your deductible), you may still pay less for generic drugs and plan-preferred brand drugs.

Generic drugs approved by the U.S. Food and Drug Administration (FDA) are just as safe and strong as the corresponding brand-name drugs.

When you visit your doctor or health provider, ask him or her to review this formulary at MedMutual.com/2021formulary so he or she can see what generic and/or plan-preferred

brand medications are covered by your plan, and which may help you save money.

If you are a member of a plan that includes a preferred pharmacy network (e.g., CLE-Care), those preferred pharmacies may offer lower cost sharing to help you save money. Check your benefit materials for more details.

Do I have to use mail order for my maintenance medications?

Depending on your plan, you may be required to use mail order for your maintenance medications (those you take for three months or more). Check your Certificate or Benefit Book for details. (Note: If you are a member of a CLE-Care plan, you must fill mail-order medications through the MetroHealth Central Fill Pharmacy. Visit metrohealth.org/pharmacy for more information and to download a form.)

Even if you are not required to do so, you may save money on your maintenance medications if you order them through the mail. In addition, you may be able to enroll in Express Scripts' Extended Payment Program. This allows you to split your cost share into three equal monthly payments while still obtaining the full amount of your prescription (limitations may apply).

To get started using mail order, ask your provider to write a prescription for up to the maximum days' supply allowed by your plan, plus refills for up to one year, if appropriate. Then:

1. Complete the home delivery form you received in the mail from Express Scripts, and return it with your payment in the envelope provided. If you need another form, visit MedMutual.com and click "Member Forms" at the bottom of the page. Download and print the Prescription Drug Mail Order Form.
2. Ask your provider to call Express Scripts at 1-888-327-9791 for instructions on how to fax the prescription or use the e-prescribing system. Your provider must have your member ID number (which is on your member Medical Mutual ID card).
3. Call the Rx Information number on your Medical Mutual ID card. A Member Services

representative can help you transfer your prescriptions to mail order.

When ordering through mail order, your medication should be delivered in about eight days (10-14 days if it's a new prescription). Please have a one-month supply of your medicine on hand when you place your order. You can check your order status by visiting the Express Scripts website through My Health Plan, or by calling the Rx Information number on your ID card.

List of Abbreviations

ACA: Affordable Care Act

OTC: Over the Counter

PA: Prior Authorization. The Plan requires you or your physician to get prior authorization for certain medications. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, your plan may not cover the medication.

QL: Quantity Limit. For certain drugs, the plan limits the amount of the medication it will cover.

ST: Step Therapy. In some cases, the plan requires you to first try certain medications to treat your medical condition before we will cover another medication for that condition. For example, if Medication A and Medication B both treat your medical condition, the plan may not cover Medication B unless you try Medication A first. If Medication A does not work for you, the plan will then cover Medication B.

LA: Limited Availability

Note: You, your doctor or your pharmacist can call Express Scripts at (800) 753-2851 to begin the review process for medications that require PA, QL and ST. After contacting Express Scripts, your doctor will receive a form to fill out and fax back to Express Scripts. Express Scripts will send you and your doctor a letter confirming if coverage has been approved (usually within three business days of receiving the necessary information).

Basic plus Formulary

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Drug Name	Drug Tier	Requirements / Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET INTRAVENOUS SUSPENSION	2	
AMBISOME INTRAVENOUS SUSPENSION FOR RECONSTITUTION	2	
<i>amphotericin b injection recon soln</i>	1	
ANCOBON ORAL CAPSULE	3	
CANCIDAS INTRAVENOUS RECON SOLN	3	
<i>caspofungin intravenous recon soln</i>	1	
<i>clotrimazole mucous membrane troche</i>	1	
CRESEMBA INTRAVENOUS RECON SOLN	2	
CRESEMBA ORAL CAPSULE	2	
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION	3	
DIFLUCAN ORAL TABLET 100 MG, 200 MG, 50 MG	3	
DIFLUCAN ORAL TABLET 150 MG	3	QL

Drug Name	Drug Tier	Requirements / Limits
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN	2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	1	
<i>fluconazole oral suspension for reconstitution</i>	1	
<i>fluconazole oral tablet 100 mg, 200 mg, 50 mg</i>	1	
<i>fluconazole oral tablet 150 mg</i>	1	QL
<i>flucytosine oral capsule</i>	1	
<i>griseofulvin microsize oral suspension</i>	1	
<i>griseofulvin microsize oral tablet</i>	1	
<i>griseofulvin ultramicrosize oral tablet</i>	1	
<i>itraconazole oral capsule</i>	1	QL
<i>itraconazole oral solution</i>	1	
<i>ketoconazole oral tablet</i>	1	
<i>micafungin intravenous recon soln</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
MYCAMINE INTRAVENOUS RECON SOLN	2	
NOXAFIL INTRAVENOUS SOLUTION	2	
NOXAFIL ORAL SUSPENSION	2	
NOXAFIL ORAL TABLET, DELAYED RELEASE (DR/EC)	3	
<i>nystatin oral suspension</i>	1	
<i>nystatin oral tablet</i>	1	
ONMEL ORAL TABLET	3	QL
ORAVIG BUCCAL MUCO-ADHESIVE BUCCAL TABLET	3	
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	2	
SPORANOX ORAL SOLUTION	3	
SPORANOX PULSEPAK ORAL CAPSULE	3	QL
<i>terbinafine hcl oral tablet</i>	1	
TOLSURA ORAL CAPSULE, SOLID DISPERSION	3	QL
VFEND IV INTRAVENOUS RECON SOLN	3	

Drug Name	Drug Tier	Requirements / Limits
VFEND ORAL SUSPENSION FOR RECONSTITUTION	3	
VFEND ORAL TABLET	3	
<i>voriconazole intravenous recon soln</i>	1	
<i>voriconazole oral suspension for reconstitution</i>	1	
<i>voriconazole oral tablet</i>	1	
ANTIVIRALS		
<i>abacavir oral solution</i>	4	
<i>abacavir oral tablet</i>	4	
<i>abacavir-lamivudine oral tablet</i>	4	
<i>abacavir-lamivudine-zidovudine oral tablet</i>	4	
<i>acyclovir oral capsule</i>	1	
<i>acyclovir oral suspension 200 mg/5 ml</i>	1	
<i>acyclovir oral tablet</i>	1	
<i>acyclovir sodium intravenous solution</i>	1	
<i>adefovir oral tablet</i>	1	
<i>amantadine hcl oral capsule</i>	1	
<i>amantadine hcl oral solution</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>amantadine hcl oral tablet</i>	1	
APTIVUS (WITH VITAMIN E) ORAL SOLUTION	4	
APTIVUS ORAL CAPSULE	4	
<i>atazanavir oral capsule</i>	4	
ATRIPLA ORAL TABLET	4	
BARACLUDE ORAL SOLUTION	2	
BARACLUDE ORAL TABLET	3	
BIKTARVY ORAL TABLET	4	
<i>cidofovir intravenous solution</i>	1	
CIMDUO ORAL TABLET	4	
COMBIVIR ORAL TABLET	4	
COMPLERA ORAL TABLET	4	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	4	
CYTOVENE INTRAVENOUS RECON SOLN	3	
DELSTRIGO ORAL TABLET	4	
DESCOVY ORAL TABLET	4	

Drug Name	Drug Tier	Requirements / Limits
<i>didanosine oral capsule, delayed release(dr/ec) 250 mg, 400 mg</i>	4	
DOVATO ORAL TABLET	4	
EDURANT ORAL TABLET	4	
<i>efavirenz oral capsule</i>	4	
<i>efavirenz oral tablet</i>	4	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate oral tablet</i>	4	
<i>emtricitabine oral capsule</i>	4	
EMTRIVA ORAL CAPSULE	4	
EMTRIVA ORAL SOLUTION	4	
<i>entecavir oral tablet</i>	1	
EPCLUSA ORAL TABLET	4	PA; LA; QL
EPIVIR HBV ORAL SOLUTION	2	
EPIVIR HBV ORAL TABLET	3	
EPIVIR ORAL SOLUTION	4	
EPIVIR ORAL TABLET	4	
EPZICOM ORAL TABLET	4	
EVOTAZ ORAL TABLET	4	
<i>famciclovir oral tablet</i>	1	QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
FLUMADINE ORAL TABLET	3	
<i>fosamprenavir oral tablet</i>	4	
FOSCAVIR INTRAVENOUS SOLUTION	3	
FUZEON SUBCUTANEOUS RECON SOLN	4	
GANCICLOVIR INTRAVENOUS SOLUTION	3	
<i>ganciclovir sodium intravenous recon soln</i>	1	
<i>ganciclovir sodium intravenous solution</i>	1	
GENVOYA ORAL TABLET	4	
HARVONI ORAL PELLETS IN PACKET	4	PA; LA; QL
HARVONI ORAL TABLET	4	PA; LA; QL
HEPSERA ORAL TABLET	3	
INTELENCE ORAL TABLET	4	
INVIRASE ORAL TABLET	4	
ISENTRESS HD ORAL TABLET	4	
ISENTRESS ORAL POWDER IN PACKET	4	
ISENTRESS ORAL TABLET	4	

Drug Name	Drug Tier	Requirements / Limits
ISENTRESS ORAL TABLET,CHEWABLE	4	
JULUCA ORAL TABLET	4	
KALETRA ORAL SOLUTION	4	QL
KALETRA ORAL TABLET	4	QL
<i>lamivudine oral solution</i>	4	
<i>lamivudine oral tablet 100 mg</i>	1	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	4	
<i>lamivudine-zidovudine oral tablet</i>	4	
LEDIPASVIR-SOFOSBUVIR ORAL TABLET	4	PA; LA; QL
LEXIVA ORAL SUSPENSION	4	
LEXIVA ORAL TABLET	4	
<i>lopinavir-ritonavir oral solution</i>	4	QL
MAVYRET ORAL TABLET	4	PA; LA; QL
<i>nevirapine oral suspension</i>	4	
<i>nevirapine oral tablet</i>	4	
<i>nevirapine oral tablet extended release 24 hr</i>	4	

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Drug Name	Drug Tier	Requirements / Limits
NORVIR ORAL POWDER IN PACKET	4	
NORVIR ORAL SOLUTION	4	
NORVIR ORAL TABLET	4	
ODEFSEY ORAL TABLET	4	
<i>oseltamivir oral capsule</i>	1	QL
<i>oseltamivir oral suspension for reconstitution</i>	1	QL
PIFELTRO ORAL TABLET	4	
PREVYMIS INTRAVENOUS SOLUTION	2	
PREVYMIS ORAL TABLET	2	QL
PREZCOBIX ORAL TABLET	4	
PREZISTA ORAL SUSPENSION	4	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	4	
RAPIVAB (PF) INTRAVENOUS SOLUTION	2	
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE	3	QL
RESCRIPTOR ORAL TABLET	4	

Drug Name	Drug Tier	Requirements / Limits
RETROVIR INTRAVENOUS SOLUTION	4	
RETROVIR ORAL CAPSULE	4	
RETROVIR ORAL SYRUP	4	
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	4	
REYATAZ ORAL POWDER IN PACKET	4	
<i>ribavirin inhalation recon soln</i>	1	
<i>rimantadine oral tablet</i>	1	
<i>ritonavir oral tablet</i>	4	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR	4	
SELZENTRY ORAL SOLUTION	4	
SELZENTRY ORAL TABLET	4	
SITAVIG BUCCAL MUCO-ADHESIVE BUCCAL TABLET	3	ST; QL
SOFOSBUVIR-VELPATASVIR ORAL TABLET	4	PA; LA; QL
SOVALDI ORAL PELLETS IN PACKET	4	PA; LA; QL
SOVALDI ORAL TABLET	4	PA; LA; QL
<i>stavudine oral capsule</i>	4	

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Drug Name	Drug Tier	Requirements / Limits
STRIBILD ORAL TABLET	4	
SUSTIVA ORAL CAPSULE	4	
SUSTIVA ORAL TABLET	4	
SYMFI LO ORAL TABLET	4	
SYMFI ORAL TABLET	4	
SYMTUZA ORAL TABLET	4	
TAMIFLU ORAL CAPSULE	3	QL
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	3	QL
TEMIXYS ORAL TABLET	4	
<i>tenofovir disoproxil fumarate oral tablet</i>	4	
TIVICAY ORAL TABLET	4	
TIVICAY PD ORAL TABLET FOR SUSPENSION	4	
TRIUMEQ ORAL TABLET	4	
TRIZIVIR ORAL TABLET	4	
TRUVADA ORAL TABLET	4	
TYBOST ORAL TABLET	4	
<i>valacyclovir oral tablet</i>	1	QL

Drug Name	Drug Tier	Requirements / Limits
VALCYTE ORAL RECON SOLN	3	
VALCYTE ORAL TABLET	3	
<i>valganciclovir oral recon soln</i>	1	
<i>valganciclovir oral tablet</i>	1	
VALTREX ORAL TABLET	3	QL
VEMLIDY ORAL TABLET	2	
VIDEX 2 GRAM PEDIATRIC ORAL RECON SOLN	4	
VIDEX EC ORAL CAPSULE, DELAYED RELEASE(DR/EC)	4	
VIEKIRA PAK ORAL TABLETS, DOSE PACK	4	PA; LA; QL
VIRACEPT ORAL TABLET	4	
VIRAMUNE ORAL SUSPENSION	4	
VIRAMUNE ORAL TABLET	4	
VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR 400 MG	4	
VIRAZOLE INHALATION RECON SOLN	3	
VIREAD ORAL POWDER	4	

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Drug Name	Drug Tier	Requirements / Limits
VIREAD ORAL TABLET	4	
VOSEVI ORAL TABLET	4	PA; LA; QL
XOFLUZA ORAL TABLET	3	QL
ZEPATIER ORAL TABLET	4	PA; LA; QL
ZIAGEN ORAL SOLUTION	4	
ZIAGEN ORAL TABLET	4	
<i>zidovudine oral capsule</i>	4	
<i>zidovudine oral syrup</i>	4	
<i>zidovudine oral tablet</i>	4	
ZOVIRAX ORAL SUSPENSION	3	
CEPHALOSPORINS		
AVYCAZ INTRAVENOUS RECON SOLN	2	
<i>cefaclor oral capsule</i>	1	
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	1	
<i>cefaclor oral tablet extended release 12 hr</i>	1	
<i>cefadroxil oral capsule</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	1	
<i>cefadroxil oral tablet</i>	1	
CEFAZOLIN IN 0.9% SOD CHLORIDE INTRAVENOUS SOLUTION	3	
<i>cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml, 2 gram/50 ml</i>	1	
CEFAZOLIN IN DEXTROSE (ISO-OS) INTRAVENOUS PIGGYBACK 2 GRAM/100 ML	3	
CEFAZOLIN IN STERILE WATER INTRAVENOUS SYRINGE 1 GRAM/10 ML, 2 GRAM/20 ML	3	
<i>cefazolin injection recon soln</i>	1	
<i>cefazolin intravenous recon soln</i>	1	
<i>cefdinir oral capsule</i>	1	
<i>cefdinir oral suspension for reconstitution</i>	1	
<i>cefditoren pivoxil oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
CEFEPIME IN DEXTROSE 5 % INTRAVENOUS PIGGYBACK	3	
<i>cefepime in dextrose, iso-osm intravenous piggyback</i>	1	
<i>cefepime injection recon soln</i>	1	
CEFEPIME INTRAVENOUS RECON SOLN	3	
<i>cefixime oral capsule</i>	1	
<i>cefixime oral suspension for reconstitution</i>	1	
CEFOTAN INJECTION RECON SOLN	3	
<i>cefotaxime injection recon soln 1 gram</i>	1	
CEFOTETAN IN DEXTROSE, ISO-OSM INTRAVENOUS PIGGYBACK	3	
<i>cefotetan injection recon soln</i>	1	
<i>cefotetan intravenous recon soln</i>	1	
<i>cefoxitin in dextrose, iso-osm intravenous piggyback</i>	1	
<i>cefoxitin intravenous recon soln</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>cefpodoxime oral suspension for reconstitution</i>	1	
<i>cefpodoxime oral tablet</i>	1	
<i>cefprozil oral suspension for reconstitution</i>	1	
<i>cefprozil oral tablet</i>	1	
CEFTAZIDIME IN D5W INTRAVENOUS PIGGYBACK	2	
<i>ceftazidime injection recon soln</i>	1	
<i>ceftriaxone in dextrose, iso-os intravenous piggyback</i>	1	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	1	
CEFTRIAZONE INJECTION RECON SOLN 100 GRAM	3	
<i>ceftriaxone intravenous recon soln</i>	1	
<i>cefuroxime axetil oral tablet</i>	1	
<i>cefuroxime sodium injection recon soln 750 mg</i>	1	
<i>cefuroxime sodium intravenous recon soln</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>cephalexin oral capsule</i>	1	
<i>cephalexin oral suspension for reconstitution</i>	1	
<i>cephalexin oral tablet</i>	1	
CLAFORAN INJECTION RECON SOLN 1 GRAM, 2 GRAM	3	
FETROJA INTRAVENOUS RECON SOLN	3	
FORTAZ INJECTION RECON SOLN 1 GRAM, 2 GRAM, 500 MG	3	
KEFLEX ORAL CAPSULE	3	
MAXIPIME INJECTION RECON SOLN	3	
MAXIPIME INTRAVENOUS RECON SOLN	3	
SPECTRACEF ORAL TABLET 400 MG	3	
SUPRAX ORAL CAPSULE	3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION	3	
SUPRAX ORAL TABLET,CHEWABLE	3	

Drug Name	Drug Tier	Requirements / Limits
<i>tazicef injection recon soln</i>	1	
<i>tazicef intravenous recon soln</i>	1	
TEFLARO INTRAVENOUS RECON SOLN	2	
ZERBAXA INTRAVENOUS RECON SOLN	2	
ERYTHROMYCINS & OTHER MACROLIDES		
<i>azithromycin intravenous recon soln</i>	1	
<i>azithromycin oral packet</i>	1	QL
<i>azithromycin oral suspension for reconstitution</i>	1	QL
<i>azithromycin oral tablet</i>	1	QL
<i>clarithromycin oral suspension for reconstitution</i>	1	
<i>clarithromycin oral tablet</i>	1	
<i>clarithromycin oral tablet extended release 24 hr</i>	1	
DIFICID ORAL TABLET	3	QL
<i>e.e.s. 400 oral tablet</i>	1	
E.E.S. GRANULES ORAL SUSPENSION FOR RECONSTITUTION	3	

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Drug Name	Drug Tier	Requirements / Limits
ERYPED 200 ORAL SUSPENSION FOR RECONSTITUTION	3	
ERYPED 400 ORAL SUSPENSION FOR RECONSTITUTION	3	
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	1	
ERY-TAB ORAL TABLET, DELAYED RELEASE (DR/EC) 500 MG	3	
<i>erythrocin (as stearate) oral tablet 250 mg</i>	1	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	1	
<i>erythromycin ethylsuccinate oral tablet</i>	1	
<i>erythromycin oral capsule, delayed release (dr/ec)</i>	1	
<i>erythromycin oral tablet</i>	1	
<i>erythromycin oral tablet, delayed release (dr/ec)</i>	1	

Drug Name	Drug Tier	Requirements / Limits
ZITHROMAX INTRAVENOUS RECON SOLN	3	
ZITHROMAX ORAL PACKET	3	QL
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	3	QL
ZITHROMAX ORAL TABLET 250 MG, 500 MG	3	QL
ZITHROMAX TRI-PAK ORAL TABLET	3	QL
ZITHROMAX Z-PAK ORAL TABLET	3	QL
MISCELLANEOUS ANTIINFECTIVES		
AEMCOLO ORAL TABLET, DELAYED RELEASE (DR/EC)	3	QL
<i>albendazole oral tablet</i>	1	QL
ALBENZA ORAL TABLET	3	QL
ALINIA ORAL SUSPENSION FOR RECONSTITUTION	2	QL
ALINIA ORAL TABLET	2	QL
<i>amikacin injection solution 1,000 mg/4 ml, 500 mg/2 ml</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
ARAKODA ORAL TABLET	3	QL
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION	4	LA
<i>atovaquone oral suspension</i>	1	
<i>atovaquone-proguanil oral tablet</i>	1	QL
AZACTAM INJECTION RECON SOLN	3	
<i>aztreonam injection recon soln</i>	1	
<i>baciim intramuscular recon soln</i>	1	
<i>bacitracin intramuscular recon soln</i>	1	
BENZNIDAZOLE ORAL TABLET	2	QL
BETHKIS INHALATION SOLUTION FOR NEBULIZATION	4	LA; QL
BILTRICIDE ORAL TABLET	3	
CAPASTAT INJECTION RECON SOLN	2	
CAYSTON INHALATION SOLUTION FOR NEBULIZATION	4	LA; QL

Drug Name	Drug Tier	Requirements / Limits
<i>chloramphenicol sod succinate intravenous recon soln</i>	1	
<i>chloroquine phosphate oral tablet</i>	1	QL
CLEOCIN HCL ORAL CAPSULE	3	
CLEOCIN INJECTION SOLUTION	3	
<i>cleocin intravenous solution 300 mg/2 ml</i>	1	
CLEOCIN INTRAVENOUS SOLUTION 600 MG/4 ML, 900 MG/6 ML	3	
CLEOCIN PEDIATRIC ORAL RECON SOLN	3	
<i>clindamycin hcl oral capsule</i>	1	
CLINDAMYCIN IN 0.9 % SOD CHLOR INTRAVENOUS PIGGYBACK	3	
<i>clindamycin in 5 % dextrose intravenous piggyback</i>	1	
<i>clindamycin palmitate hcl oral recon soln</i>	1	
<i>clindamycin pediatric oral recon soln</i>	1	
<i>clindamycin phosphate injection solution</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>clindamycin phosphate intravenous solution</i>	1	
COARTEM ORAL TABLET	2	QL
<i>colistin (colistimethate na) injection recon soln</i>	1	
COLY-MYCIN M PARENTERAL INJECTION RECON SOLN	3	
CUBICIN INTRAVENOUS RECON SOLN	3	
CUBICIN RF INTRAVENOUS RECON SOLN	3	
CYCLOSERINE ORAL CAPSULE	3	
DALVANCE INTRAVENOUS SOLUTION	2	
<i>dapsone oral tablet</i>	1	
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	3	
<i>daptomycin intravenous recon soln 500 mg</i>	1	
DARAPRIM ORAL TABLET	4	LA
EMVERM ORAL TABLET,CHEWABLE	2	QL
<i>ertapenem injection recon soln</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>ethambutol oral tablet</i>	1	
FLAGYL ORAL CAPSULE	3	
FLAGYL ORAL TABLET	3	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 70 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml, 90 mg/100 ml</i>	1	
GENTAMICIN IN NACL (ISO-OSM) INTRAVENOUS PIGGYBACK 100 MG/50 ML	2	
GENTAMICIN IN NACL (ISO-OSM) INTRAVENOUS PIGGYBACK 120 MG/100 ML	3	
<i>gentamicin injection solution</i>	1	
<i>gentamicin sulfate (ped) (pf) injection solution</i>	1	
<i>gentamicin sulfate (pf) intravenous solution 100 mg/10 ml</i>	1	
GENTAMICIN SULFATE (PF) INTRAVENOUS SOLUTION 60 MG/6 ML	3	

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Drug Name	Drug Tier	Requirements / Limits
GENTAMICIN-SODIUM CITRATE INTRA-CATHETER SOLUTION	3	
<i>hydroxychloroquine oral tablet</i>	1	QL
<i>imipenem-cilastatin intravenous recon soln</i>	1	
IMPAVIDO ORAL CAPSULE	2	QL
INVANZ INJECTION RECON SOLN	3	
<i>isoniazid injection solution</i>	1	
<i>isoniazid oral solution</i>	1	
<i>isoniazid oral tablet</i>	1	
<i>ivermectin oral tablet</i>	1	QL
KITABIS PAK INHALATION SOLUTION FOR NEBULIZATION	4	LA; QL
KRINTAFEL ORAL TABLET	3	QL
LAMPIT ORAL TABLET	3	
LINCOCIN INJECTION SOLUTION	3	
<i>lincomycin injection solution</i>	1	
<i>linezolid in dextrose 5% intravenous piggyback</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>linezolid oral suspension for reconstitution</i>	1	
<i>linezolid oral tablet</i>	1	
<i>linezolid-0.9% sodium chloride intravenous parenteral solution</i>	1	
MALARONE ORAL TABLET	3	QL
MALARONE PEDIATRIC ORAL TABLET	3	QL
<i>mefloquine oral tablet</i>	1	QL
MEPRON ORAL SUSPENSION	3	
<i>meropenem intravenous recon soln</i>	1	
MEROPENEM-0.9% SODIUM CHLORIDE INTRAVENOUS PIGGYBACK	2	
MERREM INTRAVENOUS RECON SOLN	3	
<i>metro i.v. intravenous piggyback</i>	1	
<i>metronidazole in nacl (iso-os) intravenous piggyback</i>	1	
<i>metronidazole oral capsule</i>	1	
<i>metronidazole oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
MYAMBUTOL ORAL TABLET 400 MG	3	
MYCOBUTIN ORAL CAPSULE	3	
NEBUPENT INHALATION RECON SOLN	3	QL
<i>neomycin oral tablet</i>	1	
ORBACTIV INTRAVENOUS RECON SOLN	2	
<i>paromomycin oral capsule</i>	1	
PASER ORAL GRANULES DR FOR SUSP IN PACKET	3	
PENTAM INJECTION RECON SOLN	3	
<i>pentamidine inhalation recon soln</i>	1	QL
<i>pentamidine injection recon soln</i>	1	
PLAQUENIL ORAL TABLET	3	QL
<i>polymyxin b sulfate injection recon soln</i>	1	
<i>praziquantel oral tablet</i>	1	
PRETOMANID ORAL TABLET	3	
PRIFTIN ORAL TABLET	2	
<i>primaquine oral tablet</i>	1	QL

Drug Name	Drug Tier	Requirements / Limits
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	3	
<i>pyrazinamide oral tablet</i>	1	
<i>pyrimethamine oral tablet</i>	4	LA
QUALAQUIN ORAL CAPSULE	3	QL
<i>quinine sulfate oral capsule</i>	1	QL
RECARBRIO INTRAVENOUS RECON SOLN	3	
<i>rifabutin oral capsule</i>	1	
RIFADIN INTRAVENOUS RECON SOLN	3	
RIFADIN ORAL CAPSULE	3	
RIFAMATE ORAL CAPSULE	3	
<i>rifampin intravenous recon soln</i>	1	
<i>rifampin oral capsule</i>	1	
RIFATER ORAL TABLET	3	
SIRTURO ORAL TABLET	2	
SIVEXTRO INTRAVENOUS RECON SOLN	3	
SIVEXTRO ORAL TABLET	3	

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Drug Name	Drug Tier	Requirements / Limits
SOLOSEC ORAL GRANULES DEL RELEASE IN PACKET	2	QL
STREPTOMYCIN INTRAMUSCULAR RECON SOLN	2	
STROMEKTOL ORAL TABLET	3	QL
SYNERCID INTRAVENOUS RECON SOLN	2	
<i>tigecycline intravenous recon soln</i>	1	
<i>tinidazole oral tablet</i>	1	QL
TOBI INHALATION SOLUTION FOR NEBULIZATION	4	LA; QL
TOBI PODHALER INHALATION CAPSULE	4	LA; QL
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	4	LA; QL
<i>tobramycin in 0.225 % nacl inhalation solution for nebulization</i>	4	LA; QL
<i>tobramycin in 0.9 % nacl intravenous piggyback 60 mg/50 ml</i>	1	
<i>tobramycin inhalation solution for nebulization</i>	4	LA; QL

Drug Name	Drug Tier	Requirements / Limits
<i>tobramycin sulfate injection recon soln</i>	1	
<i>tobramycin sulfate injection solution</i>	1	
TOBRAMYCIN WITH NEBULIZER INHALATION SOLUTION FOR NEBULIZATION	4	LA; QL
TRECTOR ORAL TABLET	3	
TYGACIL INTRAVENOUS RECON SOLN	3	
VABOMERE INTRAVENOUS RECON SOLN	3	
XENLETA INTRAVENOUS SOLUTION	3	
XENLETA ORAL TABLET	3	
XIFAXAN ORAL TABLET	2	QL
ZEMDRI INTRAVENOUS SOLUTION	3	
ZYVOX INTRAVENOUS PIGGYBACK	3	
ZYVOX ORAL SUSPENSION FOR RECONSTITUTION	3	
ZYVOX ORAL TABLET	3	
PENICILLINS		
<i>amoxicillin oral capsule</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>amoxicillin oral suspension for reconstitution</i>	1	
<i>amoxicillin oral tablet</i>	1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	1	
<i>amoxicillin-pot clavulanate oral tablet</i>	1	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	1	
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	1	
<i>ampicillin oral capsule 500 mg</i>	1	
<i>ampicillin sodium injection recon soln</i>	1	
<i>ampicillin sodium intravenous recon soln</i>	1	
<i>ampicillin-sulbactam injection recon soln</i>	1	
<i>ampicillin-sulbactam intravenous recon soln 3 gram</i>	1	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	2	

Drug Name	Drug Tier	Requirements / Limits
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 250-62.5 MG/5 ML	3	
AUGMENTIN XR ORAL TABLET EXTENDED RELEASE 12 HR	3	
BICILLIN C-R INTRAMUSCULAR SYRINGE	2	
BICILLIN L-A INTRAMUSCULAR SYRINGE	2	
<i>dicloxacillin oral capsule</i>	1	
MOXATAG ORAL TABLET, ER MULTIPHASE 24 HR	3	
<i>nafcillin in dextrose iso-osm intravenous piggyback</i>	1	
<i>nafcillin injection recon soln</i>	1	
<i>nafcillin intravenous recon soln</i>	1	
<i>oxacillin in dextrose(iso-osm) intravenous piggyback</i>	1	
<i>oxacillin injection recon soln</i>	1	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK	2	

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Drug Name	Drug Tier	Requirements / Limits
<i>penicillin g potassium injection recon soln</i>	1	
<i>penicillin g procaine intramuscular syringe</i>	1	
<i>penicillin g sodium injection recon soln</i>	1	
<i>penicillin v potassium oral recon soln</i>	1	
<i>penicillin v potassium oral tablet</i>	1	
<i>pfizerpen-g injection recon soln</i>	1	
<i>piperacillin-tazobactam intravenous recon soln</i>	1	
UNASYN INJECTION RECON SOLN	3	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK	2	
ZOSYN INTRAVENOUS RECON SOLN	3	
QUINOLONES		
AVELOX IN NACL (ISO-OSMOTIC) INTRAVENOUS PIGGYBACK	3	
BAXDELA INTRAVENOUS RECON SOLN	2	

Drug Name	Drug Tier	Requirements / Limits
BAXDELA ORAL TABLET	2	QL
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	3	
CIPRO ORAL TABLET 250 MG, 500 MG	3	
<i>ciprofloxacin hcl oral tablet</i>	1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback</i>	1	
<i>ciprofloxacin oral suspension,microcapsule recon</i>	1	
FACTIVE ORAL TABLET	3	
<i>levofloxacin in d5w intravenous piggyback</i>	1	
<i>levofloxacin intravenous solution</i>	1	
<i>levofloxacin oral solution</i>	1	
<i>levofloxacin oral tablet</i>	1	
<i>moxifloxacin oral tablet</i>	1	
MOXIFLOXACIN-SOD.ACE,SUL-WATER INTRAVENOUS PIGGYBACK	2	
<i>moxifloxacin-sod.chloride(iso) intravenous piggyback</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	1	
SULFA'S & RELATED AGENTS		
BACTRIM DS ORAL TABLET	3	
BACTRIM ORAL TABLET	3	
<i>sulfadiazine oral tablet</i>	1	
<i>sulfamethoxazole-trimethoprim intravenous solution</i>	1	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg</i>	1	
<i>sulfatrim oral suspension</i>	1	
TETRACYCLINES		
ACTICLATE ORAL TABLET	3	ST
AVIDOXY DK KIT	3	ST
<i>avidoxy oral tablet</i>	1	
<i>coremino oral tablet extended release 24 hr</i>	1	
<i>demeclocycline oral tablet</i>	1	
DORYX MPC ORAL TABLET, DELAYED RELEASE (DR/EC)	3	ST

Drug Name	Drug Tier	Requirements / Limits
DORYX ORAL TABLET, DELAYED RELEASE (DR/EC) 200 MG, 50 MG, 80 MG	3	ST
<i>doxy-100 intravenous reconstruction</i>	1	
<i>doxycycline hyclate oral capsule</i>	1	
<i>doxycycline hyclate oral tablet</i>	1	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg, 150 mg, 200 mg, 50 mg, 75 mg</i>	1	
DOXYCYCLINE HYCLATE ORAL TABLET, DELAYED RELEASE (DR/EC) 80 MG	3	ST
<i>doxycycline monohydrate oral capsule</i>	1	
DOXYCYCLINE MONOHYDRATE ORAL CAPSULE, IR - DELAYED RELEASE, BIPHASE	3	ST
<i>doxycycline monohydrate oral suspension for reconstitution</i>	1	
<i>doxycycline monohydrate oral tablet</i>	1	
MINOCIN INTRAVENOUS RECON SOLN	2	

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Drug Name	Drug Tier	Requirements / Limits
MINOCIN ORAL CAPSULE 50 MG	3	ST
<i>minocycline oral capsule</i>	1	
MINOCYCLINE ORAL CAPSULE,EXTENDED RELEASE 24HR	3	ST
<i>minocycline oral tablet</i>	1	
<i>minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 65 mg, 80 mg, 90 mg</i>	1	ST
<i>minocycline oral tablet extended release 24 hr 55 mg</i>	2	ST
MINOLIRA ER ORAL TABLET, IR - ER, BIPHASIC 24HR	3	ST
<i>mondoxylene nl oral capsule</i>	1	
MONODOX ORAL CAPSULE	3	ST
MORGIDOX 1X 50 KIT	3	ST
MORGIDOX 2X100 KIT	3	ST
<i>morgidox oral capsule 100 mg</i>	1	
NUZYRA (7 DAY) ORAL TABLET	3	QL
NUZYRA INTRAVENOUS RECON SOLN	3	

Drug Name	Drug Tier	Requirements / Limits
NUZYRA ORAL TABLET	3	QL
<i>okebo oral capsule 75 mg</i>	1	
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE	3	ST
SEYSARA ORAL TABLET	3	ST
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	3	ST
TARGADOX ORAL TABLET	3	ST
<i>tetracycline oral capsule</i>	1	
VIBRAMYCIN ORAL CAPSULE 100 MG	3	ST
VIBRAMYCIN ORAL SUSPENSION FOR RECONSTITUTION	3	
VIBRAMYCIN ORAL SYRUP	3	
XERAVA INTRAVENOUS RECON SOLN 50 MG	3	
XIMINO ORAL CAPSULE,EXTENDED RELEASE 24HR	3	ST

URINARY TRACT AGENTS

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Drug Name	Drug Tier	Requirements / Limits
FURADANTIN ORAL SUSPENSION	3	
HIPREX ORAL TABLET	3	
MACROBID ORAL CAPSULE	3	
MACRODANTIN ORAL CAPSULE	3	
<i>methenamine hippurate oral tablet</i>	1	
<i>methenamine mandelate oral tablet</i>	1	
MONUROL ORAL PACKET	3	
<i>nitrofurantoin macrocrystal oral capsule</i>	1	
<i>nitrofurantoin monohyd/m-cryst oral capsule</i>	1	
<i>nitrofurantoin oral suspension</i>	1	
PRIMSOL ORAL SOLUTION	3	
<i>trimethoprim oral tablet</i>	1	
TRIMPEX ORAL SOLUTION	3	
VANCOMYCIN		
FIRVANQ ORAL RECON SOLN	3	QL
VANCOCIN ORAL CAPSULE	3	QL

Drug Name	Drug Tier	Requirements / Limits
VANCOMYCIN HCL IN WATER INTRAVENOUS SOLUTION	3	
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK	2	
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS SOLUTION 1 GRAM/250 ML, 1.25 GRAM/250 ML, 1.5 GRAM/250 ML, 1.5 GRAM/300 ML, 1.5 GRAM/500 ML, 1.75 GRAM/250 ML, 1.75 GRAM/500 ML, 2 GRAM/500 ML, 750 MG/150 ML	2	
VANCOMYCIN IN DEXTROSE 5 % INTRAVENOUS PIGGYBACK	2	
VANCOMYCIN IN DEXTROSE 5 % INTRAVENOUS SOLUTION 1 GRAM/100 ML, 1 GRAM/250 ML, 1.25 GRAM/250 ML, 1.5 GRAM/250 ML, 1.5 GRAM/500 ML, 1.75 GRAM/500 ML	2	
VANCOMYCIN INJECTION RECON SOLN	3	

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Drug Name	Drug Tier	Requirements / Limits
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 5 gram, 500 mg, 750 mg</i>	1	
VANCOMYCIN INTRAVENOUS RECON SOLN 1.25 GRAM, 1.5 GRAM, 250 MG	3	
<i>vancomycin oral capsule</i>	1	QL
<i>vancomycin oral recon soln</i>	1	QL
VANCOMYCIN-WATER INJECT (PEG) INTRAVENOUS PIGGYBACK	3	
VIBATIV INTRAVENOUS RECON SOLN 750 MG	2	
ANTINEOPLASTIC & IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
<i>amifostine crystalline intravenous recon soln</i>	1	
<i>dexrazoxane hcl intravenous recon soln</i>	1	
ELITEK INTRAVENOUS RECON SOLN	2	
ETHYOL INTRAVENOUS RECON SOLN	3	

Drug Name	Drug Tier	Requirements / Limits
FUSILEV INTRAVENOUS RECON SOLN	3	
KEPIVANCE INTRAVENOUS RECON SOLN	4	LA
KHAPZORY INTRAVENOUS RECON SOLN	3	
<i>leucovorin calcium injection recon soln</i>	1	
<i>leucovorin calcium injection solution</i>	1	
<i>leucovorin calcium oral tablet</i>	1	
<i>levoleucovorin calcium intravenous recon soln 50 mg</i>	1	
<i>levoleucovorin calcium intravenous solution</i>	1	
<i>mesna intravenous solution</i>	1	
MESNEX INTRAVENOUS SOLUTION	3	
MESNEX ORAL TABLET	2	
TOTECT INTRAVENOUS RECON SOLN 500 MG	3	
VISTOGARD ORAL GRANULES IN PACKET	4	PA; LA
VORAXAZE INTRAVENOUS RECON SOLN	2	

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Drug Name	Drug Tier	Requirements / Limits
XGEVA SUBCUTANEOUS SOLUTION	4	PA; LA
ZINECARD (AS HCL) INTRAVENOUS RECON SOLN	3	
ANTINEOPLASTIC & IMMUNOSUPPRESSANT DRUGS		
<i>abiraterone oral tablet</i>	4	PA; LA; QL
ADAKVEO INTRAVENOUS SOLUTION	4	PA; LA
<i>adrucil intravenous solution</i>	1	
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION	4	PA; LA
AFINITOR ORAL TABLET	4	PA; LA
ALECENSA ORAL CAPSULE	4	PA; LA; QL
ALIQOPA INTRAVENOUS RECON SOLN	4	LA
ALKERAN (AS HCL) INTRAVENOUS RECON SOLN	3	
ALKERAN ORAL TABLET	3	
ALUNBRIG ORAL TABLET	4	PA; LA; QL
ALUNBRIG ORAL TABLETS,DOSE PACK	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
<i>anastrozole oral tablet</i>	5	ACA
ARIMIDEX ORAL TABLET	3	
AROMASIN ORAL TABLET	3	
ASPARLAS INTRAVENOUS SOLUTION	4	LA
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR	4	ST
AYVAKIT ORAL TABLET	4	PA; LA; QL
AZASAN ORAL TABLET	4	
<i>azathioprine oral tablet</i>	4	
<i>azathioprine sodium injection recon soln</i>	4	
BALVERSA ORAL TABLET	4	PA; LA
BELEODAQ INTRAVENOUS RECON SOLN	4	LA
<i>bexarotene oral capsule</i>	4	PA; LA
<i>bicalutamide oral tablet</i>	1	
BICNU INTRAVENOUS RECON SOLN	3	
<i>bleomycin injection recon soln</i>	1	
BOSULIF ORAL TABLET	4	PA; LA; QL

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Drug Name	Drug Tier	Requirements / Limits
BRAFTOVI ORAL CAPSULE	4	PA; LA; QL
BRUKINSA ORAL CAPSULE	4	PA; LA
<i>busulfan intravenous solution</i>	1	
BUSULFEX INTRAVENOUS SOLUTION	3	
BYNFEZIA SUBCUTANEOUS PEN INJECTOR	4	PA; LA
CABOMETYX ORAL TABLET	4	PA; LA; QL
CALQUENCE ORAL CAPSULE	4	PA; LA; QL
CAMPTOSAR INTRAVENOUS SOLUTION	3	
<i>capecitabine oral tablet</i>	4	LA
CAPRELSA ORAL TABLET	4	PA; LA; QL
<i>carboplatin intravenous solution</i>	1	
<i>carmustine intravenous recon soln</i>	1	
CASODEX ORAL TABLET	3	
CELLCEPT INTRAVENOUS INTRAVENOUS RECON SOLN	4	
CELLCEPT ORAL CAPSULE	4	

Drug Name	Drug Tier	Requirements / Limits
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	4	
CELLCEPT ORAL TABLET	4	
CISPLATIN INTRAVENOUS RECON SOLN	3	
<i>cisplatin intravenous solution</i>	1	
<i>cladribine intravenous solution</i>	1	
<i>clofarabine intravenous solution</i>	1	
CLOLAR INTRAVENOUS SOLUTION	3	
COMETRIQ ORAL CAPSULE	4	PA; LA
COPIKTRA ORAL CAPSULE	4	PA; LA; QL
COSMEGEN INTRAVENOUS RECON SOLN	3	
COTELLIC ORAL TABLET	4	PA; LA; QL
<i>cyclosporine intravenous solution</i>	4	
<i>cyclosporine modified oral capsule</i>	4	
<i>cyclosporine modified oral solution</i>	4	
<i>cyclosporine oral capsule</i>	4	
<i>cytarabine (pf) injection solution</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>cytarabine injection solution</i>	1	
<i>dacarbazine intravenous recon soln</i>	1	
<i>dactinomycin intravenous recon soln</i>	1	
DARZALEX FASPRO SUBCUTANEOUS SOLUTION	4	LA
<i>daunorubicin intravenous recon soln</i>	1	
<i>daunorubicin intravenous solution</i>	1	
DAURISMO ORAL TABLET	4	PA; LA; QL
DROXIA ORAL CAPSULE	2	
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE	4	PA; LA
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE	4	PA; LA
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE	4	PA; LA
ELIGARD SUBCUTANEOUS SYRINGE	4	PA; LA
ELLECE INTRAVENOUS SOLUTION	3	

Drug Name	Drug Tier	Requirements / Limits
ELZONRIS INTRAVENOUS SOLUTION	4	LA
EMCYT ORAL CAPSULE	2	
ENHERTU INTRAVENOUS RECON SOLN	4	LA
ENSPRYNG SUBCUTANEOUS SYRINGE	4	PA; LA
ENVARBUS XR ORAL TABLET EXTENDED RELEASE 24 HR	4	ST
<i>epirubicin intravenous recon soln 200 mg</i>	1	
<i>epirubicin intravenous solution</i>	1	
ERIVEDGE ORAL CAPSULE	4	PA; LA; QL
ERLEADA ORAL TABLET	4	PA; LA; QL
<i>erlotinib oral tablet</i>	4	PA; LA; QL
ETOPOPHOS INTRAVENOUS RECON SOLN	2	
<i>etoposide intravenous solution</i>	1	
<i>etoposide oral capsule</i>	1	
<i>everolimus (antineoplastic) oral tablet</i>	4	PA; LA
<i>everolimus (immunosuppressive) oral tablet</i>	4	

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Drug Name	Drug Tier	Requirements / Limits
EVOMELA INTRAVENOUS RECON SOLN	4	LA
<i>exemestane oral tablet</i>	5	ACA
FARESTON ORAL TABLET	3	
FARYDAK ORAL CAPSULE	4	PA; LA; QL
FEMARA ORAL TABLET	3	
FENSOLVI SUBCUTANEOUS SYRINGE	4	PA; LA
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN	4	LA
<i>floxuridine injection recon soln</i>	1	
<i>fludarabine intravenous recon soln</i>	1	
<i>fludarabine intravenous solution</i>	1	
<i>fluorouracil intravenous solution</i>	1	
<i>flutamide oral capsule</i>	1	
FOLOTYN INTRAVENOUS SOLUTION	4	LA
GAMIFANT INTRAVENOUS SOLUTION	4	PA; LA
GAVRETO ORAL CAPSULE	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
<i>gengraf oral capsule 100 mg, 25 mg</i>	4	
<i>gengraf oral solution</i>	4	
GILOTRIF ORAL TABLET	4	PA; LA; QL
GLEEVEC ORAL TABLET	4	PA; LA; QL
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	2	
GLIADEL WAFER IMPLANT WAFER	3	
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION	4	LA
HYCAMTIN INTRAVENOUS RECON SOLN	4	LA
HYCAMTIN ORAL CAPSULE	4	LA
HYDREA ORAL CAPSULE	3	
<i>hydroxyurea oral capsule</i>	1	
IBRANCE ORAL CAPSULE	4	PA; LA; QL
IBRANCE ORAL TABLET	4	PA; LA; QL
ICLUSIG ORAL TABLET	4	PA; LA; QL
IDAMYCIN PFS INTRAVENOUS SOLUTION	3	
<i>idarubicin intravenous solution</i>	1	
IDHIFA ORAL TABLET	4	PA; LA; QL

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Drug Name	Drug Tier	Requirements / Limits
IFEX INTRAVENOUS RECON SOLN	3	
<i>ifosfamide intravenous recon soln</i>	1	
<i>ifosfamide intravenous solution</i>	1	
<i>imatinib oral tablet</i>	4	PA; LA; QL
IMBRUVICA ORAL CAPSULE	4	PA; LA; QL
IMBRUVICA ORAL TABLET	4	PA; LA; QL
IMURAN ORAL TABLET	4	
INLYTA ORAL TABLET	4	PA; LA; QL
INQOVI ORAL TABLET	4	PA; LA
INREBIC ORAL CAPSULE	4	PA; LA; QL
IRESSA ORAL TABLET	4	PA; LA; QL
<i>irinotecan intravenous solution</i>	1	
JAKAFI ORAL TABLET	4	PA; LA; QL
JELMYTO INTRAPYELOCALYCEAL KIT	4	LA
KISQALI FEMARACO-PACK ORAL TABLET	4	PA; LA; QL
KISQALI ORAL TABLET	4	PA; LA; QL
KOSELUGO ORAL CAPSULE	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
LENVIMA ORAL CAPSULE	4	PA; LA
<i>letrozole oral tablet</i>	1	
LEUKERAN ORAL TABLET	2	
<i>leuprolide subcutaneous kit</i>	4	PA; LA
LIBTAYO INTRAVENOUS SOLUTION	4	LA
LONSURF ORAL TABLET	4	PA; LA
LORBRENA ORAL TABLET	4	PA; LA; QL
LUMOXITI INTRAVENOUS RECON SOLN	4	LA
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT	4	PA; LA
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT	4	PA; LA
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT	4	PA; LA
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT	4	PA; LA
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
LUPRON DEPOT-PED INTRAMUSCULAR KIT	4	PA; LA
LYNPARZA ORAL TABLET	4	PA; LA; QL
LYSODREN ORAL TABLET	2	
MATULANE ORAL CAPSULE	4	LA
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i>	1	
<i>megestrol oral tablet</i>	1	
MEKINIST ORAL TABLET	4	PA; LA; QL
MEKTOVI ORAL TABLET	4	PA; LA; QL
<i>melphalan hcl intravenous recon soln</i>	1	
<i>melphalan oral tablet</i>	1	
<i>mercaptopurine oral tablet</i>	1	
<i>methotrexate sodium (pf) injection recon soln</i>	1	
<i>methotrexate sodium (pf) injection solution</i>	1	
<i>methotrexate sodium injection solution</i>	1	
<i>methotrexate sodium oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>mitomycin intravenous recon soln</i>	1	
<i>mitoxantrone intravenous concentrate</i>	4	LA
MUTAMYCIN INTRAVENOUS RECON SOLN	3	
MYCAPSSA ORAL CAPSULE,DELAYED RELEASE(DR/EC)	4	PA; LA
<i>mycophenolate mofetil (hcl) intravenous recon soln</i>	4	
<i>mycophenolate mofetil oral capsule</i>	4	
<i>mycophenolate mofetil oral suspension for reconstitution</i>	4	
<i>mycophenolate mofetil oral tablet</i>	4	
<i>mycophenolate sodium oral tablet, delayed release (dr/ec)</i>	4	
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC)	4	
MYLERAN ORAL TABLET	2	
NAVELBINE INTRAVENOUS SOLUTION	3	
NEORAL ORAL CAPSULE	4	

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Drug Name	Drug Tier	Requirements / Limits
NEORAL ORAL SOLUTION	4	
NERLYNX ORAL TABLET	4	PA; LA
NEXAVAR ORAL TABLET	4	PA; LA; QL
NILANDRON ORAL TABLET	3	
<i>nilutamide oral tablet</i>	1	
NINLARO ORAL CAPSULE	4	PA; LA; QL
NIPENT INTRAVENOUS RECON SOLN	3	
NUBEQA ORAL TABLET	4	PA; LA; QL
NULOJIX INTRAVENOUS RECON SOLN	4	
ODOMZO ORAL CAPSULE	4	PA; LA; QL
ONCASPAR INJECTION SOLUTION	2	
<i>paclitaxel intravenous concentrate</i>	1	
PADCEV INTRAVENOUS RECON SOLN	4	LA
<i>paraplatin intravenous solution</i>	1	
PEMAZYRE ORAL TABLET	4	PA; LA; QL
PHESGO SUBCUTANEOUS SOLUTION	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
PHOTOFRIN INTRAVENOUS RECON SOLN	2	
PIQRAY ORAL TABLET	4	PA; LA
POLIVY INTRAVENOUS RECON SOLN 140 MG	4	LA
POTELIGEO INTRAVENOUS SOLUTION	4	LA
PROGRAF INTRAVENOUS SOLUTION	4	
PROGRAF ORAL CAPSULE	4	
PROGRAF ORAL GRANULES IN PACKET	4	
PURIXAN ORAL SUSPENSION	4	LA
QINLOCK ORAL TABLET	4	PA; LA; QL
RAPAMUNE ORAL SOLUTION	4	
RAPAMUNE ORAL TABLET	4	
RETEVMO ORAL CAPSULE	4	PA; LA; QL
RITUXAN INTRAVENOUS CONCENTRATE	4	PA; LA
ROZLYTREK ORAL CAPSULE	4	PA; LA; QL
RUBRACA ORAL TABLET	4	PA; LA; QL

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Drug Name	Drug Tier	Requirements / Limits
RUXIENCE INTRAVENOUS CONCENTRATE	4	PA; LA
RYDAPT ORAL CAPSULE	4	PA; LA
SANDIMMUNE INTRAVENOUS SOLUTION	4	
SANDIMMUNE ORAL CAPSULE	4	
SANDIMMUNE ORAL SOLUTION	4	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE	4	PA; LA
SARCLISA INTRAVENOUS SOLUTION	4	LA
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	4	PA; LA
SIGNIFOR SUBCUTANEOUS SOLUTION	4	LA
SIKLOS ORAL TABLET	3	ST
SIMULECT INTRAVENOUS RECON SOLN	4	
<i>sirolimus oral solution</i>	4	
<i>sirolimus oral tablet</i>	4	

Drug Name	Drug Tier	Requirements / Limits
SOLTAMOX ORAL SOLUTION	3	ACA
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE	4	PA; LA
SPRYCEL ORAL TABLET	4	PA; LA; QL
STIVARGA ORAL TABLET	4	PA; LA; QL
SUPPRELIN LA IMPLANT KIT	4	LA
SUTENT ORAL CAPSULE	4	PA; LA; QL
SYLVANT INTRAVENOUS RECON SOLN	4	LA
SYNRIBO SUBCUTANEOUS RECON SOLN	4	LA
TABLOID ORAL TABLET	3	
TABRECTA ORAL TABLET	4	PA; LA
<i>tacrolimus oral capsule</i>	4	
TAFINLAR ORAL CAPSULE	4	PA; LA; QL
TAGRISSO ORAL TABLET	4	PA; LA; QL
TALZENNA ORAL CAPSULE	4	PA; LA; QL
<i>tamoxifen oral tablet</i>	1	ACA
TARCEVA ORAL TABLET	4	PA; LA; QL
TARGRETIN ORAL CAPSULE	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
TARGRETIN TOPICAL GEL	4	PA; LA
TASIGNA ORAL CAPSULE	4	PA; LA; QL
TAZVERIK ORAL TABLET	4	PA; LA
TEMODAR INTRAVENOUS RECON SOLN	4	PA; LA
TEMODAR ORAL CAPSULE	4	PA; LA
<i>temozolomide oral capsule</i>	4	PA; LA
<i>temsirolimus intravenous recon soln</i>	4	LA
TENIPOSIDE INTRAVENOUS SOLUTION	2	
TEPADINA INJECTION RECON SOLN	3	
THALOMID ORAL CAPSULE	4	PA; LA
<i>thiotepa injection recon soln</i>	1	
TIBSOVO ORAL TABLET	4	PA; LA
<i>toposar intravenous solution</i>	1	
<i>topotecan intravenous recon soln</i>	4	LA
<i>topotecan intravenous solution 4 mg/4 ml (1 mg/ml)</i>	4	LA
<i>toremifene oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
TORISEL INTRAVENOUS RECON SOLN	4	LA
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	3	
<i>tretinoin (antineoplastic) oral capsule</i>	1	
TREXALL ORAL TABLET	3	
TRIPTODUR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	4	PA; LA
TRODELVY INTRAVENOUS RECON SOLN	4	LA
TRUXIMA INTRAVENOUS CONCENTRATE	4	PA; LA
TUKYSA ORAL TABLET	4	PA; LA; QL
TURALIO ORAL CAPSULE	4	PA; LA; QL
TYKERB ORAL TABLET	4	PA; LA; QL
UNITUXIN INTRAVENOUS SOLUTION	4	LA
UPLIZNA INTRAVENOUS SOLUTION	4	LA
VANTAS IMPLANT KIT	4	LA

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Drug Name	Drug Tier	Requirements / Limits
VENCLEXTA ORAL TABLET	4	PA; LA
VENCLEXTA STARTING PACK ORAL TABLETS, DOSE PACK	4	PA; LA; QL
VERZENIO ORAL TABLET	4	PA; LA; QL
<i>vinblastine intravenous solution</i>	1	
<i>vincasar pfs intravenous solution</i>	1	
<i>vincristine intravenous solution</i>	1	
<i>vinorelbine intravenous solution</i>	1	
VITRAKVI ORAL CAPSULE	4	PA; LA
VITRAKVI ORAL SOLUTION	4	PA; LA
VIZIMPRO ORAL TABLET	4	PA; LA; QL
VOTRIENT ORAL TABLET	4	PA; LA; QL
XALKORI ORAL CAPSULE	4	PA; LA; QL
XATMEP ORAL SOLUTION	3	PA
XELODA ORAL TABLET	4	ST; LA
XERMELO ORAL TABLET	4	PA; LA; QL
XOSPATA ORAL TABLET	4	PA; LA
XPOVIO ORAL TABLET	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
XTANDI ORAL CAPSULE	4	PA; LA; QL
YONSA ORAL TABLET	4	PA; LA; QL
ZANOSAR INTRAVENOUS RECON SOLN	2	
ZEJULA ORAL CAPSULE	4	PA; LA; QL
ZELBORAF ORAL TABLET	4	PA; LA; QL
ZEPZELCA INTRAVENOUS RECON SOLN	4	LA
ZEVALIN (Y-90) INTRAVENOUS KIT	2	
ZOLADEX SUBCUTANEOUS IMPLANT	4	LA
ZOLINZA ORAL CAPSULE	4	PA; LA
ZORTRESS ORAL TABLET	4	
ZYDELIG ORAL TABLET	4	PA; LA; QL
ZYKADIA ORAL TABLET	4	PA; LA; QL
ZYTIGA ORAL TABLET	4	PA; LA; QL
AUTONOMIC & CNS DRUGS, NEUROLOGY & PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET	3	
BANZEL ORAL SUSPENSION	2	

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Drug Name	Drug Tier	Requirements / Limits
BANZEL ORAL TABLET	2	
BRIVIACT INTRAVENOUS SOLUTION	3	
BRIVIACT ORAL SOLUTION	3	
BRIVIACT ORAL TABLET	3	
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	1	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	1	
<i>carbamazepine oral tablet</i>	1	
<i>carbamazepine oral tablet extended release 12 hr</i>	1	
<i>carbamazepine oral tablet, chewable</i>	1	
CARBATROL ORAL CAPSULE, ER MULTIPHASE 12 HR	3	
CELONTIN ORAL CAPSULE 300 MG	2	
CEREBYX INJECTION SOLUTION	3	
<i>clobazam oral suspension</i>	1	
<i>clobazam oral tablet</i>	1	
<i>clonazepam oral tablet</i>	1	
<i>clonazepam oral tablet, disintegrating</i>	1	

Drug Name	Drug Tier	Requirements / Limits
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR	3	
DEPAKOTE ORAL TABLET, DELAYED RELEASE (DR/EC)	3	
DEPAKOTE SPRINKLES ORAL CAPSULE, DELAYED REL SPRINKLE	3	
DIACOMIT ORAL CAPSULE	4	PA; LA
DIACOMIT ORAL POWDER IN PACKET	4	PA; LA
DIASTAT ACUDIAL RECTAL KIT	3	
DIASTAT RECTAL KIT	3	
<i>diazepam rectal kit</i>	1	
DILANTIN EXTENDED ORAL CAPSULE	3	
DILANTIN INFATABS ORAL TABLET, CHEWABLE	3	
DILANTIN ORAL CAPSULE	2	
DILANTIN-125 ORAL SUSPENSION	3	
<i>divalproex oral capsule, delayed rel sprinkle</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>divalproex oral tablet extended release 24 hr</i>	1	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	1	
EPIDIOLEX ORAL SOLUTION	4	PA; LA
<i>epitol oral tablet</i>	1	
EQUETRO ORAL CAPSULE, ER MULTIPHASE 12 HR	3	
<i>ethosuximide oral capsule</i>	1	
<i>ethosuximide oral solution</i>	1	
<i>felbamate oral suspension</i>	1	
<i>felbamate oral tablet</i>	1	
FELBATOL ORAL SUSPENSION	3	
FELBATOL ORAL TABLET	3	
FINTEPLA ORAL SOLUTION	4	PA; LA
<i>fosphenytoin injection solution</i>	1	
FYCOMPA ORAL SUSPENSION	2	
FYCOMPA ORAL TABLET	2	
<i>gabapentin oral capsule</i>	1	
<i>gabapentin oral solution 250 mg/5 ml, 300 mg/6 ml (6 ml)</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>gabapentin oral tablet 600 mg, 800 mg</i>	1	
GABITRIL ORAL TABLET	3	
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR	3	ST
KEPPRA INTRAVENOUS SOLUTION	3	
KEPPRA ORAL SOLUTION	3	
KEPPRA ORAL TABLET	3	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR	3	
KLONOPIN ORAL TABLET	3	
LAMICTAL ODT ORAL TABLET, DISINTEGRATING	3	
LAMICTAL ODT STARTER (BLUE) ORAL TABLET DISINTEGRATING , DOSE PK	3	
LAMICTAL ODT STARTER (GREEN) ORAL TABLET DISINTEGRATING , DOSE PK	3	

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Drug Name	Drug Tier	Requirements / Limits
LAMICTAL ODT STARTER (ORANGE) ORAL TABLET DISINTEGRATING , DOSE PK	3	
LAMICTAL ORAL TABLET	3	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	3	
LAMICTAL STARTER (BLUE) KIT ORAL TABLETS,DOSE PACK	3	
LAMICTAL STARTER (GREEN) KIT ORAL TABLETS,DOSE PACK	3	
LAMICTAL STARTER (ORANGE) KIT ORAL TABLETS,DOSE PACK	3	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR	3	
LAMICTAL XR STARTER (BLUE) ORAL TABLET EXTENDED REL,DOSE PACK	3	

Drug Name	Drug Tier	Requirements / Limits
LAMICTAL XR STARTER (GREEN) ORAL TABLET EXTENDED REL,DOSE PACK	3	
LAMICTAL XR STARTER (ORANGE) ORAL TABLET EXTENDED REL,DOSE PACK	3	
<i>lamotrigine oral tablet</i>	1	
<i>lamotrigine oral tablet disintegrating, dose pk</i>	1	
<i>lamotrigine oral tablet extended release 24hr</i>	1	
<i>lamotrigine oral tablet, chewable dispersible</i>	1	
<i>lamotrigine oral tablet, disintegrating</i>	1	
<i>lamotrigine oral tablets, dose pack</i>	1	
<i>levetiracetam in nacl (iso-os) intravenous piggyback</i>	1	
<i>levetiracetam intravenous solution</i>	1	
<i>levetiracetam oral solution</i>	1	
<i>levetiracetam oral tablet</i>	1	
<i>levetiracetam oral tablet extended release 24 hr</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR	3	PA
LYRICA ORAL CAPSULE	3	ST
LYRICA ORAL SOLUTION	3	ST
MYSOLINE ORAL TABLET	3	
NAYZILAM NASAL SPRAY, NON-AEROSOL	2	PA; QL
NEURONTIN ORAL CAPSULE	3	ST
NEURONTIN ORAL SOLUTION	3	ST
NEURONTIN ORAL TABLET	3	ST
ONFI ORAL SUSPENSION	3	
ONFI ORAL TABLET 10 MG, 20 MG	3	
<i>oxcarbazepine oral suspension</i>	1	
<i>oxcarbazepine oral tablet</i>	1	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR	3	
PEGANONE ORAL TABLET	2	
<i>phenobarbital oral elixir</i>	1	
<i>phenobarbital oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
PHENYTEK ORAL CAPSULE	3	
<i>phenytoin oral suspension</i>	1	
<i>phenytoin oral tablet, chewable</i>	1	
<i>phenytoin sodium extended oral capsule</i>	1	
<i>phenytoin sodium intravenous solution</i>	1	
<i>phenytoin sodium intravenous syringe</i>	1	
<i>pregabalin oral capsule</i>	1	ST
<i>pregabalin oral solution</i>	1	ST
<i>primidone oral tablet</i>	1	
QUDEXY XR ORAL CAPSULE, SPRINKLE, ER 24HR	2	
<i>roweepra oral tablet</i>	1	
SABRIL ORAL POWDER IN PACKET	4	LA
SABRIL ORAL TABLET	4	LA
SPRITAM ORAL TABLET FOR SUSPENSION	3	
<i>subvenite oral tablet</i>	1	
<i>subvenite starter (blue) kit oral tablets, dose pack</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>subvenite starter (green) kit oral tablets,dose pack</i>	1	
<i>subvenite starter (orange) kit oral tablets,dose pack</i>	1	
SYMPAZAN ORAL FILM	3	
TEGRETOL ORAL SUSPENSION	3	
TEGRETOL ORAL TABLET	3	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR	3	
<i>tiagabine oral tablet</i>	1	
TOPAMAX ORAL CAPSULE, SPRINKLE	3	
TOPAMAX ORAL TABLET	3	
<i>topiramate oral capsule, sprinkle</i>	1	
TOPIRAMATE ORAL CAPSULE,SPRINKLE,ER 24HR	3	
<i>topiramate oral tablet</i>	1	
TRILEPTAL ORAL SUSPENSION	3	
TRILEPTAL ORAL TABLET	3	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR	3	

Drug Name	Drug Tier	Requirements / Limits
<i>valproate sodium intravenous solution</i>	1	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml, 500 mg/10 ml (10 ml)</i>	1	
<i>valproic acid oral capsule</i>	1	
VALTOCO NASAL SPRAY,NON-AEROSOL	3	PA; QL
<i>vigabatrin oral powder in packet</i>	4	LA
<i>vigabatrin oral tablet</i>	4	LA
<i>vigadrone oral powder in packet</i>	4	LA
VIMPAT INTRAVENOUS SOLUTION	2	
VIMPAT ORAL SOLUTION	2	
VIMPAT ORAL TABLET	2	
XCOPRI MAINTENANCE PACK ORAL TABLET	3	PA; QL
XCOPRI ORAL TABLET	3	PA; QL
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK	3	PA; QL
ZARONTIN ORAL CAPSULE	3	

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Drug Name	Drug Tier	Requirements / Limits
ZARONTIN ORAL SOLUTION	3	
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	3	
<i>zonisamide oral capsule</i>	1	
ANTIPARKINSONISM AGENTS		
APOKYN SUBCUTANEOUS CARTRIDGE	4	PA; LA; QL
AZILECT ORAL TABLET	3	
<i>benztropine injection solution</i>	1	
<i>benztropine oral tablet</i>	1	
<i>bromocriptine oral capsule</i>	1	
<i>bromocriptine oral tablet</i>	1	
<i>carbidopa oral tablet</i>	1	
<i>carbidopa-levodopa oral tablet</i>	1	
<i>carbidopa-levodopa oral tablet extended release</i>	1	
<i>carbidopa-levodopa oral tablet, disintegrating</i>	1	
<i>carbidopa-levodopa-entacapone oral tablet</i>	1	
COGENTIN INJECTION SOLUTION	3	

Drug Name	Drug Tier	Requirements / Limits
COMTAN ORAL TABLET	3	
DUOPA J-TUBE INTESTINAL PUMP SUSPENSION	4	LA
<i>entacapone oral tablet</i>	1	
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	4	PA; LA
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	2	PA; LA
LODOSYN ORAL TABLET	3	
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HR	3	
NEUPRO TRANSDERMAL PATCH 24 HOUR	3	
NOURIANZ ORAL TABLET	4	PA; LA; QL
ONGENTYS ORAL CAPSULE	3	PA
PARLODEL ORAL CAPSULE	3	
PARLODEL ORAL TABLET	3	
<i>pramipexole oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>pramipexole oral tablet extended release 24 hr</i>	1	
<i>rasagiline oral tablet</i>	1	
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 4 MG, 6 MG, 8 MG	3	
<i>ropinirole oral tablet</i>	1	
<i>ropinirole oral tablet extended release 24 hr</i>	1	
RYTARY ORAL CAPSULE, EXTENDED RELEASE	3	
<i>selegiline hcl oral capsule</i>	1	
<i>selegiline hcl oral tablet</i>	1	
SINEMET ORAL TABLET	3	
STALEVO 100 ORAL TABLET	3	
STALEVO 125 ORAL TABLET	3	
STALEVO 150 ORAL TABLET	3	
STALEVO 200 ORAL TABLET	3	
STALEVO 50 ORAL TABLET	3	
STALEVO 75 ORAL TABLET	3	
TASMAR ORAL TABLET 100 MG	3	

Drug Name	Drug Tier	Requirements / Limits
<i>tolcapone oral tablet</i>	1	
<i>trihexyphenidyl oral elixir</i>	1	
<i>trihexyphenidyl oral tablet</i>	1	
XADAGO ORAL TABLET	3	
ZELAPAR ORAL TABLET, DISINTEGRATING	3	
MIGRAINE & CLUSTER HEADACHE THERAPY		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR	2	PA; QL
AJOVY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR	2	PA
AJOVY SYRINGE SUBCUTANEOUS SYRINGE	2	PA; QL
<i>almotriptan malate oral tablet</i>	1	QL
AMERGE ORAL TABLET	3	ST; QL
CAFERGOT ORAL TABLET	3	
D.H.E.45 INJECTION SOLUTION	3	
<i>dihydroergotamine injection solution</i>	1	
<i>dihydroergotamine nasal spray, non-aerosol</i>	1	QL
<i>eletriptan oral tablet</i>	1	QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
EMGALITY PEN SUBCUTANEOUS PEN INJECTOR	2	PA; QL
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE	2	PA; QL
ERGOMAR SUBLINGUAL TABLET	3	
<i>ergotamine-caffeine oral tablet</i>	1	
FROVA ORAL TABLET	3	ST; QL
<i>frovatriptan oral tablet</i>	1	QL
IMITREX NASAL SPRAY, NON-AEROSOL	3	ST; QL
IMITREX ORAL TABLET	3	ST; QL
IMITREX STATDOSE PEN SUBCUTANEOUS PEN INJECTOR	3	ST; QL
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE	3	ST; QL
IMITREX SUBCUTANEOUS SOLUTION	3	ST; QL
MAXALT ORAL TABLET 10 MG	3	ST; QL
MAXALT-MLT ORAL TABLET, DISINTEGRATING 10 MG	3	ST; QL

Drug Name	Drug Tier	Requirements / Limits
<i>migergot rectal suppository</i>	1	
MIGRANAL NASAL SPRAY, NON-AEROSOL	3	QL
<i>naratriptan oral tablet</i>	1	QL
NURTEC ODT ORAL TABLET, DISINTEGRATING	3	PA; QL
ONZETRA XSAIL NASAL AEROSOL POWDR BREATH ACTIVATED	3	ST; QL
RELPAK ORAL TABLET	3	ST; QL
REYVOW ORAL TABLET	3	PA; QL
<i>rizatriptan oral tablet</i>	1	QL
<i>rizatriptan oral tablet, disintegrating</i>	1	QL
<i>sumatriptan nasal spray, non-aerosol</i>	1	QL
<i>sumatriptan succinate oral tablet</i>	1	QL
<i>sumatriptan succinate subcutaneous cartridge</i>	1	QL
<i>sumatriptan succinate subcutaneous pen injector</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>sumatriptan succinate subcutaneous solution</i>	1	QL
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	1	QL
<i>sumatriptan-naproxen oral tablet</i>	1	PA; QL
TOSYMRA NASAL SPRAY, NON-AEROSOL	3	ST; QL
TREXIMET ORAL TABLET 85-500 MG	3	ST; QL
UBRELVY ORAL TABLET	3	PA; QL
VYEPTI INTRAVENOUS SOLUTION	4	PA; LA
ZEMBRACE SYMTOUCH SUBCUTANEOUS PEN INJECTOR	3	ST; QL
<i>zolmitriptan oral tablet</i>	1	QL
<i>zolmitriptan oral tablet, disintegrating</i>	1	QL
ZOMIG NASAL SPRAY, NON-AEROSOL	2	ST; QL
ZOMIG ORAL TABLET	3	ST; QL
ZOMIG ZMT ORAL TABLET, DISINTEGRATING	3	ST; QL

Drug Name	Drug Tier	Requirements / Limits
MISCELLANEOUS NEUROLOGICAL THERAPY		
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HR	4	PA; LA
ARICEPT ORAL TABLET	3	
AUSTEDO ORAL TABLET	4	PA; LA; QL
<i>dalfampridine oral tablet extended release 12 hr</i>	4	PA; LA
<i>donepezil oral tablet</i>	1	
<i>donepezil oral tablet, disintegrating</i>	1	
EVRYSDI ORAL RECON SOLN	4	PA; LA
EXELON TRANSDERMAL PATCH 24 HOUR	3	
FIRDAPSE ORAL TABLET	4	PA; LA
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	1	
<i>galantamine oral solution</i>	1	
<i>galantamine oral tablet</i>	1	
HORIZANT ORAL TABLET EXTENDED RELEASE	3	ST
INGREZZA INITIATION PACK ORAL CAPSULE, DOSE PACK	4	PA; LA; QL

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Drug Name	Drug Tier	Requirements / Limits
INGREZZA ORAL CAPSULE	4	PA; LA; QL
KEVEYIS ORAL TABLET	4	LA
<i>memantine oral capsule, sprinkle, er 24hr</i>	1	
<i>memantine oral solution</i>	1	
<i>memantine oral tablet</i>	1	
MEMANTINE ORAL TABLETS, DOSE PACK	3	
NAMENDA ORAL TABLET	3	
NAMENDA TITRATION PAK ORAL TABLETS, DOSE PACK	3	
NAMENDA XR ORAL CAP, SPRINKLE, ER 24HR DOSE PACK	3	
NAMENDA XR ORAL CAPSULE, SPRINKLE, ER 24HR	3	
NAMZARIC ORAL CAP, SPRINKLE, ER 24HR DOSE PACK	2	
NAMZARIC ORAL CAPSULE, SPRINKLE, ER 24HR	2	
NUEDEXTA ORAL CAPSULE	2	PA

Drug Name	Drug Tier	Requirements / Limits
ONPATTRO INTRAVENOUS SOLUTION	4	PA; LA
RAZADYNE ER ORAL CAPSULE, EXT REL. PELLETS 24 HR	3	
RAZADYNE ORAL TABLET 4 MG	3	
<i>rivastigmine tartrate oral capsule</i>	1	
<i>rivastigmine transdermal patch 24 hour</i>	1	
RUZURGI ORAL TABLET	4	PA; LA
TEGSEDI SUBCUTANEOUS SYRINGE	4	PA; LA
<i>tetrabenazine oral tablet</i>	4	PA; LA; QL
XENAZINE ORAL TABLET	4	PA; LA; QL
MUSCLE RELAXANTS & ANTISPASMODIC THERAPY		
<i>atracurium intravenous solution</i>	1	
<i>baclofen oral tablet 10 mg, 20 mg</i>	1	
BACLOFEN ORAL TABLET 5 MG	3	
BRIDION INTRAVENOUS SOLUTION	3	
<i>carisoprodol oral tablet</i>	1	PA

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Drug Name	Drug Tier	Requirements / Limits
<i>carisoprodol-aspirin oral tablet</i>	1	PA
<i>carisoprodol-aspirin-codeine oral tablet</i>	1	PA
<i>chlorzoxazone oral tablet 500 mg</i>	1	
<i>cisatracurium intravenous solution 2 mg/ml</i>	1	
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	1	
DANTRIUM INTRAVENOUS RECON SOLN	3	
DANTRIUM ORAL CAPSULE 25 MG, 50 MG	3	
<i>dantrolene intravenous recon soln</i>	1	
<i>dantrolene oral capsule</i>	1	
<i>meprobamate oral tablet</i>	1	
MESTINON ORAL SYRUP	3	
MESTINON ORAL TABLET	3	
MESTINON TIMESPAN ORAL TABLET EXTENDED RELEASE	3	
<i>metaxall oral tablet</i>	1	
<i>metaxalone oral tablet</i>	1	
<i>methocarbamol injection solution</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>methocarbamol oral tablet</i>	1	
NIMBEX INTRAVENOUS SOLUTION 2 MG/ML	3	
NORGESIC FORTE ORAL TABLET	3	
<i>orphenadrine citrate injection solution</i>	1	
<i>orphenadrine citrate oral tablet extended release</i>	1	
<i>orphenadrine-asa-caffeine oral tablet 50-770-60 mg</i>	1	
<i>orphengesic forte oral tablet</i>	1	
OZOBAX ORAL SOLUTION	3	
<i>pyridostigmine bromide oral syrup</i>	1	
PYRIDOSTIGMINE BROMIDE ORAL TABLET 30 MG	3	
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	
<i>pyridostigmine bromide oral tablet extended release</i>	1	
<i>regonol injection solution</i>	1	
<i>revonto intravenous recon soln</i>	1	
ROBAXIN INJECTION SOLUTION	3	

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Drug Name	Drug Tier	Requirements / Limits
ROBAXIN-750 ORAL TABLET	3	
RYANODEX INTRAVENOUS SUSPENSION FOR RECONSTITUTION	3	
SKELAXIN ORAL TABLET	3	
SOMA ORAL TABLET	3	PA
<i>tizanidine oral capsule</i>	1	
<i>tizanidine oral tablet</i>	1	
<i>vanadom oral tablet</i>	1	PA
ZANAFLEX ORAL CAPSULE	3	
ZANAFLEX ORAL TABLET	3	
NARCOTIC ANALGESICS		
ABSTRAL SUBLINGUAL TABLET	3	PA; QL
<i>acetaminophen-caff-dihydrocod oral capsule</i>	1	PA
<i>acetaminophen-caff-dihydrocod oral tablet 325-30-16 mg</i>	1	PA
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml, 300 mg-30 mg /12.5 ml</i>	1	PA
<i>acetaminophen-codeine oral tablet</i>	1	PA
ACTIQ BUCCAL LOZENGE ON A HANDLE	3	PA; QL

Drug Name	Drug Tier	Requirements / Limits
ALLZITAL ORAL TABLET	3	ST
APADAZ ORAL TABLET	3	PA
ARYMO ER ORAL TABLET, ORAL ONLY, EXTND RELEASE	3	PA; QL
<i>ascomp with codeine oral capsule</i>	1	PA
BELBUCA BUCCAL FILM	2	PA; QL
BENZHYDROCODONE-ACETAMINOPHEN ORAL TABLET	3	PA
BUPAP ORAL TABLET 50-300 MG	3	ST
BUPRENEX INJECTION SOLUTION	3	PA
<i>buprenorphine hcl injection solution</i>	1	PA
<i>buprenorphine hcl injection syringe</i>	1	PA
<i>buprenorphine hcl sublingual tablet</i>	1	
<i>buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour</i>	2	PA
<i>buprenorphine transdermal patch weekly 7.5 mcg/hour</i>	1	PA

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Drug Name	Drug Tier	Requirements / Limits
<i>butalbital compound w/codeine oral capsule</i>	1	PA
<i>butalbital-acetaminop-caf-cod oral capsule</i>	1	PA
<i>butalbital-acetaminophen oral capsule</i>	1	
<i>butalbital-acetaminophen oral tablet</i>	1	
<i>butalbital-acetaminophen-caff oral capsule</i>	1	
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	1	
<i>butalbital-aspirin-caffeine oral capsule</i>	1	
<i>butalbital-aspirin-caffeine oral tablet</i>	1	
BUTRANS TRANSDERMAL PATCH WEEKLY	3	PA
<i>codeine sulfate oral tablet</i>	1	PA
<i>codeine-butalbital-asa-caff oral capsule</i>	1	PA
DEMEROL (PF) INJECTION SOLUTION 100 MG/2 ML, 25 MG/0.5 ML, 50 MG/ML, 75 MG/1.5 ML	3	PA
<i>demerol (pf) injection solution 100 mg/ml</i>	1	PA

Drug Name	Drug Tier	Requirements / Limits
DEMEROL (PF) INJECTION SYRINGE	3	PA
DEMEROL INJECTION SOLUTION	3	PA
DILAUDID (PF) INJECTION SYRINGE	3	PA
DILAUDID ORAL LIQUID	3	PA
DILAUDID ORAL TABLET	3	PA
<i>diskets oral tablet,soluble</i>	1	PA
DOLOPHINE ORAL TABLET	3	PA
DSUVIA SUBLINGUAL TABLET IN APPLICATOR	3	
DURAGESIC TRANSDERMAL PATCH 72 HOUR	3	PA; QL
<i>duramorph (pf) injection solution</i>	1	PA
<i>dvorah oral tablet</i>	1	PA
EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL	3	PA; QL
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	PA
ESGIC ORAL CAPSULE	3	ST
ESGIC ORAL TABLET	3	ST

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Drug Name	Drug Tier	Requirements / Limits
FENTANYL (PF)- BUPIVACAINE- NACL INJECTION SOLUTION 2 MCG/ML- 0.0625 %, 2 MCG/ML- 0.1 %, 2 MCG/ML- 0.125 %	3	PA
FENTANYL CITRATE (PF) INTRAVENOUS PT CONTROLLED ANALGESIA SYRING 1,500 MCG/30 ML (50 MCG/ML), 2,750 MCG/55 ML (50 MCG/ML)	3	PA
<i>fentanyl citrate (pf) intravenous syringe 100 mcg/2 ml (50 mcg/ml)</i>	1	PA
FENTANYL CITRATE (PF) INTRAVENOUS SYRINGE 250 MCG/5 ML (50 MCG/ML), 50 MCG/ML	3	PA
FENTANYL CITRATE (PF)- 0.9%NACL INJECTION PT CONTROLLED ANALGESIA SYRING 550 MCG/55 ML	3	PA

Drug Name	Drug Tier	Requirements / Limits
FENTANYL CITRATE (PF)- 0.9%NACL INTRAVENOUS PT CONTROLLED ANALGESIA SYRING 500 MCG/50 ML (10 MCG/ML)	3	PA
FENTANYL CITRATE (PF)- 0.9%NACL INTRAVENOUS SOLUTION 10 MCG/ML, 20 MCG/ML	3	PA
<i>fentanyl citrate (pf)- 0.9%nacl intravenous solution 5 mcg/ml</i>	1	PA
<i>fentanyl citrate (pf)- 0.9%nacl intravenous syringe 10 mcg/ml</i>	1	PA
FENTANYL CITRATE (PF)- 0.9%NACL INTRAVENOUS SYRINGE 50 MCG/5 ML (10 MCG/ML)	3	PA
<i>fentanyl citrate buccal lozenge on a handle</i>	1	PA; QL
<i>fentanyl transdermal patch 72 hour</i>	1	PA; QL
FENTANYL- ROPIVACAINE- NACL (PF) INJECTION SOLUTION 2-0.2 MCG/ML-%	3	PA

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Drug Name	Drug Tier	Requirements / Limits
FENTORA BUCCAL TABLET, EFFERVESCENT	3	PA; QL
FIORICET ORAL CAPSULE	3	ST
FIORICET WITH CODEINE ORAL CAPSULE 50-300-40-30 MG	3	PA
FIORINAL ORAL CAPSULE	3	ST
FIORINAL-CODEINE #3 ORAL CAPSULE	3	PA
<i>hydrocodone bitartrate oral capsule, oral only, er 12hr</i>	1	PA; QL
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml(15 ml), 7.5-325 mg/15 ml</i>	1	PA
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	1	PA
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	PA
HYDROMORPHONE (PF) IN WATER INJECTION SYRINGE	3	PA

Drug Name	Drug Tier	Requirements / Limits
HYDROMORPHONE (PF) IN WATER INTRAVENOUS PT CONTROLLED ANALGESIA SYRINGE	3	PA
HYDROMORPHONE (PF) INJECTION SOLUTION 1 MG/ML, 4 MG/ML	3	PA
<i>hydromorphone (pf) injection solution 10 mg/ml, 2 mg/ml</i>	1	PA
HYDROMORPHONE (PF)-0.9 % NACL INTRAVENOUS PATIENT CONTROL.ANALGESIA SOLN	3	PA
HYDROMORPHONE (PF)-0.9 % NACL INTRAVENOUS PREFILLED PUMP RESERVOIR 20 MG/100 ML (0.2 MG/ML), 50 MG/50 ML (1 MG/ML)	3	PA
<i>hydromorphone (pf)-0.9 % nacl intravenous pt controlled analgesia syringe 10 mg/50 ml (0.2 mg/ml)</i>	1	PA

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Drug Name	Drug Tier	Requirements / Limits
HYDROMORPHONE (PF)-0.9 % NACL INTRAVENOUS PT CONTROLLED ANALGESIA SYRING 30 MG/30 ML (1 MG/ML), 50 MG/50 ML (1 MG/ML), 55 MG/55 ML (1 MG/ML), 6 MG/30 ML (0.2 MG/ML)	3	PA
HYDROMORPHONE (PF)-0.9 % NACL INTRAVENOUS SOLUTION	3	PA
HYDROMORPHONE (PF)-0.9 % NACL INTRAVENOUS SYRINGE 1 MG/5 ML (0.2 MG/ML), 1 MG/ML, 2 MG/ML	3	PA
HYDROMORPHONE IN 0.9 % NACL INJECTION PREFILLED PUMP RESERVOIR	3	PA
HYDROMORPHONE IN 0.9 % NACL INJECTION PT CONTROLLED ANALGESIA SYRING 55 MG/55 ML (1 MG/ML)	3	PA

Drug Name	Drug Tier	Requirements / Limits
HYDROMORPHONE IN 0.9 % NACL INTRAVENOUS PATIENT CONTROL ANALGESIA SOLN 15 MG/30 ML (0.5 MG/ML)	3	PA
HYDROMORPHONE IN 0.9 % NACL INTRAVENOUS PREFILLED PUMP RESERVOIR 10 MG/50 ML (0.2 MG/ML)	3	PA
<i>hydromorphone in 0.9 % nacl intravenous pt controlled analgesia syring 15 mg/30 ml (0.5 mg/ml)</i>	1	PA
HYDROMORPHONE IN 0.9 % NACL INTRAVENOUS PT CONTROLLED ANALGESIA SYRING 5 MG/25 ML (0.2 MG/ML), 6 MG/30 ML (0.2 MG/ML)	3	PA
HYDROMORPHONE IN 0.9 % NACL INTRAVENOUS SOLUTION 0.2 MG/ML	3	PA
HYDROMORPHONE IN 0.9 % NACL INTRAVENOUS SYRINGE 0.5 MG/ML, 1 MG/ML (1 ML), 2 MG/10 ML (0.2 MG/ML)	3	PA

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Drug Name	Drug Tier	Requirements / Limits
<i>hydromorphone injection solution</i>	1	PA
HYDROMORPHONE INJECTION SYRINGE 0.5 MG/0.5 ML	3	PA
<i>hydromorphone injection syringe 1 mg/ml, 2 mg/ml, 4 mg/ml</i>	1	PA
<i>hydromorphone oral liquid</i>	1	PA
<i>hydromorphone oral tablet</i>	1	PA
<i>hydromorphone oral tablet extended release 24 hr</i>	1	PA; QL
<i>hydromorphone rectal suppository</i>	1	PA
HYSINGLA ER ORAL TABLET, ORAL ONLY, EXT. REL. 24 HR	2	PA; QL
<i>ibuprofen-oxycodone oral tablet</i>	1	PA
INFUMORPH P/F INJECTION SOLUTION	2	PA
KADIAN ORAL CAPSULE, EXTENDED RELEASE PELLETS 10 MG, 100 MG, 20 MG, 200 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG	3	PA; QL

Drug Name	Drug Tier	Requirements / Limits
LAZANDA NASAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 400 MCG/SPRAY	3	PA; QL
<i>levorphanol tartrate oral tablet 2 mg</i>	1	PA
LEVORPHANOL TARTRATE ORAL TABLET 3 MG	3	PA
<i>lorcet (hydrocodone) oral tablet</i>	1	PA
<i>lorcet hd oral tablet</i>	1	PA
<i>lorcet plus oral tablet 7.5-325 mg</i>	1	PA
LORTAB ELIXIR ORAL SOLUTION 10-300 MG/15 ML	3	PA
<i>meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml</i>	1	PA
<i>meperidine oral solution</i>	1	PA
<i>meperidine oral tablet</i>	1	PA
<i>methadone oral tablet</i>	1	PA
<i>methadone oral tablet, soluble</i>	1	PA
<i>methadose oral tablet, soluble</i>	1	PA
MITIGO (PF) INJECTION SOLUTION	3	PA

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Drug Name	Drug Tier	Requirements / Limits
MORPHABOND ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR	3	PA; QL
MORPHINE (PF) IN 0.9 % SOD CHL INJECTION SYRINGE 2 MG/2 ML (1 MG/ML)	3	PA
MORPHINE (PF) IN 0.9 % SOD CHL INTRAVENOUS PT CONTROLLED ANALGESIA SYRING 150 MG/30 ML (5 MG/ML), 50 MG/50 ML (1 MG/ML), 55 MG/55 ML (1 MG/ML)	3	PA
<i>morphine (pf) in 0.9 % sod chl intravenous pt controlled analgesia syring 30 mg/30 ml (1 mg/ml)</i>	1	PA
<i>morphine (pf) in 0.9 % sod chl intravenous solution 1 mg/ml</i>	1	PA
<i>morphine (pf) in 0.9 % sod chl intravenous syringe 0.5 mg/ml, 2 mg/2 ml (1 mg/ml), 5 mg/5 ml (1 mg/ml)</i>	1	PA
MORPHINE (PF) IN 0.9 % SOD CHL INTRAVENOUS SYRINGE 2 MG/ML, 4 MG/ML	3	PA

Drug Name	Drug Tier	Requirements / Limits
<i>morphine (pf) injection solution 0.5 mg/ml, 1 mg/ml</i>	1	PA
<i>morphine (pf) intravenous patient control.analgesia soln</i>	1	PA
MORPHINE (PF) INTRAVENOUS SYRINGE	3	PA
<i>morphine concentrate oral solution</i>	1	PA
MORPHINE IN 0.9 % SODIUM CHLOR INJECTION PT CONTROLLED ANALGESIA SYRING 55 MG/55 ML (1 MG/ML)	3	PA
MORPHINE IN 0.9 % SODIUM CHLOR INTRAVENOUS PREFILLED PUMP RESERVOIR 50 MG/50 ML (1 MG/ML)	3	PA
MORPHINE IN 0.9 % SODIUM CHLOR INTRAVENOUS SOLUTION 1 MG/ML, 5 MG/ML	3	PA
MORPHINE INJECTION SOLUTION 10 MG/ML, 2 MG/ML, 4 MG/ML, 5 MG/ML	3	PA

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Drug Name	Drug Tier	Requirements / Limits
<i>morphine injection solution 8 mg/ml</i>	1	PA
<i>morphine injection syringe 10 mg/ml, 2 mg/ml, 4 mg/ml, 5 mg/ml, 8 mg/ml</i>	1	PA
MORPHINE INTRAMUSCULAR PEN INJECTOR	3	PA
<i>morphine intravenous solution 10 mg/ml, 4 mg/ml</i>	1	PA
MORPHINE INTRAVENOUS SOLUTION 8 MG/ML	3	PA
<i>morphine intravenous syringe 10 mg/ml, 2 mg/ml, 4 mg/ml</i>	1	PA
MORPHINE INTRAVENOUS SYRINGE 8 MG/ML	3	PA
<i>morphine oral capsule, er multiphase 24 hr</i>	1	PA; QL
<i>morphine oral capsule, extend. release pellets</i>	1	PA; QL
<i>morphine oral solution</i>	1	PA
<i>morphine oral tablet</i>	1	PA
<i>morphine oral tablet extended release</i>	1	PA; QL
MS CONTIN ORAL TABLET EXTENDED RELEASE	3	PA; QL

Drug Name	Drug Tier	Requirements / Limits
NALOCET ORAL TABLET	3	PA
NORCO ORAL TABLET	3	PA
OXAYDO ORAL TABLET, ORAL ONLY	3	PA
<i>oxycodone oral capsule</i>	1	PA
<i>oxycodone oral concentrate</i>	1	PA
<i>oxycodone oral solution</i>	1	PA
<i>oxycodone oral tablet</i>	1	PA
OXYCODONE ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR	3	PA; QL
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-300 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	PA
<i>oxycodone-aspirin oral tablet</i>	1	PA
OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR	2	PA; QL
<i>oxymorphone oral tablet</i>	1	PA
<i>oxymorphone oral tablet extended release 12 hr</i>	1	PA; QL

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Drug Name	Drug Tier	Requirements / Limits
PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	3	PA
<i>phrenilin forte(with caffeine) oral capsule</i>	1	
<i>prolate oral tablet</i>	1	PA
ROXICODONE ORAL TABLET	3	PA
ROXYBOND ORAL TABLET, ORAL ONLY	3	PA
SUBLOCADE SUBCUTANEOUS SOLUTION, EXTENDED REL SYRINGE	4	LA
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL	3	PA; QL
<i>tencon oral tablet 50-325 mg</i>	1	
TREZIX ORAL CAPSULE 320.5-30-16 MG	3	PA
VANATOL LQ ORAL SOLUTION	3	ST
VANATOL S ORAL SOLUTION	3	ST
<i>vtol lq oral solution</i>	1	
XTAMPZA ER ORAL CAP, SPRINKL, ER 12HR (DONT CRUSH)	3	PA; QL

Drug Name	Drug Tier	Requirements / Limits
<i>zebutal oral capsule 50-325-40 mg</i>	1	
ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR	3	PA; QL
NON-NARCOTIC ANALGESICS		
<i>adult aspirin regimen oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
ANAPROX DS ORAL TABLET	3	ST
ANJESO INTRAVENOUS SUSPENSION	3	
ARTHROTEC 50 ORAL TABLET, IR, DELAYED REL, BIPHASIC	3	ST
ARTHROTEC 75 ORAL TABLET, IR, DELAYED REL, BIPHASIC	3	ST
<i>aspir-81 oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>aspirin low dose oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>aspirin oral tablet</i>	5	ACA; OTC
<i>aspirin oral tablet, chewable</i>	5	ACA; OTC
<i>aspirin oral tablet, delayed release (dr/ec) 325 mg, 81 mg</i>	5	ACA; OTC

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Drug Name	Drug Tier	Requirements / Limits
<i>aspir-low oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>aspir-trin oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>bayer aspirin oral tablet</i>	5	ACA; OTC
BAYER CHEWABLE ASPIRIN ORAL TABLET, CHEWABLE	5	ACA; OTC
BUNAVAIL BUCCAL FILM 2.1-0.3 MG, 4.2-0.7 MG	3	QL
BUNAVAIL BUCCAL FILM 6.3-1 MG	3	
<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	1	
<i>buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	1	QL
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	1	QL
<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	1	
<i>butorphanol injection solution</i>	1	PA
<i>butorphanol nasal spray, non-aerosol</i>	1	PA; QL
CALDOLOR INTRAVENOUS PIGGYBACK	3	

Drug Name	Drug Tier	Requirements / Limits
CALDOLOR INTRAVENOUS RECON SOLN 800 MG/8 ML (100 MG/ML)	2	
CAMBIA ORAL POWDER IN PACKET	3	ST; QL
CELEBREX ORAL CAPSULE	3	ST
<i>celecoxib oral capsule</i>	1	ST
<i>children's aspirin oral tablet, chewable</i>	5	ACA; OTC
CONZIP ORAL CAPSULE, ER BIPHASE 24 HR 17-83	3	PA; QL
CONZIP ORAL CAPSULE, ER BIPHASE 24 HR 25-75	3	PA; QL
DAYPRO ORAL TABLET	3	ST
DICLOFENAC EPOLAMINE TRANSDERMAL PATCH 12 HOUR	3	ST; QL
<i>diclofenac potassium oral tablet</i>	1	
<i>diclofenac sodium oral tablet extended release 24 hr</i>	1	
<i>diclofenac sodium oral tablet, delayed release (dr/ec)</i>	1	
<i>diclofenac sodium topical drops</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>diclofenac-misoprostol oral tablet,ir,delayed rel,biphasic</i>	1	
<i>diflunisal oral tablet</i>	1	
DISALCID ORAL TABLET	3	
<i>e.c. prin oral tablet,delayed release (dr/ec)</i>	5	ACA; OTC
EC-NAPROSYN ORAL TABLET,DELAYED RELEASE (DR/EC)	3	ST
<i>ecotrin low strength oral tablet,delayed release (dr/ec)</i>	5	ACA; OTC
<i>ecotrin oral tablet,delayed release (dr/ec)</i>	5	ACA; OTC
<i>etodolac oral capsule</i>	1	
<i>etodolac oral tablet</i>	1	
<i>etodolac oral tablet extended release 24 hr</i>	1	
EVZIO INJECTION AUTO-INJECTOR 2 MG/0.4 ML	3	QL
FELDENE ORAL CAPSULE	3	ST
FLECTOR TRANSDERMAL PATCH 12 HOUR	2	ST; QL
<i>flurbiprofen oral tablet 100 mg</i>	1	
<i>ibu oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>ibuprofen oral suspension</i>	1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
INDOCIN RECTAL SUPPOSITORY	3	
<i>indomethacin oral capsule</i>	1	
<i>indomethacin oral capsule, extended release</i>	1	
<i>ketoprofen oral capsule 50 mg, 75 mg</i>	1	
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	1	ST
<i>ketorolac injection cartridge</i>	1	
<i>ketorolac injection solution</i>	1	
<i>ketorolac injection syringe</i>	1	
<i>ketorolac intramuscular cartridge</i>	1	
<i>ketorolac intramuscular solution</i>	1	
<i>ketorolac intramuscular syringe</i>	1	
KETOROLAC NASAL SPRAY,NON-AEROSOL	3	ST; QL
<i>ketorolac oral tablet</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
LICART TRANSDERMAL PATCH 24 HOUR	2	ST; QL
<i>lite coat aspirin oral tablet</i>	5	ACA; OTC
LODINE ORAL TABLET	3	ST
LUCEMYRA ORAL TABLET	2	QL
<i>meclofenamate oral capsule</i>	1	
<i>mefenamic acid oral capsule</i>	1	
<i>meloxicam oral tablet 15 mg</i>	1	
<i>meloxicam oral tablet 7.5 mg</i>	1	QL
MOBIC ORAL TABLET 15 MG	3	ST
MOBIC ORAL TABLET 7.5 MG	3	ST; QL
<i>nabumetone oral tablet</i>	1	
<i>nalbuphine injection solution</i>	1	PA
NALOXONE INJECTION AUTO-INJECTOR	3	QL
<i>naloxone injection solution</i>	1	
<i>naloxone injection syringe</i>	1	
<i>naltrexone oral tablet</i>	1	
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR	3	ST

Drug Name	Drug Tier	Requirements / Limits
NAPROSYN ORAL SUSPENSION	3	ST
NAPROSYN ORAL TABLET 500 MG	3	ST
<i>naproxen oral suspension</i>	1	ST
<i>naproxen oral tablet</i>	1	
<i>naproxen oral tablet, delayed release (dr/ec)</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	1	ST
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	2	QL
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR	3	PA; QL
NUCYNTA ORAL TABLET	3	PA; QL
<i>oxaprozin oral tablet</i>	1	
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	3	ST; QL
<i>pentazocine-naloxone oral tablet</i>	1	PA
<i>piroxicam oral capsule</i>	1	
QMIIZ ODT ORAL TABLET, DISINTEGRATING 15 MG	3	ST

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Drug Name	Drug Tier	Requirements / Limits
QMIIZ ODT ORAL TABLET,DISINTEGRATING 7.5 MG	3	ST; QL
RELAFEN DS ORAL TABLET	3	ST
RELAFEN ORAL TABLET	3	ST
<i>salsalate oral tablet</i>	1	
<i>st joseph aspirin oral tablet,chewable</i>	5	ACA; OTC
<i>st. joseph aspirin oral tablet,delayed release (dr/ec)</i>	5	ACA; OTC
SUBOXONE SUBLINGUAL FILM 12-3 MG	3	
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG	3	QL
<i>sulindac oral tablet</i>	1	
<i>tolmetin oral capsule</i>	1	ST
<i>tolmetin oral tablet 200 mg</i>	1	
<i>tolmetin oral tablet 600 mg</i>	1	ST
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 17-83	3	PA; QL
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 25-75	3	PA; QL
TRAMADOL ORAL TABLET 100 MG	3	PA

Drug Name	Drug Tier	Requirements / Limits
<i>tramadol oral tablet 50 mg</i>	1	PA; QL
<i>tramadol oral tablet extended release 24 hr</i>	1	PA; QL
<i>tramadol oral tablet, er multiphase 24 hr</i>	1	PA; QL
<i>tramadol-acetaminophen oral tablet</i>	1	PA; QL
ULTRACET ORAL TABLET	3	PA; QL
ULTRAM ORAL TABLET	3	PA; QL
VIVITROL INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON	4	LA
ZIPSOR ORAL CAPSULE	3	ST
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG	2	QL
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG	2	
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY MAINTENANCE INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON	2	

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Drug Name	Drug Tier	Requirements / Limits
ABILIFY MAINTENANCE INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING	2	
ABILIFY MYCITORAL TABLET WITH SENSOR AND PATCH	3	QL
ABILIFY ORAL TABLET	3	QL
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED	3	
ADDERALL ORAL TABLET	3	
ADDERALL XR ORAL CAPSULE, EXTENDED RELEASE 24HR	3	ST
ADDYI ORAL TABLET	3	PA
ADHANSIA XR ORAL CAPSULE, ER BIPHASIC 20-80	3	ST
ADZENYS ER ORAL SUSPENSION, IR - ER, BIPHASIC 24HR	3	ST
ADZENYS XR-ODT ORAL TABLET, DISINTEGRATING ER BIPHASIC 24H	3	ST

Drug Name	Drug Tier	Requirements / Limits
<i>alprazolam intensol oral concentrate</i>	1	
<i>alprazolam oral tablet</i>	1	
<i>alprazolam oral tablet extended release 24 hr</i>	1	
<i>alprazolam oral tablet, disintegrating</i>	1	
AMBIEN CR ORAL TABLET, EXTENDED RELEASE MULTIPHASE	3	ST; QL
AMBIEN ORAL TABLET	3	ST; QL
<i>amitriptyline oral tablet</i>	1	
<i>amitriptyline-chlordiazepoxide oral tablet</i>	1	
<i>amoxapine oral tablet</i>	1	
AMPHETAMINE ORAL SUSPENSION, IR - ER, BIPHASIC 24HR	3	ST
<i>amphetamine sulfate oral tablet</i>	1	
ANAFRANIL ORAL CAPSULE	3	
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
APTENSIO XR ORAL CAPSULE, ER SPRINKLE, BIPHASIC 40-60	3	ST

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Drug Name	Drug Tier	Requirements / Limits
CONCERTA ORAL TABLET EXTENDED RELEASE 24HR	3	ST
COTEMPLA XR-ODT ORAL TABLET,DISINTEGRER BIPHASE 24H	3	ST
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC)	3	ST; QL
DAYTRANA TRANSDERMAL PATCH 24 HOUR	2	ST
DAYVIGO ORAL TABLET	3	ST
<i>desipramine oral tablet</i>	1	
DESOXYN ORAL TABLET	3	
DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
<i>desvenlafaxine succinate oral tablet extended release 24 hr</i>	1	QL
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE	3	ST
<i>dexmethylphenidate oral capsule,erbiphasic 50-50</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>dexmethylphenidate oral tablet</i>	1	
<i>dextroamphetamine oral capsule, extended release</i>	1	
<i>dextroamphetamine oral solution</i>	1	
<i>dextroamphetamine oral tablet</i>	1	
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr</i>	1	
<i>dextroamphetamine-amphetamine oral tablet</i>	1	
<i>diazepam injection solution</i>	1	
<i>diazepam injection syringe</i>	1	
<i>diazepam intensol oral concentrate</i>	1	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	1	
<i>diazepam oral tablet</i>	1	
<i>doxepin oral capsule</i>	1	
<i>doxepin oral concentrate</i>	1	
<i>doxepin oral tablet</i>	1	QL
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE	3	ST; QL
<i>duloxetine oral capsule,delayed release(dr/ec)</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
DYANA VEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR	2	ST
EDLUAR SUBLINGUAL TABLET	3	ST; QL
EFFEXOR XR ORAL CAPSULE, EXTENDED RELEASE 24HR	3	ST; QL
EMSAM TRANSDERMAL PATCH 24 HOUR	3	
<i>ergoloid oral tablet</i>	1	
<i>escitalopram oxalate oral solution</i>	1	
<i>escitalopram oxalate oral tablet</i>	1	QL
<i>estazolam oral tablet</i>	1	
<i>eszopiclone oral tablet</i>	1	QL
EVEKEO ODT ORAL TABLET, DISINTEGRATING	3	
EVEKEO ORAL TABLET	3	
FANAPT ORAL TABLET	3	QL
FANAPT ORAL TABLETS, DOSE PACK	3	QL
FAZACLO ORAL TABLET, DISINTEGRATING 100 MG, 12.5 MG, 200 MG	3	

Drug Name	Drug Tier	Requirements / Limits
FETZIMA ORAL CAPSULE, EXTENDED RELEASE 24HR DOSE PACK	2	ST; QL
FETZIMA ORAL CAPSULE, EXTENDED RELEASE 24HR	2	ST; QL
<i>flumazenil intravenous solution</i>	1	
<i>fluoxetine oral capsule 10 mg, 40 mg</i>	1	QL
<i>fluoxetine oral capsule 20 mg</i>	1	
<i>fluoxetine oral capsule, delayed release (dr/ec)</i>	1	QL
<i>fluoxetine oral solution</i>	1	
<i>fluoxetine oral tablet 10 mg</i>	1	QL
<i>fluoxetine oral tablet 20 mg, 60 mg</i>	1	
<i>fluphenazine decanoate injection solution</i>	1	
<i>fluphenazine hcl injection solution</i>	1	
<i>fluphenazine hcl oral concentrate</i>	1	
<i>fluphenazine hcl oral elixir</i>	1	
<i>fluphenazine hcl oral tablet</i>	1	
<i>flurazepam oral capsule</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>fluvoxamine oral capsule,extended release 24hr</i>	1	QL
<i>fluvoxamine oral tablet</i>	1	QL
FOCALIN ORAL TABLET	3	
FOCALIN XR ORAL CAPSULE,ER BIPHASIC 50-50	3	ST
FORFIVO XL ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
GEODON INTRAMUSCULAR RECON SOLN	3	
GEODON ORAL CAPSULE	3	QL
<i>guanfacine oral tablet extended release 24 hr</i>	1	PA
<i>guanidine oral tablet</i>	1	
HALCION ORAL TABLET 0.25 MG	3	
HALDOL DECANOATE INTRAMUSCULAR SOLUTION	3	
HALDOL INJECTION SOLUTION	3	
<i>haloperidol decanoate intramuscular solution</i>	1	
<i>haloperidol lactate injection solution</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>haloperidol lactate intramuscular syringe</i>	1	
<i>haloperidol lactate oral concentrate</i>	1	
<i>haloperidol oral tablet</i>	1	
HETLIOZ ORAL CAPSULE	4	PA; LA; QL
<i>imipramine hcl oral tablet</i>	1	
<i>imipramine pamoate oral capsule</i>	1	
INTERMEZZO SUBLINGUAL TABLET 1.75 MG	3	ST; QL
INTUNIV ER ORAL TABLET EXTENDED RELEASE 24 HR	3	PA
INVEGA ORAL TABLET EXTENDED RELEASE 24HR	3	QL
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE	3	
INVEGA TRINZA INTRAMUSCULAR SYRINGE	3	
JORNAY PM ORAL CAPSULE,DEL REL,EXT REL SPRINK	3	ST
KAPVAY ORAL TABLET EXTENDED RELEASE 12 HR	3	PA

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Drug Name	Drug Tier	Requirements / Limits
KETAMINE SUBLINGUAL TROCHE	3	
LATUDA ORAL TABLET	2	QL
LEXAPRO ORAL TABLET	3	ST; QL
<i>lithium carbonate oral capsule</i>	1	
<i>lithium carbonate oral tablet</i>	1	
<i>lithium carbonate oral tablet extended release</i>	1	
<i>lithium citrate oral solution 8 meq/5 ml</i>	1	
LITHOBID ORAL TABLET EXTENDED RELEASE	3	
<i>lorazepam injection solution</i>	1	
<i>lorazepam injection syringe</i>	1	
<i>lorazepam intensol oral concentrate</i>	1	
<i>lorazepam oral concentrate</i>	1	
<i>lorazepam oral tablet</i>	1	
<i>loxapine succinate oral capsule</i>	1	
LUNESTA ORAL TABLET	3	ST; QL
<i>maprotiline oral tablet</i>	1	
MARPLAN ORAL TABLET	3	

Drug Name	Drug Tier	Requirements / Limits
<i>methamphetamine oral tablet</i>	1	
METHYLIN ORAL SOLUTION	3	
METHYLPHENIDATE HCL ORAL CAP,ER SPRINKLE,BIPHASIC 40-60	3	ST
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	1	
<i>methylphenidate hcl oral capsule,er biphasic 50-50</i>	1	
<i>methylphenidate hcl oral solution</i>	1	
<i>methylphenidate hcl oral tablet</i>	1	
<i>methylphenidate hcl oral tablet extended release</i>	1	
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg</i>	1	
METHYLPHENIDATE HCL ORAL TABLET EXTENDED RELEASE 24HR 72 MG	3	ST
<i>methylphenidate hcl oral tablet, chewable</i>	1	
<i>midazolam (pf) in 0.9 % nacl intravenous solution</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
MIDAZOLAM (PF) IN 0.9 % NACL INTRAVENOUS SYRINGE	3	
<i>midazolam (pf) injection cartridge</i>	1	
<i>midazolam (pf) injection solution</i>	1	
<i>midazolam (pf) injection syringe</i>	1	
MIDAZOLAM IN 0.9 % SOD CHLORID INTRAVENOUS SOLUTION 1 MG/ML	3	
MIDAZOLAM IN 0.9 % SOD CHLORID INTRAVENOUS SYRINGE 2 MG/2 ML (1 MG/ML), 5 MG/5 ML (1 MG/ML), 55 MG/55 ML (1 MG/ML)	3	
MIDAZOLAM IN NACL,ISO- OSMO(PF) INTRAVENOUS SOLUTION	3	
<i>midazolam injection solution</i>	1	
MIDAZOLAM INTRAVENOUS SYRINGE 150 MG/30 ML (5 MG/ML)	3	
<i>midazolam oral syrup 2 mg/ml</i>	1	
<i>mirtazapine oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>mirtazapine oral tablet,disintegrating</i>	1	
<i>modafinil oral tablet</i>	1	PA; QL
<i>molindone oral tablet</i>	1	
MYDAYIS ORAL CAPSULE, ER TRIPHASIC 24 HR	2	ST
NARDIL ORAL TABLET	3	
<i>nefazodone oral tablet</i>	1	
NORPRAMIN ORAL TABLET 10 MG, 25 MG	3	
<i>nortriptyline oral capsule</i>	1	
<i>nortriptyline oral solution</i>	1	
NUPLAZID ORAL CAPSULE	4	PA; LA; QL
NUPLAZID ORAL TABLET 10 MG	4	PA; LA; QL
NUVIGIL ORAL TABLET	3	PA; QL
<i>olanzapine intramuscular recon soln</i>	1	
<i>olanzapine oral tablet</i>	1	QL
<i>olanzapine oral tablet,disintegrating</i>	1	QL
<i>olanzapine- fluoxetine oral capsule</i>	1	
<i>oxazepam oral capsule</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>paliperidone oral tablet extended release 24hr</i>	1	QL
PAMELOR ORAL CAPSULE	3	
PARNATE ORAL TABLET	3	
<i>paroxetine hcl oral tablet</i>	1	QL
<i>paroxetine hcl oral tablet extended release 24 hr</i>	1	QL
<i>paroxetine mesylate(menop.sym) oral capsule</i>	1	QL
PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
PAXIL ORAL SUSPENSION	3	ST
PAXIL ORAL TABLET	3	ST; QL
<i>perphenazine oral tablet</i>	1	
<i>perphenazine-amitriptyline oral tablet</i>	1	
PERSERIS ABDOMINAL SUBCUTANEOUS SUSPENSION,EXT END REL SYR KIT	3	
PEXEVA ORAL TABLET	3	ST; QL
<i>phenelzine oral tablet</i>	1	
<i>pimozide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
<i>procentra oral solution</i>	1	
<i>protriptyline oral tablet</i>	1	
PROVIGIL ORAL TABLET	3	PA; QL
PROZAC ORAL CAPSULE 10 MG, 40 MG	3	ST; QL
PROZAC ORAL CAPSULE 20 MG	3	ST
<i>quetiapine oral tablet</i>	1	QL
<i>quetiapine oral tablet extended release 24 hr</i>	1	QL
QUILLICHEW ER ORAL TABLET,CHEW,IR - ER.BIPHASIC24HR	2	ST
QUILLIVANT XR ORAL SUSPENSION,EXT REL 24HR,RECON	2	ST
<i>ramelteon oral tablet</i>	1	ST; QL
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR	3	ST
REMERON ORAL TABLET 15 MG, 30 MG	3	ST

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Drug Name	Drug Tier	Requirements / Limits
REMERON SOLTAB ORAL TABLET,DISINTE GRATING	3	ST
RESTORIL ORAL CAPSULE	3	
REXULTI ORAL TABLET	3	ST; QL
RISPERDAL CONSTA INTRAMUSCULA R SUSPENSION,EXT ENDED REL RECON	2	
RISPERDAL ORAL SOLUTION	3	
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	3	QL
<i>risperidone oral solution</i>	1	
<i>risperidone oral tablet</i>	1	QL
<i>risperidone oral tablet,disintegrating</i>	1	QL
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG, 20 MG, 30 MG, 40 MG	3	ST
RITALIN ORAL TABLET	3	
ROZEREM ORAL TABLET	3	ST; QL
SAPHRIS SUBLINGUAL TABLET	3	QL

Drug Name	Drug Tier	Requirements / Limits
SARAFEM ORAL TABLET 10 MG	3	ST; QL
SARAFEM ORAL TABLET 20 MG	3	ST
<i>seconal sodium oral capsule</i>	1	QL
SECUADO TRANSDERMAL PATCH 24 HOUR	3	QL
SEROQUEL ORAL TABLET	3	QL
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	3	QL
<i>sertraline oral concentrate</i>	1	
<i>sertraline oral tablet</i>	1	QL
SILENOR ORAL TABLET	3	ST; QL
SPRAVATO NASAL SPRAY, NON- AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)	4	PA; LA
STRATTERA ORAL CAPSULE	3	PA
SUNOSI ORAL TABLET	2	PA; QL
SYMBYAX ORAL CAPSULE 12-50 MG, 3-25 MG, 6-25 MG, 6-50 MG	3	
<i>temazepam oral capsule</i>	1	
<i>thioridazine oral tablet</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
<i>thiothixene oral capsule</i>	1	
TOFRANIL ORAL TABLET	3	
TRANXENE T-TAB ORAL TABLET 7.5 MG	3	
<i>tranylcypromine oral tablet</i>	1	
<i>trazodone oral tablet</i>	1	
<i>triazolam oral tablet</i>	1	
<i>trifluoperazine oral tablet</i>	1	
<i>trimipramine oral capsule</i>	1	
TRINTELLIX ORAL TABLET	3	ST; QL
VALIUM ORAL TABLET	3	
<i>venlafaxine oral capsule, extended release 24hr</i>	1	QL
<i>venlafaxine oral tablet</i>	1	QL
<i>venlafaxine oral tablet extended release 24hr</i>	1	QL
VERSACLOZ ORAL SUSPENSION	3	
VIIBRYD ORAL TABLET	2	ST; QL
VIIBRYD ORAL TABLETS, DOSE PACK 10 MG (7)-20 MG (23)	2	ST; QL
VRAYLAR ORAL CAPSULE	3	QL

Drug Name	Drug Tier	Requirements / Limits
VRAYLAR ORAL CAPSULE, DOSE PACK	3	QL
VYLEESI SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA; QL
VYVANSE ORAL CAPSULE	2	ST
VYVANSE ORAL TABLET, CHEWABLE	2	ST
WAKIX ORAL TABLET	4	PA; LA; QL
WELLBUTRIN SR ORAL TABLET SUSTAINED-RELEASE 12 HR	3	ST; QL
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
XANAX ORAL TABLET	3	
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR	3	
XYREM ORAL SOLUTION	4	PA; LA
<i>zaleplon oral capsule</i>	1	QL
<i>zenzedi oral tablet 10 mg, 5 mg</i>	1	
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	3	
<i>ziprasidone hcl oral capsule</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>ziprasidone mesylate intramuscular recon soln</i>	1	
ZOLOFT ORAL CONCENTRATE	3	ST
ZOLOFT ORAL TABLET	3	ST; QL
<i>zolpidem oral tablet</i>	1	QL
<i>zolpidem oral tablet,ext release multiphase</i>	1	QL
<i>zolpidem sublingual tablet</i>	1	QL
ZOLPIMIST ORAL SPRAY, NON-AEROSOL	3	ST; QL
ZULRESSO INTRAVENOUS SOLUTION	4	PA; LA
ZYPREXA INTRAMUSCULAR RECON SOLN	3	
ZYPREXA ORAL TABLET	3	QL
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	3	
ZYPREXA ZYDIS ORAL TABLET, DISINTEGRATING	3	QL

**CARDIOVASCULAR,
HYPERTENSION & LIPIDS**

ANTIARRHYTHMIC AGENTS

Drug Name	Drug Tier	Requirements / Limits
<i>amiodarone oral tablet</i>	1	
BETAPACE AF ORAL TABLET	3	ST
BETAPACE ORAL TABLET	3	ST
<i>bretylum tosylate injection solution</i>	1	
<i>disopyramide phosphate oral capsule</i>	1	
<i>dofetilide oral capsule</i>	1	
<i>flecainide oral tablet</i>	1	
<i>mexiletine oral capsule</i>	1	
MULTAQ ORAL TABLET	3	
NORPACE CR ORAL CAPSULE, EXTENDED RELEASE	3	
NORPACE ORAL CAPSULE	3	
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	1	
<i>procainamide injection solution</i>	1	
<i>propafenone oral capsule, extended release 12 hr</i>	1	
<i>propafenone oral tablet</i>	1	
<i>quinidine gluconate oral tablet extended release</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>quinidine sulfate oral tablet</i>	1	
RYTHMOL SR ORAL CAPSULE, EXTENDED RELEASE 12 HR	3	
<i>sotalol af oral tablet</i>	1	
SOTALOL INTRAVENOUS SOLUTION	2	
<i>sotalol oral tablet</i>	1	
SOTYLIZE ORAL SOLUTION	2	
TIKOSYN ORAL CAPSULE	3	
ANTIHYPERTENSIVE THERAPY		
ACCUPRIL ORAL TABLET	3	
ACCURETIC ORAL TABLET	3	
<i>acebutolol oral capsule</i>	1	
ADALAT CC ORAL TABLET EXTENDED RELEASE	3	
ALDACTAZIDE ORAL TABLET	3	
ALDACTONE ORAL TABLET	3	
<i>aliskiren oral tablet</i>	1	
ALTACE ORAL CAPSULE	3	
<i>amiloride oral tablet</i>	1	
<i>amiloride-hydrochlorothiazide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>amlodipine oral tablet</i>	1	
<i>amlodipine-benazepril oral capsule</i>	1	
<i>amlodipine-olmesartan oral tablet</i>	1	
<i>amlodipine-valsartan oral tablet</i>	1	
<i>amlodipine-valsartan-hcthiazyd oral tablet</i>	1	
ATACAND HCT ORAL TABLET	3	ST
ATACAND ORAL TABLET	3	ST
<i>atenolol oral tablet</i>	1	
<i>atenolol-chlorthalidone oral tablet</i>	1	
AVALIDE ORAL TABLET	3	ST
AVAPRO ORAL TABLET	3	ST
AZOR ORAL TABLET	3	ST
<i>benazepril oral tablet</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet</i>	1	
BENICAR HCT ORAL TABLET	3	ST
BENICAR ORAL TABLET	3	ST
<i>betaxolol oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
BIDIL ORAL TABLET	3	
<i>bisoprolol fumarate oral tablet</i>	1	
<i>bisoprolol-hydrochlorothiazide oral tablet</i>	1	
BREVIBLOC IN NACL (ISO-OSM) INTRAVENOUS PARENTERAL SOLUTION	3	
BREVIBLOC INTRAVENOUS SOLUTION 100 MG/10 ML (10 MG/ML)	3	
<i>bumetanide injection solution</i>	1	
<i>bumetanide oral tablet</i>	1	
BYSTOLIC ORAL TABLET	2	ST
CALAN ORAL TABLET 120 MG	3	
CALAN SR ORAL TABLET EXTENDED RELEASE	3	
<i>candesartan oral tablet</i>	1	
<i>candesartan-hydrochlorothiazid oral tablet</i>	1	
<i>captopril oral tablet</i>	1	
<i>captopril-hydrochlorothiazide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR	3	
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR	3	
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	3	
CARDURA ORAL TABLET	3	QL
CARDURA XL ORAL TABLET EXTENDED RELEASE 24HR	3	QL
CAROSPIR ORAL SUSPENSION	3	ST
<i>cartia xt oral capsule,extended release 24hr</i>	1	
<i>carvedilol oral tablet</i>	1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr</i>	1	
CATAPRES ORAL TABLET	3	
CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY	3	QL
CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY	3	QL
CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY	3	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>chlorothiazide sodium intravenous recon soln</i>	1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>clonidine hcl oral tablet</i>	1	
<i>clonidine transdermal patch weekly</i>	1	QL
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR	3	ST
COREG ORAL TABLET	3	ST
CORGARD ORAL TABLET	3	ST
<i>corlopam intravenous solution</i>	1	
COZAAR ORAL TABLET	3	ST
DEMSER ORAL CAPSULE	3	PA
DIBENZYLINE ORAL CAPSULE	3	PA
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	1	
<i>diltiazem hcl oral capsule, extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	
<i>diltiazem hcl oral capsule, extended release 24hr</i>	1	
<i>diltiazem hcl oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>diltiazem hcl oral tablet extended release 24 hr</i>	1	
<i>dilt-xr oral capsule, ext. rel 24h degradable</i>	1	
DIOVAN HCT ORAL TABLET	3	ST
DIOVAN ORAL TABLET	3	ST
DIURIL IV INTRAVENOUS RECON SOLN	3	
DIURIL ORAL SUSPENSION	3	
<i>doxazosin oral tablet</i>	1	QL
DUTOPROL ORAL TABLET EXTENDED RELEASE 24 HR	3	ST
DYAZIDE ORAL CAPSULE	3	
DYRENIUM ORAL CAPSULE	3	
EDARBI ORAL TABLET	2	ST
EDARBYCLOR ORAL TABLET	2	ST
EDECIN ORAL TABLET	3	
<i>enalapril maleate oral tablet</i>	1	
<i>enalaprilat intravenous solution</i>	1	
<i>enalapril-hydrochlorothiazide oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
EPANED ORAL SOLUTION	3	ST
<i>eplerenone oral tablet</i>	1	
<i>epoprostenol (glycine) intravenous recon soln</i>	4	PA; LA
<i>eprosartan oral tablet</i>	1	
<i>esmolol in nacl (iso-osm) intravenous parenteral solution</i>	1	
ESMOLOL IN STERILE WATER INTRAVENOUS PARENTERAL SOLUTION	3	
<i>esmolol intravenous solution</i>	1	
<i>ethacrynate sodium intravenous recon soln</i>	1	
<i>ethacrynic acid oral tablet</i>	1	
EXFORGE HCT ORAL TABLET	3	ST
EXFORGE ORAL TABLET	3	ST
<i>felodipine oral tablet extended release 24 hr</i>	1	
FLOLAN INTRAVENOUS RECON SOLN	4	PA; LA
<i>fosinopril oral tablet</i>	1	
<i>fosinopril-hydrochlorothiazide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
FUROSEMIDE IN 0.9 % NACL INTRAVENOUS PIGGYBACK	3	
<i>furosemide injection solution</i>	1	
<i>furosemide injection syringe</i>	1	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	
<i>furosemide oral tablet</i>	1	
<i>guanfacine oral tablet</i>	1	
HEMANGEOL ORAL SOLUTION	4	LA
<i>hydralazine injection solution</i>	1	
<i>hydralazine oral tablet</i>	1	
<i>hydrochlorothiazide oral capsule</i>	1	
<i>hydrochlorothiazide oral tablet</i>	1	
HYZAAR ORAL TABLET	3	ST
<i>indapamide oral tablet</i>	1	
INDERAL LA ORAL CAPSULE, EXTENDED RELEASE 24 HR	3	ST

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Drug Name	Drug Tier	Requirements / Limits
INDERAL XL ORAL CAPSULE,EXTENDED RELEASE 24HR	3	ST
INNOPRAN XL ORAL CAPSULE,EXTENDED RELEASE 24HR	3	ST
INSPRA ORAL TABLET	3	
<i>irbesartan oral tablet</i>	1	
<i>irbesartan-hydrochlorothiazide oral tablet</i>	1	
<i>isradipine oral capsule</i>	1	
KAPSPARGO SPRINKLE ORAL CAPSULE,SPRINKLE,ER 24HR	3	ST
KATERZIA ORAL SUSPENSION	3	ST
<i>labetalol intravenous solution</i>	1	
<i>labetalol intravenous syringe 20 mg/4 ml (5 mg/ml)</i>	1	
<i>labetalol oral tablet</i>	1	
LASIX ORAL TABLET	3	
<i>lisinopril oral tablet</i>	1	
<i>lisinopril-hydrochlorothiazide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
LOPRESSOR ORAL TABLET	3	ST
<i>losartan oral tablet</i>	1	
<i>losartan-hydrochlorothiazide oral tablet</i>	1	
LOTENSIN HCT ORAL TABLET	3	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	3	
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG	3	
<i>matzim la oral tablet extended release 24 hr</i>	1	
MAXZIDE ORAL TABLET	3	
MAXZIDE-25MG ORAL TABLET	3	
<i>methyldopa oral tablet</i>	1	
<i>methyldopa-hydrochlorothiazide oral tablet</i>	1	
<i>methyldopate intravenous solution</i>	1	
<i>metolazone oral tablet</i>	1	
<i>metoprolol succinate oral tablet extended release 24 hr</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
METOPROLOL SU-HYDROCHLOROTHIAZ ORAL TABLET EXTENDED RELEASE 24 HR 100-12.5 MG, 25-12.5 MG	3	ST
<i>metoprolol tartrate hydrochlorothiazide oral tablet</i>	1	
<i>metoprolol tartrate intravenous solution</i>	1	
<i>metoprolol tartrate intravenous syringe</i>	1	
<i>metoprolol tartrate oral tablet</i>	1	
<i>metyrosine oral capsule</i>	1	PA
MICARDIS HCT ORAL TABLET	3	ST
MICARDIS ORAL TABLET	3	ST
MICROZIDE ORAL CAPSULE	3	
MINIPRESS ORAL CAPSULE	3	
<i>minoxidil oral tablet</i>	1	
<i>moexipril oral tablet</i>	1	
<i>nadolol oral tablet</i>	1	
<i>nadolol-bendroflumethiazide oral tablet 80-5 mg</i>	1	
<i>nicardipine oral capsule</i>	1	
<i>nifedipine oral capsule</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>nifedipine oral tablet extended release</i>	1	
<i>nifedipine oral tablet extended release 24hr</i>	1	
<i>nimodipine oral capsule</i>	1	
<i>nisoldipine oral tablet extended release 24 hr</i>	1	
NORVASC ORAL TABLET	3	ST
NYMALIZE ORAL SOLUTION	3	
NYMALIZE ORAL SYRINGE	3	
<i>olmesartan-amlodipin-hcthiaazid oral tablet</i>	1	
<i>olmesartan-hydrochlorothiazide oral tablet</i>	1	
ORENITRAM ORAL TABLET EXTENDED RELEASE	4	PA; LA
<i>osmitrol 20 % intravenous parenteral solution</i>	1	
<i>perindopril erbumine oral tablet</i>	1	
<i>phentolamine injection recon soln</i>	1	
<i>pindolol oral tablet</i>	1	
<i>prazosin oral capsule</i>	1	
PRESTALIA ORAL TABLET	3	

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Drug Name	Drug Tier	Requirements / Limits
PRINIVIL ORAL TABLET 10 MG, 20 MG	3	
PROCARDIA ORAL CAPSULE	3	
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24HR	3	
<i>propranolol intravenous solution</i>	1	
<i>propranolol oral capsule, extended release 24 hr</i>	1	
<i>propranolol oral solution</i>	1	
<i>propranolol oral tablet</i>	1	
<i>propranolol-hydrochlorothiazid oral tablet</i>	1	
QBRELIS ORAL SOLUTION	3	ST
<i>quinapril oral tablet</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet</i>	1	
<i>ramipril oral capsule</i>	1	
SODIUM EDECRIN INTRAVENOUS RECON SOLN	3	
<i>spironolactone oral tablet</i>	1	
<i>spironolacton-hydrochlorothiaz oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	3	
TARKA ORAL TABLET, IR - ER, BIPHASIC 24HR 2-180 MG, 2-240 MG, 4-240 MG	3	
<i>taztia xt oral capsule, extended release 24 hr</i>	1	
TEKTURNA HCT ORAL TABLET	2	
TEKTURNA ORAL TABLET	3	
<i>telmisartan oral tablet</i>	1	
<i>telmisartan-amlodipine oral tablet</i>	1	
<i>telmisartan-hydrochlorothiazid oral tablet</i>	1	
TENORETIC 100 ORAL TABLET	3	ST
TENORETIC 50 ORAL TABLET	3	ST
TENORMIN ORAL TABLET	3	ST
<i>terazosin oral capsule</i>	1	QL
<i>tiadylt er oral capsule, extended release 24 hr</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
TIAZAC ORAL CAPSULE,EXTENDED RELEASE 24 HR	3	
<i>timolol maleate oral tablet</i>	1	
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HR	3	ST
<i>toremide oral tablet</i>	1	
<i>trandolapril oral tablet</i>	1	
<i>trandolapril-verapamil oral tablet, ir - er, biphasic 24hr</i>	1	
<i>triamterene oral capsule</i>	1	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hydrochlorothiazid oral tablet</i>	1	
TRIBENZOR ORAL TABLET	3	ST
UPTRAVI ORAL TABLET	4	PA; LA
UPTRAVI ORAL TABLETS,DOSE PACK	4	PA; LA
<i>valsartan oral tablet</i>	1	
<i>valsartan-hydrochlorothiazide oral tablet</i>	1	
VASERETIC ORAL TABLET	3	

Drug Name	Drug Tier	Requirements / Limits
VASOTEC ORAL TABLET	3	
<i>veletri intravenous recon soln</i>	4	PA; LA
<i>verapamil oral capsule, 24 hr er pellet ct</i>	1	
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	1	
<i>verapamil oral tablet</i>	1	
<i>verapamil oral tablet extended release</i>	1	
VERELAN ORAL CAPSULE,EXT REL. PELLETS 24 HR	3	
VERELAN PM ORAL CAPSULE, 24 HR ER PELLET CT	3	
ZESTORETIC ORAL TABLET	3	
ZESTRIL ORAL TABLET	3	
ZIAC ORAL TABLET	3	ST
CARDIAC GLYCOSIDES		
<i>digitek oral tablet</i>	1	
<i>digox oral tablet</i>	1	
<i>digoxin oral solution 50 mcg/ml (0.05 mg/ml)</i>	1	
<i>digoxin oral tablet</i>	1	
LANOXIN ORAL TABLET	3	
COAGULATION THERAPY		

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Drug Name	Drug Tier	Requirements / Limits
ADVATE INTRAVENOUS RECON SOLN	4	LA
ADYNOVATE INTRAVENOUS SOLUTION	4	LA
AFSTYLA INTRAVENOUS RECON SOLN	4	LA
AGGRENOLX ORAL CAPSULE, ER MULTIPHASE 12 HR	3	
ALPHANATE INTRAVENOUS RECON SOLN	4	LA
ALPHANINE SD INTRAVENOUS RECON SOLN	4	LA
ALPROLIX INTRAVENOUS RECON SOLN	4	LA
AMICAR ORAL SOLUTION	3	
AMICAR ORAL TABLET	3	
<i>aminocaproic acid intravenous solution</i>	1	
<i>aminocaproic acid oral solution</i>	1	
<i>aminocaproic acid oral tablet</i>	1	
ANDEXXA INTRAVENOUS RECON SOLN	3	
ANGIOMAX INTRAVENOUS RECON SOLN	3	

Drug Name	Drug Tier	Requirements / Limits
ARGATROBAN IN 0.9 % SOD CHLOR INTRAVENOUS PARENTERAL SOLUTION	3	
ARGATROBAN IN 0.9 % SOD CHLOR INTRAVENOUS SOLUTION	3	
ARGATROBAN IN NAACL (ISO-OS) INTRAVENOUS SOLUTION	3	
ARGATROBAN INTRAVENOUS SOLUTION	3	
ARIIXTRA SUBCUTANEOUS SYRINGE	4	
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr</i>	1	
ASPIRIN- OMEPRAZOLE ORAL TABLET, IR, DELAYED REL, BIPHASIC	3	ST
BENEFIX INTRAVENOUS RECON SOLN	4	LA
BEVYXXA ORAL CAPSULE	3	QL
<i>bivalirudin intravenous recon soln</i>	1	
BIVALIRUDIN INTRAVENOUS SOLUTION	3	

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Drug Name	Drug Tier	Requirements / Limits
BIVALIRUDIN-0.9 % SODIUM CHLOR INTRAVENOUS PIGGYBACK	3	
BRILINTA ORAL TABLET	2	
CABLIVI INJECTION KIT	4	PA; LA
CEPROTIN (BLUE BAR) INTRAVENOUS RECON SOLN	4	LA
CEPROTIN (GREEN BAR) INTRAVENOUS RECON SOLN	4	LA
<i>cilostazol oral tablet</i>	1	
<i>clopidogrel oral tablet</i>	1	
COAGADEX INTRAVENOUS RECON SOLN	4	LA
COUMADIN ORAL TABLET	3	
CYKLOKAPRON INTRAVENOUS SOLUTION	3	
DEFITELIO INTRAVENOUS SOLUTION	3	
<i>dipyridamole oral tablet</i>	1	
DOPTELET (15 TAB PACK) ORAL TABLET	4	PA; LA; QL
EFFIENT ORAL TABLET	3	

Drug Name	Drug Tier	Requirements / Limits
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	2	PA
ELIQUIS ORAL TABLET	2	PA
ELOCTATE INTRAVENOUS RECON SOLN	4	PA; LA
<i>enoxaparin subcutaneous solution</i>	4	
<i>enoxaparin subcutaneous syringe</i>	4	
ESPEROCT INTRAVENOUS RECON SOLN	4	PA; LA
FEIBA NF INTRAVENOUS RECON SOLN 1,750-3,250 UNIT, 350-650 UNIT, 700-1,300 UNIT	4	LA
FIBRYGA INTRAVENOUS RECON SOLN	4	LA
<i>fondaparinux subcutaneous syringe</i>	4	
FRAGMIN SUBCUTANEOUS SOLUTION	4	
FRAGMIN SUBCUTANEOUS SYRINGE	4	
HEMLIBRA SUBCUTANEOUS SOLUTION	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
HEMOFIL M HIGH INTRAVENOUS RECON SOLN	4	LA
HEMOFIL M LOW INTRAVENOUS RECON SOLN	4	LA
HEMOFIL M MID INTRAVENOUS RECON SOLN	4	LA
HEMOFIL M SUPER HIGH INTRAVENOUS RECON SOLN	4	LA
<i>hep flush-10 (pf) intravenous solution</i>	1	
HEPARIN (PORCINE) IN 0.9% NACL INTRAVENOUS PARENTERAL SOLUTION 2,500 UNIT/500 ML (5 UNIT/ML), 30,000 UNIT/1,000 ML, 5,000 UNIT/1,000 ML, 5,000 UNIT/500 ML (10 UNIT/ML)	3	
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	1	
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution</i>	1	
<i>heparin (porcine) injection cartridge</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>heparin (porcine) injection solution</i>	1	
<i>heparin (porcine) injection syringe 5,000 unit/ml</i>	1	
<i>heparin flush(porcine)- 0.9nacl intravenous kit</i>	1	
<i>heparin lock flush (porcine) intravenous solution 100 unit/ml</i>	1	
<i>heparin lock flush intravenous solution</i>	1	
<i>heparin lock flush intravenous syringe</i>	1	
<i>heparin lockflush(porcine)(pf) intravenous syringe</i>	1	
HEPARIN(PORCINE) IN 0.45% NACL INTRAVENOUS PARENTERAL SOLUTION 12,500 UNIT/250 ML	3	
<i>heparin(porcine) in 0.45% nacl intravenous parenteral solution 25,000 unit/250 ml, 25,000 unit/500 ml</i>	1	
<i>heparin, porcine (pf) injection solution</i>	1	
<i>heparin, porcine (pf) injection syringe 5,000 unit/0.5 ml</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
HEPARIN, PORCINE (PF) INJECTION SYRINGE 5,000 UNIT/ML	3	
<i>heparin, porcine (pf) intravenous solution 100 unit/ml (1 ml)</i>	1	
<i>heparin, porcine (pf) intravenous syringe 1 unit/ml, 100 unit/ml</i>	1	
HEPARIN, PORCINE (PF) SUBCUTANEOUS SYRINGE	3	
HUMATE-P INTRAVENOUS RECON SOLN	4	LA
IDELVION INTRAVENOUS RECON SOLN	4	LA
IXINITY INTRAVENOUS RECON SOLN	4	LA
<i>jantoven oral tablet</i>	1	
JIVI INTRAVENOUS RECON SOLN	4	LA
KCENTRA INTRAVENOUS RECON SOLN	3	
KOATE INTRAVENOUS RECON SOLN	4	LA
KOGENATE FS INTRAVENOUS RECON SOLN	4	LA

Drug Name	Drug Tier	Requirements / Limits
KOVALTRY INTRAVENOUS RECON SOLN	4	LA
LOVENOX SUBCUTANEOUS SOLUTION	4	
LOVENOX SUBCUTANEOUS SYRINGE	4	
MEPHYTON ORAL TABLET	3	QL
MONONINE INTRAVENOUS RECON SOLN	4	LA
MULPLETA ORAL TABLET	4	PA; LA; QL
NOVOEIGHT INTRAVENOUS RECON SOLN	4	LA
NOVOSEVEN RT INTRAVENOUS RECON SOLN	4	LA
NUWIQ INTRAVENOUS RECON SOLN	4	LA
OBIZUR INTRAVENOUS RECON SOLN	4	LA
<i>pentoxifylline oral tablet extended release</i>	1	
<i>phytonadione (vitamin k1) injection solution</i>	1	
PHYTONADIONE (VITAMIN K1) INJECTION SYRINGE	2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
<i>phytonadione (vitamin k1) oral tablet 5 mg</i>	1	QL
PLAVIX ORAL TABLET 75 MG	3	
PRADAXA ORAL CAPSULE	3	PA
<i>prasugrel oral tablet</i>	1	
PRAXBIND INTRAVENOUS SOLUTION	3	
PROFILNINE INTRAVENOUS RECON SOLN	4	LA
PROMACTA ORAL POWDER IN PACKET	4	PA; LA
PROMACTA ORAL TABLET	4	PA; LA
<i>protamine intravenous solution</i>	1	
REBINYN INTRAVENOUS RECON SOLN	4	LA
RECOMBINATE INTRAVENOUS RECON SOLN	4	PA; LA
RIASTAP INTRAVENOUS RECON SOLN	4	LA
RIXUBIS INTRAVENOUS RECON SOLN	4	LA
SAVAYSA ORAL TABLET	3	PA
TAVALISSE ORAL TABLET	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
TRANEXAMIC ACID IN NACL,ISO-OS INTRAVENOUS PIGGYBACK	3	
<i>tranexamic acid intravenous solution</i>	1	
<i>vitamin k injection solution</i>	1	
<i>vitamin k1 injection solution</i>	1	
<i>warfarin oral tablet</i>	1	
WILATE INTRAVENOUS RECON SOLN 1,000-1,000 UNIT, 500-500 UNIT	4	LA
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	2	PA
XARELTO ORAL TABLET	2	PA
XYNTHA INTRAVENOUS SOLUTION	4	PA; LA
XYNTHA SOLOFUSE INTRAVENOUS SYRINGE	4	PA; LA
YOSPRALA ORAL TABLET,IR,DELA YED REL,BIPHASIC	3	ST
ZONTIVITY ORAL TABLET	3	

LIPID/CHOLESTEROL LOWERING AGENTS

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
<i>amlodipine-atorvastatin oral tablet</i>	1	QL
ANTARA ORAL CAPSULE 30 MG, 90 MG	3	
<i>atorvastatin oral tablet</i>	1	QL
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	3	ST; QL
<i>cholestyramine (with sugar) oral powder</i>	1	
<i>cholestyramine (with sugar) oral powder in packet</i>	1	
<i>cholestyramine light oral powder</i>	1	
<i>cholestyramine light oral powder in packet</i>	1	
<i>colesevelam oral powder in packet</i>	1	
<i>colesevelam oral tablet</i>	1	
COLESTID FLAVORED ORAL PACKET	3	ST
COLESTID ORAL GRANULES	3	ST
COLESTID ORAL PACKET	3	ST

Drug Name	Drug Tier	Requirements / Limits
COLESTID ORAL TABLET	3	ST
<i>colestipol oral granules</i>	1	
<i>colestipol oral packet</i>	1	
<i>colestipol oral tablet</i>	1	
CRESTOR ORAL TABLET	3	ST; QL
EZALLOR SPRINKLE ORAL CAPSULE, SPRINKLE	3	ST; QL
<i>ezetimibe oral tablet</i>	1	
<i>ezetimibe-simvastatin oral tablet</i>	1	QL
<i>fenofibrate micronized oral capsule</i>	1	
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	1	
FENOFIBRATE ORAL CAPSULE	3	
<i>fenofibrate oral tablet</i>	1	
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec)</i>	1	
<i>fenofibric acid oral tablet</i>	1	
FENOGLIDE ORAL TABLET	3	
FIBRICOR ORAL TABLET	3	

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Drug Name	Drug Tier	Requirements / Limits
FLOLIPID ORAL SUSPENSION	3	ST; QL
<i>fluvastatin oral capsule</i>	1	QL
<i>fluvastatin oral tablet extended release 24 hr</i>	1	QL
<i>gemfibrozil oral tablet</i>	1	
JUXTAPID ORAL CAPSULE	4	PA; LA
LESCOL XL ORAL TABLET EXTENDED RELEASE 24 HR	3	ST; QL
LIPITOR ORAL TABLET	3	ST; QL
LIPOFEN ORAL CAPSULE	2	
LIVALO ORAL TABLET	2	ST; QL
LOPID ORAL TABLET	3	
<i>lovastatin oral tablet</i>	1	QL
LOVAZA ORAL CAPSULE	3	PA
NEXLETOL ORAL TABLET	2	PA
NEXLIZET ORAL TABLET	2	PA
<i>niacin oral tablet 500 mg</i>	1	
<i>niacin oral tablet extended release 24 hr</i>	1	
NIACOR ORAL TABLET	3	

Drug Name	Drug Tier	Requirements / Limits
NIASPAN EXTENDED-RELEASE ORAL TABLET EXTENDED RELEASE 24 HR	3	
<i>omega-3 acid ethyl esters oral capsule</i>	1	PA
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR	4	PA; QL
PRAVACHOL ORAL TABLET 20 MG, 40 MG	3	ST; QL
<i>pravastatin oral tablet</i>	1	QL
<i>prevalite oral powder</i>	1	
<i>prevalite oral powder in packet</i>	1	
QUESTRAN LIGHT ORAL POWDER	3	ST
QUESTRAN ORAL POWDER	3	ST
QUESTRAN ORAL POWDER IN PACKET	3	ST
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR	4	PA; QL
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR	4	PA; QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
REPATHA SYRINGE SUBCUTANEOUS SYRINGE	4	PA; QL
<i>rosuvastatin oral tablet</i>	1	QL
SIMVASTATIN ORAL SUSPENSION	3	ST; QL
<i>simvastatin oral tablet</i>	1	QL
TRICOR ORAL TABLET	3	
TRIGLIDE ORAL TABLET 160 MG	3	
<i>triklo oral capsule</i>	1	PA
TRILIPIX ORAL CAPSULE,DELAYED RELEASE(DR/EC)	3	
VASCEPA ORAL CAPSULE	2	PA
VYTORIN 10-10 ORAL TABLET	3	ST; QL
VYTORIN 10-20 ORAL TABLET	3	ST; QL
VYTORIN 10-40 ORAL TABLET	3	ST; QL
VYTORIN 10-80 ORAL TABLET	3	ST; QL
WELCHOL ORAL POWDER IN PACKET	3	ST
WELCHOL ORAL TABLET	3	ST
ZETIA ORAL TABLET	3	ST

Drug Name	Drug Tier	Requirements / Limits
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG	3	ST; QL
ZYPITAMAG ORAL TABLET	3	ST; QL
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CORLANOR ORAL SOLUTION	2	PA
CORLANOR ORAL TABLET	2	PA
ENTRESTO ORAL TABLET	2	PA; QL
GIAPREZA INTRAVENOUS SOLUTION	3	
NIPRIDE RTU INTRAVENOUS SOLUTION 20 MG/100 ML (0.2 MG/ML), 50 MG/100 ML (0.5 MG/ML)	3	
RANEXA ORAL TABLET EXTENDED RELEASE 12 HR	3	
<i>ranolazine oral tablet extended release 12 hr</i>	1	
VECAMYL ORAL TABLET	3	
VYNDAMAX ORAL CAPSULE	4	PA; LA
VYNDAQEL ORAL CAPSULE	4	PA; LA
NITRATES		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
DILATRATE-SR ORAL CAPSULE, EXTENDED RELEASE	2	
GONITRO SUBLINGUAL POWDER IN PACKET	3	
ISORDIL ORAL TABLET	3	
ISORDIL TITRADOSE ORAL TABLET 5 MG	3	
<i>isosorbide dinitrate oral tablet</i>	1	
<i>isosorbide mononitrate oral tablet</i>	1	
<i>isosorbide mononitrate oral tablet extended release 24 hr</i>	1	
MINITRAN TRANSDERMAL PATCH 24 HOUR	3	
<i>nitro-bid transdermal ointment</i>	1	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR	3	
<i>nitroglycerin in 5 % dextrose intravenous solution</i>	1	
<i>nitroglycerin intravenous solution</i>	1	
<i>nitroglycerin oral capsule, extended release</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>nitroglycerin sublingual tablet</i>	1	
<i>nitroglycerin transdermal patch 24 hour</i>	1	
<i>nitroglycerin translingual spray,non-aerosol</i>	1	
NITROLINGUAL TRANSLINGUAL SPRAY,NON- AEROSOL	3	
NITROMIST TRANSLINGUAL AEROSOL,SPRAY	3	
NITROSTAT SUBLINGUAL TABLET	3	
<i>nitro-time oral capsule, extended release</i>	1	

DERMATOLOGICALS/TOPICAL THERAPY

ANTIPSORIATIC / ANTISEBORRHEIC

<i>acitretin oral capsule</i>	1	
ANALPRAM-HC TOPICAL LOTION	3	ST
<i>calcipotriene scalp solution</i>	1	QL
<i>calcipotriene topical cream</i>	1	QL
CALCIPOTRIENE TOPICAL FOAM	3	QL
<i>calcipotriene topical ointment</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>calcipotriene-betamethasone topical ointment</i>	1	QL
<i>calcipotriene-betamethasone topical suspension</i>	1	QL
<i>calcitriol topical ointment</i>	1	
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE	4	PA; LA; QL
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
COSENTYX PEN SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
COSENTYX SUBCUTANEOUS SYRINGE	4	PA; LA; QL
DOVONEX TOPICAL CREAM	3	QL
ENSTILAR TOPICAL FOAM	2	QL
EPIFOAM TOPICAL FOAM	3	ST
ILUMYA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
PRAMOSONE TOPICAL CREAM 1-1 %	3	ST
PRAMOSONE TOPICAL LOTION	3	ST
<i>selenium sulfide topical lotion</i>	1	

Drug Name	Drug Tier	Requirements / Limits
SILIQ SUBCUTANEOUS SYRINGE	4	PA; LA; QL
SKYRIZI SUBCUTANEOUS SYRINGE KIT	4	PA; LA; QL
SORIATANE ORAL CAPSULE 10 MG, 25 MG	3	
SORILUX TOPICAL FOAM	3	QL
STELARA SUBCUTANEOUS SOLUTION	4	PA; LA; QL
STELARA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
<i>sulfacetamide sodium topical cleanser</i>	1	
TACLONEX TOPICAL OINTMENT	3	QL
TACLONEX TOPICAL SUSPENSION	3	QL
TALTZ AUTOINJECTOR (2 PACK) SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA; QL
TALTZ AUTOINJECTOR (3 PACK) SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA; QL
TALTZ AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA; QL

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Drug Name	Drug Tier	Requirements / Limits
TALTZ SYRINGE SUBCUTANEOUS SYRINGE	4	PA; LA; QL
TREMFYA SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA; QL
TREMFYA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
VECTICAL TOPICAL OINTMENT	3	
BURN THERAPY		
SILVADENE TOPICAL CREAM	3	
<i>silver sulfadiazine topical cream</i>	1	
<i>ssd topical cream</i>	1	
KERATOLYTICS		
INOVA 4-1 TOPICAL COMBO PACK	3	ST
INOVA 8-2 TOPICAL COMBO PACK	3	ST
MISCELLANEOUS DERMATOLOGICALS		
AMELUZ TOPICAL GEL	3	
<i>ammonium lactate topical cream</i>	1	
<i>ammonium lactate topical lotion</i>	1	
CANTHARIDIN IN ACETONE TOPICAL SOLUTION	3	

Drug Name	Drug Tier	Requirements / Limits
CARAC TOPICAL CREAM	3	ST
CONDYLOX TOPICAL GEL	3	
<i>diclofenac sodium topical gel 3 %</i>	1	PA; QL
<i>doxepin topical cream</i>	1	QL
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE	4	PA; LA; QL
EFUDEX TOPICAL CREAM	3	ST
ELIDEL TOPICAL CREAM	3	ST; QL
ESKATA TOPICAL SOLUTION WITH APPLICATOR	3	
EUCRISA TOPICAL OINTMENT	3	ST; QL
FLUOROPLEX TOPICAL CREAM	3	
FLUOROURACIL TOPICAL CREAM 0.5 %	3	
<i>fluorouracil topical cream 5 %</i>	1	
<i>fluorouracil topical solution</i>	1	
<i>iodine-sodium iodide topical tincture 2 %</i>	1	
IODOFLEX TOPICAL PADS, MEDICATED	3	

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Drug Name	Drug Tier	Requirements / Limits
IODOSORB TOPICAL GEL	3	
LEVULAN TOPICAL SOLUTION	3	
<i>methoxsalen oral capsule, liqd-filled, rapid rel</i>	1	
<i>methyl salicylate oil</i>	1	
<i>methyl salicylate topical liquid</i>	1	
OXSORALEN ULTRA ORAL CAPSULE, LIQD-FILLED, RAPID REL	3	
PANRETIN TOPICAL GEL	3	
PICATO TOPICAL GEL	2	
<i>pimecrolimus topical cream</i>	1	ST; QL
<i>podofilox topical solution</i>	1	
PROTOPIC TOPICAL OINTMENT	3	ST; QL
<i>pradoxin topical cream</i>	1	QL
QBREXZA TOPICAL TOWELETTE	3	PA
REGRANEX TOPICAL GEL	2	QL
SCENESSE SUBCUTANEOUS IMPLANT	4	PA; LA
<i>tacrolimus topical ointment</i>	1	ST; QL

Drug Name	Drug Tier	Requirements / Limits
TOLAK TOPICAL CREAM	3	
UVADEX INJECTION SOLUTION	2	
VALCHLOR TOPICAL GEL	4	LA
VEREGEN TOPICAL OINTMENT	3	PA; QL
<i>wintergreen oil oil</i>	1	
ZONALON TOPICAL CREAM	3	QL
THERAPY FOR ACNE		
ABSORICA LD ORAL CAPSULE	3	ST
ABSORICA ORAL CAPSULE	3	ST
ACANYA TOPICAL GEL WITH PUMP	3	ST
ACZONE TOPICAL GEL	3	ST
ACZONE TOPICAL GEL WITH PUMP	3	ST
<i>adapalene topical gel 0.3 %</i>	1	PA
<i>adapalene topical gel with pump</i>	1	PA
<i>adapalene-benzoyl peroxide topical gel with pump</i>	1	PA
AKLIEF TOPICAL CREAM	3	PA
AKTIPAK TOPICAL GEL	3	ST

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
ALTRENO TOPICAL LOTION	3	PA
<i>amnesteem oral capsule</i>	1	
AMZEEQ TOPICAL FOAM	2	ST
ARAZLO TOPICAL LOTION	3	PA
ATRALIN TOPICAL GEL	3	PA
<i>avita topical cream</i>	1	PA
AVITA TOPICAL GEL	3	PA
<i>azelaic acid topical gel</i>	1	
AZELEX TOPICAL CREAM	3	ST
BENZAACLIN PUMP TOPICAL GEL WITH PUMP	3	ST
BENZAACLIN TOPICAL GEL	3	ST
BENZAMYCIN TOPICAL GEL	3	ST
<i>benzoyl peroxide topical cleanser 7 %</i>	1	
<i>benzoyl peroxide topical foam 9.8 %</i>	1	
<i>claravis oral capsule</i>	1	
CLEOCIN T TOPICAL GEL	3	ST; QL
CLEOCIN T TOPICAL LOTION	3	ST; QL
CLINDACIN ETZ TOPICAL KIT	3	ST
<i>clindacin p topical swab</i>	1	

Drug Name	Drug Tier	Requirements / Limits
CLINDACIN PAC TOPICAL KIT	3	ST
<i>clindamycin phosphate topical foam</i>	1	QL
<i>clindamycin phosphate topical gel</i>	1	QL
CLINDAMYCIN PHOSPHATE TOPICAL GEL, ONCE DAILY	3	ST; QL
<i>clindamycin phosphate topical lotion</i>	1	QL
<i>clindamycin phosphate topical solution</i>	1	QL
<i>clindamycin phosphate topical swab</i>	1	
<i>clindamycin-benzoyl peroxide topical gel</i>	1	
<i>clindamycin-benzoyl peroxide topical gel with pump</i>	1	
<i>clindamycin-tretinoin topical gel</i>	1	PA
<i>dapsone topical gel</i>	1	
DAPSONE TOPICAL GEL WITH PUMP	3	ST
DIFFERIN TOPICAL GEL WITH PUMP	3	PA
ENZOCLEAR TOPICAL FOAM	3	ST

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Drug Name	Drug Tier	Requirements / Limits
EPIDUO FORTE TOPICAL GEL WITH PUMP	3	PA
EPIDUO TOPICAL GEL WITH PUMP	3	PA
<i>ery pads topical swab</i>	1	
<i>erygel topical gel</i>	1	
<i>erythromycin with ethanol topical gel</i>	1	
<i>erythromycin with ethanol topical solution</i>	1	
<i>erythromycin with ethanol topical swab</i>	1	
<i>erythromycin-benzoyl peroxide topical gel</i>	1	
EVOCLIN TOPICAL FOAM	3	ST; QL
FABIOR TOPICAL FOAM	3	PA
FINACEA TOPICAL FOAM	2	ST
FINACEA TOPICAL GEL	3	ST
INOVA TOPICAL COMBO PACK	3	ST
<i>isotretinoin oral capsule</i>	1	
<i>ivermectin topical cream</i>	1	QL
METROCREAM TOPICAL CREAM	3	ST
METROGEL TOPICAL GEL 1 %	3	ST

Drug Name	Drug Tier	Requirements / Limits
METROGEL TOPICAL GEL WITH PUMP	3	ST
<i>metronidazole topical cream</i>	1	
<i>metronidazole topical gel</i>	1	
<i>metronidazole topical gel with pump</i>	1	
<i>metronidazole topical lotion</i>	1	
MIRVASO TOPICAL GEL	2	PA
MIRVASO TOPICAL GEL WITH PUMP	2	PA
<i>myorisan oral capsule</i>	1	
NEUAC KIT TOPICAL COMBO PACK, CREAM AND GEL	3	ST
<i>neuac topical gel</i>	1	
NORITATE TOPICAL CREAM	3	ST
ONEXTON TOPICAL GEL WITH PUMP	2	ST
PACNEX TOPICAL CLEANSER	3	ST
PR BENZOYL PEROXIDE TOPICAL CLEANSER	3	ST
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP	3	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
RETIN-A MICRO TOPICAL GEL	3	PA
RETIN-A TOPICAL CREAM	3	PA
RETIN-A TOPICAL GEL	3	PA
RHOFADE TOPICAL CREAM	3	PA
<i>rosadan topical cream</i>	1	
<i>rosadan topical gel</i>	1	
ROSADAN TOPICAL KIT, CLEANSER AND GEL	3	ST
ROSADAN TOPICAL KIT, CLEANSER AND CREAM	3	ST
SOOLANTRA TOPICAL CREAM	3	ST; QL
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	1	
<i>tazarotene topical cream</i>	1	PA
TAZORAC TOPICAL CREAM 0.05 %	2	PA
TAZORAC TOPICAL CREAM 0.1 %	3	PA
TAZORAC TOPICAL GEL	2	PA
<i>tretinoin microspheres topical gel</i>	1	PA

Drug Name	Drug Tier	Requirements / Limits
<i>tretinoin microspheres topical gel with pump</i>	1	PA
<i>tretinoin topical cream</i>	1	PA
<i>tretinoin topical gel</i>	1	PA
TRETIN-X CREAM KIT TOPICAL COMBO PACK	3	PA
TRETIN-X TOPICAL CREAM 0.075 %	3	PA
VELTIN TOPICAL GEL	3	PA; ST
<i>zenatane oral capsule</i>	1	
ZIANA TOPICAL GEL	3	PA; ST
ZILXI TOPICAL FOAM	3	ST
TOPICAL ANESTHETICS		
<i>glydo mucous membrane jelly in applicator</i>	1	QL
<i>lidocaine (pf) injection solution</i>	1	
LIDOCAINE (PF) INJECTION SYRINGE 100 MG/5 ML (2 %), 200 MG/10 ML (2 %), 400 MG/20 ML (2 %), 60 MG/3 ML (2 %)	3	
<i>lidocaine (pf) injection syringe 50 mg/5 ml (1 %)</i>	1	
<i>lidocaine hcl injection solution</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>lidocaine hcl injection syringe 10 mg/ml (1 %), 100 mg/10 ml (1 %)</i>	1	
LIDOCAINE HCL INJECTION SYRINGE 100 MG/5 ML (2 %), 30 MG/3 ML (1%), 50 MG/5 ML (1 %)	3	
LIDOCAINE HCL INTRADERMAL PEN INJECTOR	3	
<i>lidocaine hcl laryngotracheal solution</i>	1	
<i>lidocaine hcl mucous membrane jelly</i>	1	QL
<i>lidocaine hcl mucous membrane jelly in applicator</i>	1	QL
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	1	
<i>lidocaine hcl-hydrocortison ac topical cream</i>	1	
<i>lidocaine topical adhesive patch,medicated 5 %</i>	1	PA
<i>lidocaine topical ointment</i>	1	QL
<i>lidocaine viscous mucous membrane solution</i>	1	
<i>lidocaine-epinephrine injection solution</i>	1	
<i>lidocaine-prilocaine topical cream</i>	1	QL

Drug Name	Drug Tier	Requirements / Limits
<i>lidocaine-prilocaine topical kit</i>	1	
LIDODERM TOPICAL ADHESIVE PATCH,MEDICATED	3	PA
NUMBRINO NASAL SOLUTION	3	
SYNERA TOPICAL PATCH, MEDICATED SELF-HEATING	3	
XYLOCAINE INJECTION SOLUTION	3	
XYLOCAINE WITH EPINEPHRINE INJECTION SOLUTION	3	
XYLOCAINE-MPF INJECTION SOLUTION 10 MG/ML (1 %), 15 MG/ML (1.5 %), 20 MG/ML (2 %), 5 MG/ML (0.5 %)	3	
ZINGO INTRADERMAL PEN INJECTOR	3	
ZTLIDO TOPICAL ADHESIVE PATCH,MEDICATED	2	PA
TOPICAL ANTIBACTERIALS		
ALTABAX TOPICAL OINTMENT	3	ST; QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
CENTANY AT TOPICAL OINTMENT KIT	3	ST; QL
CENTANY TOPICAL OINTMENT	3	ST; QL
CORTISPORIN TOPICAL CREAM	3	
CORTISPORIN TOPICAL OINTMENT	3	
<i>gentamicin topical cream</i>	1	
<i>gentamicin topical ointment</i>	1	
KLARON TOPICAL SUSPENSION	3	ST
<i>lugols topical solution</i>	1	
<i>mafenide acetate topical packet</i>	1	
<i>mupirocin calcium topical cream</i>	1	ST; QL
<i>mupirocin topical ointment</i>	1	QL
NEO-SYNALAR KIT TOPICAL CREAM	3	
NEO-SYNALAR TOPICAL CREAM	3	
<i>strong iodine topical solution</i>	1	
<i>sulfacetamide sodium (acne) topical suspension</i>	1	
SULFAMYLON TOPICAL CREAM	2	

Drug Name	Drug Tier	Requirements / Limits
SULFAMYLON TOPICAL PACKET	3	
XEPI TOPICAL CREAM	3	ST; QL
TOPICAL ANTIFUNGALS		
CICLODAN KIT TOPICAL COMBO PACK	3	
<i>ciclodan topical cream</i>	1	QL
<i>ciclodan topical solution</i>	1	
<i>ciclopirox topical cream</i>	1	QL
<i>ciclopirox topical gel</i>	1	QL
<i>ciclopirox topical shampoo</i>	1	QL
<i>ciclopirox topical solution</i>	1	
<i>ciclopirox topical suspension</i>	1	QL
<i>clotrimazole topical cream</i>	1	QL
<i>clotrimazole topical solution</i>	1	QL
<i>clotrimazole-betamethasone topical cream</i>	1	QL
<i>clotrimazole-betamethasone topical lotion</i>	1	QL
<i>econazole topical cream</i>	1	QL
ECOZA TOPICAL FOAM	3	QL
ERTACZO TOPICAL CREAM	3	QL

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Drug Name	Drug Tier	Requirements / Limits
EXELDERM TOPICAL CREAM	3	QL
EXELDERM TOPICAL SOLUTION	3	QL
EXTINA TOPICAL FOAM	3	QL
<i>ketconazole topical cream</i>	1	QL
<i>ketconazole topical foam</i>	1	QL
<i>ketconazole topical shampoo</i>	1	QL
<i>ketodan kit topical combo pack</i>	1	
<i>ketodan topical foam</i>	1	QL
LOPROX (AS OLAMINE) TOPICAL CREAM	3	QL
LOPROX (AS OLAMINE) TOPICAL SUSPENSION	3	QL
LOPROX KIT TOPICAL COMBO PACK	3	QL
LOPROX KIT TOPICAL KIT, SUSPENSION AND CLEANSER	3	QL
LOPROX TOPICAL SHAMPOO	3	QL
LULICONAZOLE TOPICAL CREAM	3	PA; QL
LUZU TOPICAL CREAM	3	PA; QL
MENTAX TOPICAL CREAM	3	QL

Drug Name	Drug Tier	Requirements / Limits
MICONAZOLE NITRATE-ZINC OX-PET TOPICAL OINTMENT	3	QL
<i>naftifine topical cream</i>	1	QL
<i>naftifine topical gel</i>	1	QL
NAFTIN TOPICAL CREAM 2 %	3	QL
NAFTIN TOPICAL GEL	3	QL
<i>nyamyc topical powder</i>	1	QL
<i>nystatin topical cream</i>	1	QL
<i>nystatin topical ointment</i>	1	QL
<i>nystatin topical powder</i>	1	QL
<i>nystatin-triamcinolone topical cream</i>	1	QL
<i>nystatin-triamcinolone topical ointment</i>	1	QL
<i>nystop topical powder</i>	1	QL
<i>oxiconazole topical cream</i>	1	QL
OXISTAT TOPICAL CREAM	3	QL
OXISTAT TOPICAL LOTION	3	QL
SULCONAZOLE TOPICAL CREAM	3	QL
SULCONAZOLE TOPICAL SOLUTION	3	QL

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Drug Name	Drug Tier	Requirements / Limits
VUSION TOPICAL OINTMENT	3	QL
XOLEGEL TOPICAL GEL	3	QL
TOPICAL ANTIVIRALS		
<i>acyclovir topical cream</i>	1	PA; QL
<i>acyclovir topical ointment</i>	1	PA; QL
DENAVIR TOPICAL CREAM	3	
XERESE TOPICAL CREAM	3	
ZOVIRAX TOPICAL CREAM	3	PA; QL
ZOVIRAX TOPICAL OINTMENT	3	PA; QL
TOPICAL CORTICOSTEROIDS		
<i>ala-cort topical cream 1 %</i>	1	
ALA-SCALP TOPICAL LOTION	3	ST
<i>alclometasone topical cream</i>	1	
<i>alclometasone topical ointment</i>	1	
<i>amcinonide topical cream</i>	1	ST
<i>amcinonide topical lotion</i>	1	ST
<i>beseer topical lotion</i>	1	ST
<i>betamethasone dipropionate topical cream</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>betamethasone dipropionate topical lotion</i>	1	
<i>betamethasone dipropionate topical ointment</i>	1	
<i>betamethasone valerate topical cream</i>	1	
<i>betamethasone valerate topical foam</i>	1	ST
<i>betamethasone valerate topical lotion</i>	1	
<i>betamethasone valerate topical ointment</i>	1	
<i>betamethasone, augmented topical cream</i>	1	
<i>betamethasone, augmented topical gel</i>	1	
<i>betamethasone, augmented topical lotion</i>	1	
<i>betamethasone, augmented topical ointment</i>	1	
CAPEX TOPICAL SHAMPOO	3	ST
<i>clobetasol scalp solution</i>	1	QL
<i>clobetasol topical cream</i>	1	QL
<i>clobetasol topical foam</i>	1	ST; QL

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Drug Name	Drug Tier	Requirements / Limits
<i>clobetasol topical gel</i>	1	QL
<i>clobetasol topical lotion</i>	1	ST; QL
<i>clobetasol topical ointment</i>	1	QL
<i>clobetasol topical shampoo</i>	1	ST; QL
<i>clobetasol topical spray,non-aerosol</i>	1	ST; QL
<i>clobetasol-emollient topical cream</i>	1	QL
<i>clobetasol-emollient topical foam</i>	1	ST; QL
CLOBEX TOPICAL LOTION	3	ST; QL
CLOBEX TOPICAL SHAMPOO	3	ST; QL
CLOBEX TOPICAL SPRAY,NON-AEROSOL	3	ST; QL
CLOCORTOLONE PIVALATE TOPICAL CREAM	3	ST
CLODAN KIT TOPICAL KIT,SHAMPOO AND CLEANSER	3	ST
<i>clodan topical shampoo</i>	1	ST; QL
CLODERM TOPICAL CREAM	3	ST
CORDRAN TAPE LARGE ROLL TOPICAL TAPE	3	ST
CORDRAN TOPICAL CREAM	3	ST; QL

Drug Name	Drug Tier	Requirements / Limits
CORDRAN TOPICAL LOTION	3	ST; QL
CORDRAN TOPICAL OINTMENT	3	ST; QL
CUTIVATE TOPICAL CREAM	3	ST
CUTIVATE TOPICAL LOTION	3	ST
DERMA-SMOOTHIE/FS BODY OIL TOPICAL OIL	3	ST
DERMA-SMOOTHIE/FS SCALP OIL SCALP OIL	3	ST
DERMASORB HC COMPLETE KIT TOPICAL COMBO PACK,CLEANSER AND LOTION	3	ST
DERMASORB TA COMPLETE KIT TOPICAL CREAM	3	ST
DERMATOP TOPICAL OINTMENT	3	ST
DESONATE TOPICAL GEL	3	ST
<i>desonide topical cream</i>	1	
<i>desonide topical gel</i>	1	ST
<i>desonide topical lotion</i>	1	ST
<i>desonide topical ointment</i>	1	
DESOWEN TOPICAL LOTION	3	ST

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Drug Name	Drug Tier	Requirements / Limits
<i>desoximetasone topical cream</i>	1	ST
<i>desoximetasone topical gel</i>	1	ST
<i>desoximetasone topical ointment</i>	1	ST
<i>desoximetasone topical spray,non-aerosol</i>	1	ST
<i>diflorasone topical cream</i>	1	ST; QL
<i>diflorasone topical ointment</i>	1	ST; QL
DIPROLENE TOPICAL OINTMENT	3	ST
<i>fluocinolone and shower cap scalp oil</i>	1	
<i>fluocinolone topical cream</i>	1	
<i>fluocinolone topical oil</i>	1	
<i>fluocinolone topical ointment</i>	1	
<i>fluocinolone topical solution</i>	1	
<i>fluocinonide topical cream 0.05 %</i>	1	QL
<i>fluocinonide topical cream 0.1 %</i>	1	ST; QL
<i>fluocinonide topical gel</i>	1	QL
<i>fluocinonide topical ointment</i>	1	QL
<i>fluocinonide topical solution</i>	1	QL
<i>fluocinonide-e topical cream</i>	1	QL

Drug Name	Drug Tier	Requirements / Limits
<i>flurandrenolide topical cream</i>	1	ST; QL
<i>flurandrenolide topical lotion</i>	1	ST; QL
<i>flurandrenolide topical ointment</i>	1	ST; QL
<i>fluticasone propionate topical cream</i>	1	
<i>fluticasone propionate topical lotion</i>	1	ST
<i>fluticasone propionate topical ointment</i>	1	
<i>halcinonide topical cream</i>	1	ST
<i>halobetasol propionate topical cream</i>	1	
HALOBETASOL PROPIONATE TOPICAL FOAM	3	ST
<i>halobetasol propionate topical ointment</i>	1	
HALOG TOPICAL CREAM	3	ST
HALOG TOPICAL OINTMENT	3	ST
HALOG TOPICAL SOLUTION	3	ST
<i>hydrocortisone butyrate topical cream</i>	1	QL
<i>hydrocortisone butyrate topical lotion</i>	1	ST; QL

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Drug Name	Drug Tier	Requirements / Limits
<i>hydrocortisone butyrate topical ointment</i>	1	ST
<i>hydrocortisone butyrate topical solution</i>	1	ST; QL
<i>hydrocortisone butyr-emollient topical cream</i>	1	QL
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	1	
<i>hydrocortisone topical lotion 2.5 %</i>	1	
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	1	
<i>hydrocortisone valerate topical cream</i>	1	
<i>hydrocortisone valerate topical ointment</i>	1	
<i>hydrocortisone-min oil-wht pet topical ointment</i>	1	
IMPOYZ TOPICAL CREAM	3	ST; QL
KENALOG TOPICAL AEROSOL	3	ST; QL
LEXETTE TOPICAL FOAM	3	ST
LOCOID LIPOCREAM TOPICAL CREAM	3	ST; QL
LOCOID TOPICAL CREAM	3	ST; QL

Drug Name	Drug Tier	Requirements / Limits
LOCOID TOPICAL LOTION	3	ST; QL
LOCOID TOPICAL SOLUTION	3	ST; QL
LUXIQ TOPICAL FOAM	3	ST
<i>mometasone topical cream</i>	1	
<i>mometasone topical ointment</i>	1	
<i>mometasone topical solution</i>	1	
<i>nolix topical cream</i>	1	ST; QL
<i>nolix topical lotion</i>	1	ST; QL
OLUX TOPICAL FOAM	3	ST; QL
OLUX-E TOPICAL FOAM	3	ST; QL
PANDEL TOPICAL CREAM	3	ST
<i>prednicarbate topical cream</i>	1	
<i>prednicarbate topical ointment</i>	1	
PROCTOCORT TOPICAL CREAM	3	ST
PSORCON TOPICAL CREAM	3	ST; QL
SCALACORT DK TOPICAL COMBO PACK	3	ST
<i>scalacort topical lotion</i>	1	
SERNIVO TOPICAL SPRAY WITH PUMP	3	ST

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Drug Name	Drug Tier	Requirements / Limits
SYNALAR CREAM KIT TOPICAL CREAM	3	ST
SYNALAR OINTMENT KIT TOPICAL COMBO PACK, OINTMENT AND CREAM	3	ST
SYNALAR TOPICAL CREAM	3	ST
SYNALAR TOPICAL OINTMENT	3	ST
SYNALAR TOPICAL SOLUTION	3	ST
SYNALAR TS TOPICAL KIT	3	ST
TEMOVATE TOPICAL CREAM	3	ST; QL
TEMOVATE TOPICAL OINTMENT	3	ST; QL
TEXACORT TOPICAL SOLUTION	3	ST
TOPICORT TOPICAL CREAM	3	ST
TOPICORT TOPICAL GEL	3	ST
TOPICORT TOPICAL OINTMENT	3	ST
TOPICORT TOPICAL SPRAY, NON-AEROSOL	3	ST
<i>tovet emollient topical foam</i>	1	ST; QL

Drug Name	Drug Tier	Requirements / Limits
<i>triamcinolone acetonide topical aerosol</i>	1	ST; QL
<i>triamcinolone acetonide topical cream</i>	1	
<i>triamcinolone acetonide topical lotion</i>	1	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triamcinolone acetonide topical ointment 0.05 %</i>	1	ST
<i>trianex topical ointment</i>	1	ST
<i>triderm topical cream 0.1 %</i>	1	
<i>triderm topical cream 0.5 %</i>	1	ST
TRIDESILON TOPICAL CREAM	3	ST
ULTRAVATE TOPICAL LOTION	3	ST
VANOS TOPICAL CREAM	3	ST; QL
VERDESO TOPICAL FOAM	3	ST
TOPICAL ENZYMES		
SANTYL TOPICAL OINTMENT	2	QL
TOPICAL SCABICIDES / PEDICULICIDES		
<i>croton topical lotion</i>	1	
ELIMITE TOPICAL CREAM	3	

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Drug Name	Drug Tier	Requirements / Limits
EURAX TOPICAL CREAM	3	
EURAX TOPICAL LOTION	3	
<i>lindane topical shampoo</i>	1	
<i>malathion topical lotion</i>	1	
NATROBA TOPICAL SUSPENSION	3	
OVIDE TOPICAL LOTION	3	
<i>permethrin topical cream</i>	1	
SKLICE TOPICAL LOTION	3	
<i>spinosad topical suspension</i>	1	
ULESFIA TOPICAL LOTION	3	
DIAGNOSTICS & MISCELLANEOUS AGENTS		
ANTIDOTES		
ATROPEN INTRAMUSCULAR PEN INJECTOR 0.5 MG/0.7 ML, 1 MG/0.7 ML, 2 MG/0.7 ML	3	
DUODOTE INTRAMUSCULAR PEN INJECTOR	3	
IRRIGATING SOLUTIONS		
<i>lactated ringers irrigation solution</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>neomycin-polymyxin b gu irrigation solution</i>	1	
PHYSIOLYTE IRRIGATION SOLUTION	3	
PHYSIOSOL IRRIGATION IRRIGATION SOLUTION	3	
<i>ringer's irrigation solution</i>	1	
SORBITOL IRRIGATION SOLUTION	3	
SORBITOL-MANNITOL TRANSURETHRAL SOLUTION	3	
<i>tis-u-sol pentalyte irrigation irrigation solution</i>	1	
MISCELLANEOUS AGENTS		
ABLYSINOL INTRA-ARTERIAL SOLUTION	3	
<i>acamprosate oral tablet, delayed release (dr/ec)</i>	1	
<i>acetic acid irrigation solution</i>	1	
AGRYLIN ORAL CAPSULE	3	
<i>alendronate oral tablet 40 mg</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
AMMONIA N-13 INTRAVENOUS SOLUTION 3.75 MCI TO 37.5 MCI/ML	3	
AMMONUL INTRAVENOUS SOLUTION	3	
AMPHADASE INJECTION SOLUTION	3	
<i>anagrelide oral capsule</i>	1	
ANTABUSE ORAL TABLET	3	
<i>aqua care sodium chloride irrigation solution</i>	1	
<i>aqua care sterile water irrigation solution</i>	1	
AXUMIN INTRAVENOUS SOLUTION	3	
BUPHENYL ORAL POWDER	3	
BUPHENYL ORAL TABLET	3	
<i>caffeine citrate oral solution</i>	1	
CARBAGLU ORAL TABLET, DISPERSIBLE	4	LA
CARNITOR (SUGAR-FREE) ORAL SOLUTION	3	
CARNITOR INTRAVENOUS SOLUTION	3	

Drug Name	Drug Tier	Requirements / Limits
CARNITOR ORAL SOLUTION	3	
CARNITOR ORAL TABLET	3	
<i>cevimeline oral capsule</i>	1	
CHEMET ORAL CAPSULE	2	
CHOLETEC INTRAVENOUS RECON SOLN	3	
<i>clovique oral capsule</i>	1	PA
<i>deferasirox oral granules in packet</i>	4	PA; LA
<i>deferasirox oral tablet</i>	4	PA; LA
<i>deferasirox oral tablet, dispersible</i>	4	PA; LA
<i>disulfiram oral tablet</i>	1	
ENDARI ORAL POWDER IN PACKET	4	PA; LA
EVOXAC ORAL CAPSULE	3	
EXJADE ORAL TABLET, DISPERSIBLE	4	PA; LA
FERRIPROX ORAL SOLUTION	4	PA; LA
FERRIPROX ORAL TABLET	4	PA; LA
FERRLECIT INTRAVENOUS SOLUTION	3	

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Drug Name	Drug Tier	Requirements / Limits
FLUDEOXYGLUCOSE F-18 INTRAVENOUS SOLUTION 20 MCI TO 300 MCI/ML	3	
GIVLAARI SUBCUTANEOUS SOLUTION	4	PA; LA
GLEOLAN ORAL RECON SOLN	3	
HYLENEX INJECTION SOLUTION	3	
<i>ic green injection recon soln</i>	1	
INCRELEX SUBCUTANEOUS SOLUTION	4	PA; LA
<i>indocyanine green injection recon soln</i>	1	
INFASURF INTRATRACHEAL SUSPENSION	3	
JADENU ORAL TABLET	4	PA; LA
JADENU SPRINKLE ORAL GRANULES IN PACKET	4	PA; LA
KIT FOR TC 99M-SESTAMIBI NO.1 INTRAVENOUS RECON SOLN	3	
KIT PREP OF TC-99M-MEBROFENIN INTRAVENOUS RECON SOLN	3	

Drug Name	Drug Tier	Requirements / Limits
KIT PREP OF TC-99M-SOD PYROPH INTRAVENOUS RECON SOLN	3	
<i>levocarnitine (with sugar) oral solution</i>	1	
<i>levocarnitine oral solution 100 mg/ml</i>	1	
<i>levocarnitine oral tablet</i>	1	
LITHOSTAT ORAL TABLET	3	
METOPIRONE ORAL CAPSULE	3	
<i>midodrine oral tablet</i>	1	
MYOVIEW KIT INTRAVENOUS RECON SOLN	3	
<i>nitisinone oral capsule</i>	4	PA; LA
NITYR ORAL TABLET	4	PA; LA
NORTHERA ORAL CAPSULE	4	PA; LA
ORFADIN ORAL CAPSULE	4	PA; LA
ORFADIN ORAL SUSPENSION	4	PA; LA
OXBRYTA ORAL TABLET	4	PA; LA; QL
<i>pilocarpine hcl oral tablet 5 mg</i>	1	
RADIOGARDASE ORAL CAPSULE	3	
RAVICTI ORAL LIQUID	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
RECLAST INTRAVENOUS PIGGYBACK	4	LA
REVCIVI INTRAMUSCULAR SOLUTION	4	PA; LA
RILUTEK ORAL TABLET	3	PA
<i>riluzole oral tablet</i>	1	
<i>risedronate oral tablet 30 mg</i>	1	QL
SALAGEN (PILOCARPINE) ORAL TABLET 5 MG	3	
SINOGRAFIN INJECTION SOLUTION	3	
<i>sodium benzoate-sodium phenylacetate intravenous solution</i>	1	
<i>sodium chlor 0.9% bacteriostat injection solution</i>	1	
<i>sodium chloride 0.9% (flush) injection syringe</i>	1	
<i>sodium chloride 0.9% injection solution</i>	1	
<i>sodium chloride 0.9% intravenous parenteral solution</i>	1	
<i>sodium chloride 0.9% intravenous piggyback</i>	1	
<i>sodium chloride injection syringe</i>	1	
<i>sodium chloride irrigation solution</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>sodium ferric gluconate-sucrose intravenous solution</i>	1	
<i>sodium phenylbutyrate oral powder</i>	1	
<i>sodium phenylbutyrate oral tablet</i>	1	
SOLIRIS INTRAVENOUS SOLUTION	4	PA; LA
SURVANTA INTRATRACHEAL SUSPENSION	3	
SYPRINE ORAL CAPSULE	3	PA
THALLOUS CHLORIDE TL-201 INTRAVENOUS SOLUTION	3	
THIOLA EC ORAL TABLET, DELAYED RELEASE (DR/EC)	4	PA; LA
THIOLA ORAL TABLET	4	PA; LA
TIGLUTIK ORAL SUSPENSION	3	PA
<i>trientine oral capsule</i>	1	PA
ULTOMIRIS INTRAVENOUS SOLUTION	4	PA; LA
<i>water for irrigation, sterile irrigation solution</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
XURIDEN ORAL GRANULES IN PACKET	4	PA; LA
zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml	4	LA
SMOKING DETERRENTS		
bupropion hcl (smoking deter) oral tablet extended release 12 hr	5	ACA
CHANTIX CONTINUING MONTH BOX ORAL TABLET	5	ACA
CHANTIX ORAL TABLET	5	ACA
CHANTIX STARTING MONTH BOX ORAL TABLETS,DOSE PACK	5	ACA
NICODERM CQ TRANSDERMAL PATCH 24 HOUR	5	ACA; OTC; QL
NICORETTE BUCCAL GUM 2 MG	5	ACA; OTC; QL
nicorette buccal gum 4 mg	5	ACA; OTC; QL
NICORETTE BUCCAL LOZENGE	5	ACA; OTC; QL
NICORETTE BUCCAL MINI LOZENGE	5	ACA; OTC; QL

Drug Name	Drug Tier	Requirements / Limits
nicotine (polacrilex) buccal gum	5	ACA; OTC; QL
nicotine (polacrilex) buccal lozenge	5	ACA; OTC; QL
nicotine (polacrilex) buccal mini lozenge	5	ACA; OTC; QL
nicotine transdermal patch 24 hour 14 mg/24 hr, 21 mg/24 hr, 7 mg/24 hr	5	ACA; OTC; QL
nicotine transdermal patch, td daily, sequential	5	ACA; OTC; QL
NICOTROL INHALATION CARTRIDGE	5	ACA
NICOTROL NS NASAL SPRAY, NON-AEROSOL	5	ACA
quit 2 buccal gum	5	ACA; OTC; QL
quit 2 buccal lozenge	5	ACA; OTC; QL
quit 4 buccal gum	5	ACA; OTC; QL
quit 4 buccal lozenge	5	ACA; OTC; QL
stop smoking aid buccal lozenge	5	ACA; OTC; QL
EAR, NOSE & THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine nasal aerosol,spray	1	QL
azelastine nasal spray,non-aerosol	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>chlorhexidine gluconate mucous membrane mouthwash</i>	1	
CLINPRO 5000 DENTAL PASTE	3	
<i>denta 5000 plus dental cream</i>	1	
<i>dentagel dental gel</i>	1	
<i>fluoride (sodium) dental cream</i>	1	
<i>fluoride (sodium) dental gel</i>	1	
<i>fluoride (sodium) dental paste</i>	1	
FLUORIDEX DAILY DEFENSE DENTAL PASTE	3	
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE	3	
GELX MUCOUS MEMBRANE GEL	3	
<i>ipratropium bromide nasal spray,non-aerosol</i>	1	QL
<i>olopatadine nasal spray,non-aerosol</i>	1	QL
<i>oralone dental paste</i>	1	
ORAMAGICRX MUCOUS MEMBRANE MOUTHWASH	3	
<i>paroex oral rinse mucous membrane mouthwash</i>	1	

Drug Name	Drug Tier	Requirements / Limits
PATANASE NASAL SPRAY,NON-AEROSOL	3	QL
PERIDEX MUCOUS MEMBRANE MOUTHWASH	3	
<i>periogard mucous membrane mouthwash</i>	1	
<i>pilocarpine hcl oral tablet 7.5 mg</i>	1	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE	3	
PREVIDENT 5000 DRY MOUTH DENTAL GEL	3	
PREVIDENT 5000 ENAMEL PROTECT DENTAL PASTE	3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE	3	
PREVIDENT 5000 PLUS DENTAL CREAM	3	
PREVIDENT 5000 SENSITIVE DENTAL PASTE	3	
PREVIDENT DENTAL GEL	3	
PREVIDENT DENTAL SOLUTION	3	

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Drug Name	Drug Tier	Requirements / Limits
SALAGEN (PILOCARPINE) ORAL TABLET 7.5 MG	3	
<i>sf 5000 plus dental cream</i>	1	
<i>sf dental gel</i>	1	
<i>sodium fluoride 5000 plus dental cream</i>	1	
<i>sodium fluoride-pot nitrate dental paste</i>	1	
<i>triamcinolone acetonide dental paste</i>	1	
MISCELLANEOUS OTIC PREPARATIONS		
<i>acetic acid otic (ear) solution</i>	1	
<i>ciprofloxacin hcl otic (ear) dropperette</i>	1	
DERMOTIC OIL OTIC (EAR) DROPS	3	
<i>flac otic oil otic (ear) drops</i>	1	
<i>fluocinolone acetonide oil otic (ear) drops</i>	1	
<i>hydrocortisone- acetic acid otic (ear) drops</i>	1	
<i>ofloxacin otic (ear) drops</i>	1	
OTIPRIO INTRATYMPANIC SUSPENSION	3	QL

Drug Name	Drug Tier	Requirements / Limits
OTIC STEROID / ANTIBIOTIC		
CIPRO HC OTIC (EAR) DROPS,SUSPENSION	3	
CIPRODEX OTIC (EAR) DROPS,SUSPENSION	3	
<i>ciprofloxacin- dexamethasone otic (ear) drops,suspension</i>	1	
CIPROFLOXACIN- FLUOCINOLONE OTIC (EAR) SOLUTION	3	
CORTISPORIN-TC OTIC (EAR) DROPS,SUSPENSION	3	
<i>neomycin- polymyxin-hc otic (ear) drops,suspension</i>	1	
<i>neomycin- polymyxin-hc otic (ear) solution</i>	1	
OTOVEL OTIC (EAR) SOLUTION	2	
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
ACTHAR INJECTION GEL	4	PA; LA; QL
BETAMETH AC,SOD PHOS(PF)-WATER INJECTION SUSPENSION	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
BETAMETHASON E ACE,SOD PHOS-WTR INJECTION SUSPENSION	3	
<i>betamethasone acet,sod phos injection suspension</i>	1	
BETAMETHASON E SOD PHOSPH-WATER INJECTION SOLUTION	3	
CELESTONE SOLUSPAN INJECTION SUSPENSION	3	
CORTEF ORAL TABLET	3	
<i>cortisone oral tablet</i>	1	
CORTROSYN INJECTION RECON SOLN	3	
<i>cosyntropin injection recon soln</i>	1	
<i>decadron oral elixir</i>	1	
<i>decadron oral tablet</i>	1	
<i>deltasone oral tablet 20 mg</i>	1	
DEPO-MEDROL INJECTION SUSPENSION	3	
<i>dexabliss oral tablets,dose pack</i>	1	ST
DEXAMETHASON E AC, SOD PH-WATER INJECTION SUSPENSION	3	

Drug Name	Drug Tier	Requirements / Limits
DEXAMETHASON E ACE-NACL,ISO-OSM INJECTION SUSPENSION	3	
<i>dexamethasone intensol oral drops</i>	1	
<i>dexamethasone oral elixir</i>	1	
<i>dexamethasone oral solution</i>	1	
<i>dexamethasone oral tablet</i>	1	
<i>dexamethasone oral tablets,dose pack</i>	1	ST
<i>dexamethasone sodium phos (pf) injection solution</i>	1	
<i>dexamethasone sodium phosphate injection solution</i>	1	
<i>dexamethasone sodium phosphate injection syringe</i>	1	
DXEVO ORAL TABLETS,DOSE PACK	3	ST
EMFLAZA ORAL SUSPENSION	4	PA; LA
EMFLAZA ORAL TABLET	4	PA; LA
<i>fludrocortisone oral tablet</i>	1	
HEMADY ORAL TABLET	3	
<i>hidex oral tablets,dose pack</i>	1	ST
<i>hydrocortisone oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
KENALOG INJECTION SUSPENSION	3	
KENALOG-80 INJECTION SUSPENSION	3	
MEDROL (PAK) ORAL TABLETS,DOSE PACK	3	
MEDROL ORAL TABLET	3	
METHYLPRED AC(PF)-NACL,ISO-OSM INJECTION SUSPENSION	3	
METHYLPREDNISOL AC-BUPIVAC-WAT INJECTION SUSPENSION	3	
<i>methylprednisolone acetate injection suspension</i>	1	
METHYLPREDNISOLONE ACET-WATER INJECTION SUSPENSION 50 MG/ML	3	
<i>methylprednisolone oral tablet</i>	1	
<i>methylprednisolone oral tablets,dose pack</i>	1	
<i>millipred dp oral tablets,dose pack</i>	1	
<i>millipred oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
ORAPRED ODT ORAL TABLET,DISINTEGRATING	3	
<i>prednisolone oral solution 15 mg/5 ml</i>	1	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 15 mg/5 ml (3 mg/ml), 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	1	
<i>prednisolone sodium phosphate oral tablet,disintegrating</i>	1	
<i>prednisone intensol oral concentrate</i>	1	
<i>prednisone oral solution</i>	1	
<i>prednisone oral tablet</i>	1	
<i>prednisone oral tablets,dose pack</i>	1	
RAYOS ORAL TABLET,DELAYED RELEASE (DR/EC)	3	ST
TAPERDEX ORAL TABLETS,DOSE PACK	3	ST
TRIAMCINOL AC (PF) IN 0.9%NACL INJECTION SUSPENSION	3	

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Drug Name	Drug Tier	Requirements / Limits
TRIAMCINOL ACE-BUPIV-0.9% NACL INJECTION SUSPENSION	3	
TRIAMCINOLONE ACETON-0.9% NACL INJECTION SUSPENSION	3	
<i>triamcinolone acetonide injection suspension</i>	1	
TRIAMCINOLONE DIA(PF)-0.9%NACL INJECTION SUSPENSION	3	
TRIAMCINOLONE DIACET-0.9% NACL INJECTION SUSPENSION	3	
TRIESENCE (PF) INTRAOCULAR SUSPENSION	3	
ZCORT ORAL TABLETS,DOSE PACK	3	ST
ANTITHYROID AGENTS		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	
<i>propylthiouracil oral tablet</i>	1	
SSKI ORAL SOLUTION	3	
TAPAZOLE ORAL TABLET	3	
BLOOD GLUCOSE MONITORING DEVICES & SUPPLIES		

Drug Name	Drug Tier	Requirements / Limits
ASSURE PLATINUM TEST STRIP STRIP	3	ST; OTC
CONTOUR NEXT TEST STRIPS STRIP	3	ST; OTC
EASY TRAK II TEST STRIP STRIP	3	ST; OTC
FORA GTEL GLUCOSE TEST STRIP STRIP	3	ST; OTC
GOJJI BLOOD GLUCOSE TEST STRIP STRIP	3	ST; OTC
MICRODOT XTRA BLOOD GLUCOSE STRIP	3	ST; OTC
VIVAGUARD INO TEST STRIP STRIP	3	ST; OTC
DIABETES, SUPPLIES, & DURABLE MEDICAL EQUIPMENT		
GLUCAGON HCL INJECTION RECON SOLN	3	
SPACE CHAMBER SPACER	2	
GLUCOSE ELEVATING AGENTS		
BAQSIMI NASAL SPRAY,NON-AEROSOL	2	QL
<i>diazoxide oral suspension</i>	1	
GLUCAGEN HYPOKIT INJECTION RECON SOLN	2	QL

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Drug Name	Drug Tier	Requirements / Limits
GLUCAGON (HCL) EMERGENCY KIT INJECTION RECON SOLN	2	QL
GLUCAGON EMERGENCY KIT (HUMAN) INJECTION RECON SOLN	2	QL
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR	2	QL
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE	2	QL
PROGLYCEM ORAL SUSPENSION	3	
INSULIN SYRINGES/MISCELLANEOUS DURABLE MEDICAL EQU		
ACCU-CHEK GUIDE ME GLUCOSE MTR	3	OTC
CEQR SIMPLICITY DEVICE	3	
EASY STEP HIGH CONTROL SOLN SOLUTION	3	OTC
EASY TRAK II CTRL SOLN-NORMAL SOLUTION	3	OTC
FORA GTEL MULTI-FUNCTN MONITOR DEVICE	3	OTC

Drug Name	Drug Tier	Requirements / Limits
GENTEEL VACUUM LANCING DEVICE COMBO PACK	3	OTC
GLUCOCARD SHINE CONNEX METER	3	OTC
GLUCOCARD SHINE EXPRESS METER	3	OTC
GOJJI GLUCOSE CNTRL SOL-NORMAL SOLUTION	3	OTC
GOJJI KETONE CONTROL SOLN-L1 SOLUTION	3	OTC
GOJJI MULTI-FUNCTIONAL METER KIT	3	OTC
MINIMED MIO 32" INFUSION SET	2	
MINIMED MIO ADVANCE INF SET 23" INFUSION SET	2	OTC
MINIMED QUICK SET 43" INFUSION SET	2	
MINIMED SILHOUETTE 23" INFUSION SET	2	
MINIMED SURE T 32" INFUSION SET	2	
OMNIPOD DASH 5 PACK POD SUBCUTANEOUS CARTRIDGE	2	

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Drug Name	Drug Tier	Requirements / Limits
ONETOUGH VERIO REFLECT METER	2	OTC
PRECISION XTRA KETONE-GLUCOSE KIT	2	OTC
PREMIER COMPACT GLUCOSE METER KIT	3	OTC
VIVAGUARD INO CTRL SOLN-L1,2,3 SOLUTION	3	OTC
VIVAGUARD INO GLUCOSE METER	3	OTC
INSULIN THERAPY		
ADMELOG SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN	3	ST
ADMELOG U-100 INSULIN LISPRO SUBCUTANEOUS SOLUTION	3	ST
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT, 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT, 8 UNIT (90)/ 12 UNIT (90)	3	
APIDRA SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN	3	ST

Drug Name	Drug Tier	Requirements / Limits
APIDRA U-100 INSULIN SUBCUTANEOUS SOLUTION	3	ST
BASAGLAR KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN	3	
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN	3	ST
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE	3	ST
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION	3	ST
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT	2	
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN	2	
HUMALOG MIX 50-50 INSULN U-100 SUBCUTANEOUS SUSPENSION	2	
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN	2	

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Drug Name	Drug Tier	Requirements / Limits
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN	2	
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION	2	
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE	2	
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION	2	
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION	2	
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN	2	
HUMULIN N NPH INSULIN KWIKPEN SUBCUTANEOUS INSULIN PEN	2	
HUMULIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION	2	
HUMULIN R REGULAR U-100 INSULN INJECTION SOLUTION	2	

Drug Name	Drug Tier	Requirements / Limits
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION	2	
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN	2	
INSULIN ASP PRT-INSULIN ASPART SUBCUTANEOUS INSULIN PEN	3	ST
INSULIN ASP PRT-INSULIN ASPART SUBCUTANEOUS SOLUTION	3	ST
INSULIN ASPART U-100 SUBCUTANEOUS CARTRIDGE	3	ST
INSULIN ASPART U-100 SUBCUTANEOUS INSULIN PEN	3	ST
INSULIN ASPART U-100 SUBCUTANEOUS SOLUTION	3	ST
INSULIN LISPRO PROTAMIN-LISPRO SUBCUTANEOUS INSULIN PEN	3	
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN	3	ST
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN, HALF-UNIT	3	

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Drug Name	Drug Tier	Requirements / Limits
INSULIN LISPRO SUBCUTANEOUS SOLUTION	3	ST
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN	2	
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION	2	
LEVEMIR FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN	2	
LEVEMIR U-100 INSULIN SUBCUTANEOUS SOLUTION	2	
LYUMJEV KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN	2	
LYUMJEV KWIKPEN U-200 INSULIN SUBCUTANEOUS INSULIN PEN	2	
LYUMJEV U-100 INSULIN SUBCUTANEOUS SOLUTION	2	
MYXREDLIN INTRAVENOUS SOLUTION	3	

Drug Name	Drug Tier	Requirements / Limits
NOVOLIN 70-30 100 UNIT/ML VIAL LATEX-FREE 100 UNIT/ML (70-30)	3	ST
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN N 100 UNIT/ML VIAL 100 UNIT/ML	3	ST
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN R 100 UNIT/ML VIAL 100 UNIT/ML	3	ST
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN	3	
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN	3	ST
NOVOLOG MIX 70-30 U-100 INSULIN SUBCUTANEOUS SOLUTION	3	ST
NOVOLOG MIX 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN	3	ST

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Drug Name	Drug Tier	Requirements / Limits
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE	3	ST
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION	3	ST
RELION NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	3	
RELION NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	
RELION NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	3	
SEMGLEE PEN U- 100 INSULIN SUBCUTANEOUS INSULIN PEN	3	
SEMGLEE U-100 INSULIN SUBCUTANEOUS SOLUTION	3	
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN	2	PA; QL
TOUJEO MAX U- 300 SOLOSTAR SUBCUTANEOUS INSULIN PEN	2	

Drug Name	Drug Tier	Requirements / Limits
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN	2	
TRESIBA FLEXTOUCH U- 100 SUBCUTANEOUS INSULIN PEN	2	
TRESIBA FLEXTOUCH U- 200 SUBCUTANEOUS INSULIN PEN	2	
TRESIBA U-100 INSULIN SUBCUTANEOUS SOLUTION	2	
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN	2	PA; QL
MISCELLANEOUS HORMONES		
ACTHREL INTRAVENOUS RECON SOLN	2	
ANADROL-50 ORAL TABLET	3	PA
ANDRODERM TRANSDERMAL PATCH 24 HOUR	2	PA; QL
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	3	PA; QL

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Drug Name	Drug Tier	Requirements / Limits
ANDROGEL TRANSDERMAL GEL IN PACKET	3	PA; QL
ANDROID ORAL CAPSULE	3	PA
AVEED INTRAMUSCULAR SOLUTION	4	PA; LA
<i>cabergoline oral tablet</i>	1	QL
<i>calcitonin (salmon) nasal spray, non-aerosol</i>	1	
<i>calcitriol intravenous solution 1 mcg/ml</i>	1	
<i>calcitriol oral capsule</i>	1	
<i>calcitriol oral solution</i>	1	
CERDELGA ORAL CAPSULE	4	PA; LA
CETROTIDE SUBCUTANEOUS KIT 0.25 MG	4	LA
CHORIONIC GONADOTROPIN, HUMAN INJECTION RECON SOLN	3	LA
CHORIONIC GONADOTROPIN, HUMAN INTRAMUSCULAR RECON SOLN	4	LA; QL
<i>cinacalcet oral tablet</i>	1	
<i>clomiphene citrate oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
CRYSVITA SUBCUTANEOUS SOLUTION	4	PA; LA; QL
<i>danazol oral capsule</i>	1	PA
DDAVP NASAL SOLUTION	2	
DDAVP NASAL SPRAY WITH PUMP	3	
DDAVP ORAL TABLET	3	
DEPO-TESTOSTERONE INTRAMUSCULAR OIL	3	PA
<i>desmopressin nasal spray, non-aerosol</i>	1	
<i>desmopressin oral tablet</i>	1	
<i>doxercalciferol intravenous solution</i>	1	
<i>doxercalciferol oral capsule</i>	1	
FOLLISTIM AQ SUBCUTANEOUS CARTRIDGE	4	ST; LA
FORTESTA TRANSDERMAL GEL IN METERED-DOSE PUMP	3	PA; QL
GALAFOLD ORAL CAPSULE	4	PA; LA; QL
<i>ganirelix subcutaneous syringe</i>	4	ST; LA

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Drug Name	Drug Tier	Requirements / Limits
GONAL-F RFF REDI-JECT SUBCUTANEOUS PEN INJECTOR	4	ST; LA
GONAL-F RFF SUBCUTANEOUS RECON SOLN	4	ST; LA
GONAL-F SUBCUTANEOUS RECON SOLN	4	ST; LA
HECTOROL INTRAVENOUS SOLUTION	3	
ISTURISA ORAL TABLET	4	PA; LA; QL
JATENZO ORAL CAPSULE	3	PA; QL
JYNARQUE ORAL TABLET	4	PA; LA; QL
JYNARQUE ORAL TABLETS, SEQUENTIAL	4	PA; LA; QL
KORLYM ORAL TABLET	4	PA; LA
KUVAN ORAL POWDER IN PACKET	4	PA; LA
KUVAN ORAL TABLET,SOLUBL E	4	PA; LA
MENOPUR SUBCUTANEOUS RECON SOLN	4	LA
METHITEST ORAL TABLET	2	PA
<i>methyltestosterone oral capsule</i>	1	PA

Drug Name	Drug Tier	Requirements / Limits
MIACALCIN INJECTION SOLUTION	2	
<i>miglustat oral capsule</i>	4	PA; LA
MYALEPT SUBCUTANEOUS RECON SOLN	4	PA; LA
<i>nandrolone decanoate intramuscular oil</i>	1	PA
NATESTO NASAL GEL IN METERED-DOSE PUMP	2	PA; QL
NATPARA SUBCUTANEOUS CARTRIDGE	4	PA; LA
NOCDURNA (MEN) SUBLINGUAL TABLET,DISINTE GRATING	3	PA; QL
NOCDURNA (WOMEN) SUBLINGUAL TABLET,DISINTE GRATING	3	PA; QL
NOCTIVA NASAL SPRAY, NON- AEROSOL	3	PA; QL
NOVAREL INTRAMUSCULA R RECON SOLN	4	LA; QL
ORLISSA ORAL TABLET	2	PA; QL
OVIDREL SUBCUTANEOUS SYRINGE	4	LA

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Drug Name	Drug Tier	Requirements / Limits
<i>oxandrolone oral tablet</i>	1	PA
PALYNZIQ SUBCUTANEOUS SYRINGE	4	PA; LA; QL
<i>pamidronate intravenous recon soln</i>	1	
<i>pamidronate intravenous solution</i>	1	
PARICALCITOL HEMODIALYSIS PORT INJECTION SOLUTION	3	
<i>paricalcitol intravenous solution</i>	1	
<i>paricalcitol oral capsule</i>	1	
PREGNYL INTRAMUSCULAR RECON SOLN	4	LA; QL
RAYALDEE ORAL CAPSULE, EXTENDED RELEASE 24 HR	3	
ROCALTROL ORAL CAPSULE	3	
ROCALTROL ORAL SOLUTION	3	
SAMSCA ORAL TABLET	4	PA; LA; QL
<i>sapropterin oral powder in packet</i>	1	PA; LA
<i>sapropterin oral tablet, soluble</i>	1	PA; LA
SENSIPAR ORAL TABLET	3	

Drug Name	Drug Tier	Requirements / Limits
SOMAVERT SUBCUTANEOUS RECON SOLN	4	PA; LA
STIMATE NASAL SPRAY, NON-AEROSOL	4	LA
STRENSIQ SUBCUTANEOUS SOLUTION	4	PA; LA
SYNAREL NASAL SPRAY, NON-AEROSOL	2	
TEPEZZA INTRAVENOUS RECON SOLN	4	LA
TESTIM TRANSDERMAL GEL	3	PA; QL
TESTOPEL IMPLANT PELLETT	4	PA; LA
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	1	PA
TESTOSTERONE CYPIONATE INTRAMUSCULAR OIL 50 MG/ML	3	PA
<i>testosterone enanthate intramuscular oil</i>	1	PA
TESTOSTERONE IMPLANT PELLETT 200 MG	3	PA
<i>testosterone propionate intramuscular oil</i>	1	PA
<i>testosterone transdermal gel</i>	1	PA; QL

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Drug Name	Drug Tier	Requirements / Limits
<i>testosterone transdermal gel in metered-dose pump</i>	1	PA; QL
<i>testosterone transdermal gel in packet</i>	1	PA; QL
<i>testosterone transdermal solution in metered pump w/app</i>	1	PA; QL
TESTRED ORAL CAPSULE	3	PA
<i>tolvaptan oral tablet 30 mg</i>	4	PA; LA; QL
VAPRISOL IN 5 % DEXTROSE INTRAVENOUS SOLUTION	3	
VOGELXO TRANSDERMAL GEL	3	PA; QL
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	3	PA; QL
VOGELXO TRANSDERMAL GEL IN PACKET	3	PA; QL
XYOSTED SUBCUTANEOUS AUTO-INJECTOR	3	PA
ZAVESCA ORAL CAPSULE	4	PA; LA
ZEMPLAR INTRAVENOUS SOLUTION	3	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	3	

Drug Name	Drug Tier	Requirements / Limits
NON-INSULIN HYPOGLYCEMIC AGENTS		
<i>acarbose oral tablet</i>	1	
ACTOPLUS MET ORAL TABLET	3	QL
ACTOPLUS MET XR ORAL TABLET, ER MULTIPHASE 24 HR 15-1,000 MG	3	QL
ACTOS ORAL TABLET	3	QL
ADLYXIN SUBCUTANEOUS PEN INJECTOR	3	ST; QL
ALOGLIPTIN ORAL TABLET	3	ST; QL
ALOGLIPTIN-METFORMIN ORAL TABLET	3	ST; QL
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET	3	ST; QL
AMARYL ORAL TABLET	3	
AVANDIA ORAL TABLET 2 MG, 4 MG	3	QL
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR	2	QL
BYDUREON SUBCUTANEOUS PEN INJECTOR	2	QL
BYETTA SUBCUTANEOUS PEN INJECTOR	2	QL

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Drug Name	Drug Tier	Requirements / Limits
CYCLOSET ORAL TABLET	3	
DUETACT ORAL TABLET	3	QL
FARXIGA ORAL TABLET	2	ST; QL
<i>glimepiride oral tablet</i>	1	
<i>glipizide oral tablet</i>	1	
<i>glipizide oral tablet extended release 24hr</i>	1	
<i>glipizide-metformin oral tablet</i>	1	
GLUCOPHAGE ORAL TABLET	3	
GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR	3	QL
GLUCOTROL ORAL TABLET	3	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR	3	
<i>glyburide micronized oral tablet</i>	1	
<i>glyburide oral tablet</i>	1	
<i>glyburide-metformin oral tablet</i>	1	
GLYNASE ORAL TABLET	3	
GLYSET ORAL TABLET	3	
GLYXAMBI ORAL TABLET	2	ST; QL

Drug Name	Drug Tier	Requirements / Limits
INVOKAMET ORAL TABLET	2	ST; QL
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR	2	ST; QL
INVOKANA ORAL TABLET	2	ST; QL
JANUMET ORAL TABLET	2	QL
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR	2	QL
JANUVIA ORAL TABLET	2	QL
JARDIANCE ORAL TABLET	2	ST; QL
JENTADUETO ORAL TABLET	2	QL
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR	2	QL
KAZANO ORAL TABLET	3	ST; QL
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR	3	ST; QL
<i>metformin oral solution</i>	1	PA
<i>metformin oral tablet</i>	1	
<i>metformin oral tablet extended release 24 hr</i>	1	QL
<i>miglitol oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>nateglinide oral tablet</i>	1	
NESINA ORAL TABLET	3	ST; QL
ONGLYZA ORAL TABLET	3	ST; QL
OSENI ORAL TABLET	3	ST; QL
OZEMPIC SUBCUTANEOUS PEN INJECTOR	2	QL
<i>pioglitazone oral tablet</i>	1	QL
<i>pioglitazone-glimepiride oral tablet</i>	1	QL
<i>pioglitazone-metformin oral tablet</i>	1	QL
PRANDIN ORAL TABLET 1 MG, 2 MG	3	
PRECOSE ORAL TABLET	3	
QTERN ORAL TABLET	3	ST
<i>repaglinide oral tablet</i>	1	
<i>repaglinide-metformin oral tablet</i>	1	QL
RIOMET ER ORAL SUSPENSION,EXTENDED REL RECON	3	PA
RIOMET ORAL SOLUTION	3	PA
RYBELSUS ORAL TABLET	2	QL

Drug Name	Drug Tier	Requirements / Limits
SEGLUROMET ORAL TABLET	2	ST; QL
STARLIX ORAL TABLET	3	
STEGLATRO ORAL TABLET	2	ST; QL
STEGLUJAN ORAL TABLET	2	ST; QL
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR	2	QL
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR	2	QL
SYNJARDY ORAL TABLET	2	ST; QL
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR	2	ST; QL
TRADJENTA ORAL TABLET	2	QL
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR	2	ST
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML	2	QL
TRULICITY SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML, 4.5 MG/0.5 ML	2	
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR	2	ST; QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR	2	ST; QL
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR	2	ST; QL
THYROID HORMONES		
ARMOUR THYROID ORAL TABLET	2	
CYTOMEL ORAL TABLET	3	
<i>euthyrox oral tablet</i>	1	
<i>levo-t oral tablet</i>	1	
<i>levothyroxine intravenous recon soln 100 mcg</i>	2	
<i>levothyroxine intravenous recon soln 200 mcg, 500 mcg</i>	1	
LEVOTHYROXINE INTRAVENOUS SOLUTION	3	
<i>levothyroxine oral tablet</i>	1	
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>liothyronine intravenous solution</i>	1	
<i>liothyronine oral tablet</i>	1	
<i>nature-throid oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>np thyroid oral tablet</i>	1	
SYNTHROID ORAL TABLET	3	
<i>thyroid (pork) oral tablet</i>	1	
THYROLAR-1 ORAL TABLET	3	
THYROLAR-1/2 ORAL TABLET	3	
THYROLAR-1/4 ORAL TABLET	3	
THYROLAR-2 ORAL TABLET	3	
THYROLAR-3 ORAL TABLET	3	
TIROSINT ORAL CAPSULE	3	
TIROSINT-SOL ORAL SOLUTION	3	
TRIOSTAT INTRAVENOUS SOLUTION	3	
<i>unithroid oral tablet</i>	1	
<i>westhroid oral tablet 130 mg, 195 mg, 32.5 mg, 65 mg, 97.5 mg</i>	1	
WP THYROID ORAL TABLET	3	
GASTROENTEROLOGY		
ANTIDIARRHEALS & ANTISPASMODICS		
<i>atropine in 0.9 % sod chloride intravenous syringe 0.8 mg/2 ml (0.4 mg/ml)</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
ATROPINE IN 0.9 % SOD CHLORIDE INTRAVENOUS SYRINGE 1 MG/2.5 ML (0.4 MG/ML), 1.2 MG/3 ML (0.4 MG/ML), 2 MG/5 ML (0.4 MG/ML)	3	
<i>atropine injection syringe 0.05 mg/ml, 0.1 mg/ml</i>	1	
BENTYL INTRAMUSCULAR SOLUTION	3	
<i>chlordiazepoxide-clidinium oral capsule</i>	1	
CUVPOSA ORAL SOLUTION	3	
<i>dicyclomine intramuscular solution</i>	1	
<i>dicyclomine oral capsule</i>	1	
<i>dicyclomine oral solution</i>	1	
<i>dicyclomine oral tablet</i>	1	
<i>diphenoxylate-atropine oral tablet</i>	1	
DONNATAL ORAL ELIXIR 16.2-0.1037 -0.0194 MG/5 ML	3	
DONNATAL ORAL TABLET	3	
GLYCATE ORAL TABLET	3	

Drug Name	Drug Tier	Requirements / Limits
GLYCOPYRROLATE (PF) IN WATER INJECTION SYRINGE	3	
<i>glycopyrrolate (pf) in water intravenous syringe 0.4 mg/2 ml (0.2 mg/ml), 1 mg/5 ml (0.2 mg/ml)</i>	1	
GLYCOPYRROLATE (PF) IN WATER INTRAVENOUS SYRINGE 0.6 MG/3 ML (0.2 MG/ML)	3	
<i>glycopyrrolate injection solution</i>	1	
GLYCOPYRROLATE INTRAVENOUS SYRINGE	3	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	
GLYRX-PF INJECTION SOLUTION	3	
HYOSCYAMINE SULFATE INJECTION SOLUTION	3	
LIBRAX (WITH CLIDINIUM) ORAL CAPSULE	3	
LOMOTIL ORAL TABLET	3	
<i>loperamide oral capsule</i>	1	
<i>methscopolamine oral tablet</i>	1	
MOTOFEN ORAL TABLET	3	

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Drug Name	Drug Tier	Requirements / Limits
MYTESI ORAL TABLET, DELAYED RELEASE (DR/EC)	3	
<i>phenobarb-hyoscy-atropine-scop oral elixir 16.2-0.1037 - 0.0194 mg/5 ml</i>	1	
<i>phenobarb-hyoscy-atropine-scop oral tablet</i>	1	
<i>phenohydro oral elixir 16.2-0.1037 - 0.0194 mg/5 ml</i>	1	
<i>phenohydro oral tablet</i>	1	
<i>propantheline oral tablet</i>	1	
MISCELLANEOUS GASTROINTESTINAL AGENTS		
ACTIGALL ORAL CAPSULE	3	
AKYNZEO (FOSNETUPITANT) INTRAVENOUS RECON SOLN	3	
AKYNZEO (FOSNETUPITANT) INTRAVENOUS SOLUTION	3	
AKYNZEO (NETUPITANT) ORAL CAPSULE	3	QL
<i>alophen (bisacodyl) oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>alosetron oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
ALOXI INTRAVENOUS SOLUTION	3	
AMITIZA ORAL CAPSULE	3	PA; QL
ANA-LEX KIT RECTAL KIT	3	
ANALPRAM-HC RECTAL CREAM 1-1 %	3	
ANUSOL-HC TOPICAL CREAM WITH PERINEAL APPLICATOR	3	ST
<i>aprepitant oral capsule</i>	1	QL
<i>aprepitant oral capsule, dose pack</i>	1	QL
APRISO ORAL CAPSULE, EXTENDED RELEASE 24HR	3	
ASACOL HD ORAL TABLET, DELAYED RELEASE (DR/EC)	3	ST
AURYXIA ORAL TABLET	3	PA
AZULFIDINE ENTABS ORAL TABLET, DELAYED RELEASE (DR/EC)	3	ST
AZULFIDINE ORAL TABLET	3	ST
<i>balsalazide oral capsule</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
BARHEMSYS INTRAVENOUS SOLUTION	3	
<i>bisacodyl oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>bisa-lax (bisacodyl) oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
BONJESTA ORAL TABLET, IR, DELAYED REL, BIPHASIC	3	PA; QL
<i>budesonide oral capsule, delayed, extended release</i>	1	
<i>budesonide oral tablet, delayed and extended release</i>	1	
<i>calcium acetate (phosphate bind) oral capsule</i>	1	
<i>calcium acetate (phosphate bind) oral tablet</i>	1	
CANASA RECTAL SUPPOSITORY	3	
CHENODAL ORAL TABLET	4	LA
CHOLBAM ORAL CAPSULE 250 MG	4	PA; LA
CHOLBAM ORAL CAPSULE 50 MG	4	PA; LA; QL
CIMZIA POWDER FOR RECONSTITUTION SUBCUTANEOUS KIT	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
CIMZIA SUBCUTANEOUS SYRINGE KIT	4	PA; LA; QL
CINVANTI INTRAVENOUS EMULSION	2	
<i>citrate of magnesia oral solution</i>	5	ACA; OTC
<i>citroma oral solution</i>	5	ACA; OTC
<i>clearlax oral powder</i>	5	ACA; OTC
<i>clearlax oral powder in packet</i>	5	ACA; OTC
CLENPIQ ORAL SOLUTION	5	ACA
COLAZAL ORAL CAPSULE	3	ST
<i>colocort rectal enema</i>	1	
COLYTE WITH FLAVOR PACKS ORAL RECONSTITUTION SOLUTION 240-22.72-6.72 -5.84 GRAM	3	
COMPAZINE ORAL TABLET	3	
COMPAZINE RECTAL SUPPOSITORY	3	
<i>compro rectal suppository</i>	1	
<i>constulose oral solution</i>	1	
CORTENEMA RECTAL ENEMA	3	
CORTIFOAM RECTAL FOAM	3	

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Drug Name	Drug Tier	Requirements / Limits
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC)	2	
<i>cromolyn oral concentrate</i>	1	
CYSTADANE ORAL POWDER	4	LA
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	3	ST
DICLEGIS ORAL TABLET,DELAYED RELEASE (DR/EC)	3	PA; QL
<i>dimenhydrinate injection solution</i>	1	
DIPENTUM ORAL CAPSULE	3	ST
<i>doxylamine-pyridoxine (vit b6) oral tablet,delayed release (dr/ec)</i>	1	PA; QL
<i>dronabinol oral capsule</i>	1	
<i>droperidol injection solution</i>	1	
<i>ducodyl (bisacodyl) oral tablet,delayed release (dr/ec)</i>	5	ACA; OTC
EMEND (FOSAPREPITANT) INTRAVENOUS RECON SOLN	3	
EMEND ORAL CAPSULE 40 MG, 80 MG	3	QL

Drug Name	Drug Tier	Requirements / Limits
EMEND ORAL CAPSULE,DOSE PACK	3	QL
EMEND ORAL SUSPENSION FOR RECONSTITUTION	3	QL
ENTEREG ORAL CAPSULE	3	
ENTOCORT EC ORAL CAPSULE,DELAYED,EXTEND.RELEASE	3	
ENTYVIO INTRAVENOUS RECON SOLN	4	PA; LA
<i>enulose oral solution</i>	1	
<i>fosaprepitant intravenous recon soln</i>	1	
FOSRENOL ORAL POWDER IN PACKET	3	
FOSRENOL ORAL TABLET,CHEWABLE	3	
GASTROCROM ORAL CONCENTRATE	3	
GATTEX 30-VIAL SUBCUTANEOUS KIT	4	PA; LA
<i>gavilax oral powder</i>	5	ACA; OTC
<i>gavilyte-c oral recon soln</i>	5	ACA
<i>gavilyte-g oral recon soln</i>	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
<i>gavilyte-n oral recon soln</i>	5	ACA
<i>generlac oral solution</i>	1	
<i>gentle laxative (bisacodyl) oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>gentlelax oral powder</i>	5	ACA; OTC
GIALAX ORAL KIT	5	ACA
GIMOTI NASAL SPRAY WITH PUMP	3	ST
<i>glycolax oral powder</i>	5	ACA; OTC
GOLYTELY ORAL POWDER IN PACKET	5	ACA
GOLYTELY ORAL RECON SOLN	3	
<i>granisetron (pf) intravenous solution 1 mg/ml (1 ml)</i>	1	
<i>granisetron hcl intravenous solution</i>	1	
<i>granisetron hcl oral tablet</i>	1	QL
<i>healthylax oral powder in packet</i>	5	ACA; OTC
<i>hydrocortisone acetate rectal suppository 25 mg</i>	1	
<i>hydrocortisone rectal enema</i>	1	
<i>hydrocortisone topical cream with perineal applicator</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>hydrocortisone-pramoxine rectal cream</i>	1	
KINEVAC INJECTION RECON SOLN	2	
<i>kionex (with sorbitol) oral suspension</i>	1	
KRISTALOSE ORAL PACKET	3	
<i>lactulose oral solution 10 gram/15 ml, 20 gram/30 ml</i>	1	
<i>lanthanum oral tablet, chewable</i>	1	
<i>laxaclear oral powder</i>	5	ACA; OTC
<i>laxative (bisacodyl) oral tablet</i>	5	ACA; OTC
<i>laxative (bisacodyl) oral tablet, delayed release (dr/ec)</i>	5	ACA; OTC
<i>laxative peg 3350 oral powder</i>	5	ACA; OTC
LIALDA ORAL TABLET, DELAYED RELEASE (DR/EC)	3	ST
LINZESS ORAL CAPSULE	2	PA; QL
LOKELMA ORAL POWDER IN PACKET	2	QL
LOTRONEX ORAL TABLET	3	
<i>magnesium citrate oral solution</i>	5	ACA; OTC

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Drug Name	Drug Tier	Requirements / Limits
MARINOL ORAL CAPSULE	3	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	1	
<i>mesalamine oral capsule (with del rel tablets)</i>	1	
<i>mesalamine oral capsule, extended release 24hr</i>	1	
<i>mesalamine oral tablet, delayed release (dr/ec)</i>	1	
<i>mesalamine rectal enema</i>	1	
<i>mesalamine rectal suppository</i>	1	
<i>mesalamine with cleansing wipe rectal enema kit</i>	1	
<i>metoclopramide hcl injection solution</i>	1	
<i>metoclopramide hcl injection syringe</i>	1	
<i>metoclopramide hcl oral solution</i>	1	ST
<i>metoclopramide hcl oral tablet</i>	1	
<i>metoclopramide hcl oral tablet, disintegrating</i>	1	ST
<i>milk of magnesia concentrated oral suspension</i>	5	ACA; OTC
<i>milk of magnesia oral suspension</i>	5	ACA; OTC
<i>miralax oral powder in packet</i>	5	ACA; OTC

Drug Name	Drug Tier	Requirements / Limits
MOTEGRITY ORAL TABLET	3	PA; QL
MOVANTIK ORAL TABLET	2	PA; QL
MOVIPREP ORAL POWDER IN PACKET	5	ACA
<i>natura-lax oral powder</i>	5	ACA; OTC
NULYTELY LEMON-LIME ORAL RECON SOLN	5	ACA
NULYTELY WITH FLAVOR PACKS ORAL RECON SOLN	3	
OCALIVA ORAL TABLET	4	PA; LA; QL
<i>ondansetron hcl (pf) injection solution</i>	1	
<i>ondansetron hcl (pf) injection syringe</i>	1	
<i>ondansetron hcl intravenous solution</i>	1	
<i>ondansetron hcl oral solution</i>	1	QL
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	QL
<i>ondansetron oral tablet, disintegrating</i>	1	QL
<i>oral saline laxative oral liquid</i>	5	ACA; OTC
ORTIKOS ORAL CAPSULE, EXTENDED RELEASE	3	
OSMOPREP ORAL TABLET	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
PALONOSETRON INTRAVENOUS SOLUTION 0.25 MG/2 ML	3	
<i>palonosetron intravenous solution 0.25 mg/5 ml</i>	1	
<i>palonosetron intravenous syringe</i>	1	
PANCREAZE ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 10,500-35,500-61,500 UNIT, 16,800-56,800-98,400 UNIT, 2,600-6,200- 10,850 UNIT, 21,000-54,700-83,900 UNIT, 4,200-14,200- 24,600 UNIT	3	ST
PEDIA-LAX ORAL TABLET,CHEWABLE	5	ACA; OTC
<i>peg 3350-electrolytes oral recon soln</i>	5	ACA
<i>peg3350-sod sul-nacl-kcl-asb-c oral powder in packet</i>	5	ACA
<i>peg-electrolyte soln oral recon soln</i>	5	ACA
<i>peg-prep oral kit</i>	5	ACA
PENTASA ORAL CAPSULE, EXTENDED RELEASE	2	

Drug Name	Drug Tier	Requirements / Limits
PERTZYE ORAL CAPSULE,DELAY ED RELEASE(DR/EC)	3	ST
PHOSLYRA ORAL SOLUTION	2	
<i>phosphate laxative oral liquid</i>	5	ACA; OTC
PLENVU ORAL POWDER IN PACKET, SEQUENTIAL	5	ACA
<i>polyethylene glycol 3350 oral powder</i>	5	ACA; OTC
<i>polyethylene glycol 3350 oral powder in packet</i>	5	ACA; OTC
<i>powderlax oral powder</i>	5	ACA; OTC
<i>powderlax oral powder in packet</i>	5	ACA; OTC
<i>prochlorperazine edisylate injection solution</i>	1	
<i>prochlorperazine maleate oral tablet</i>	1	
<i>prochlorperazine rectal suppository</i>	1	
PROCTOFOAM HC RECTAL FOAM	3	ST
<i>procto-med hc topical cream with perineal applicator</i>	1	
<i>procto-pak topical cream with perineal applicator</i>	1	
<i>proctosol hc topical cream with perineal applicator</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>proctozone-hc topical cream with perineal applicator</i>	1	
<i>purelax oral powder</i>	5	ACA; OTC
<i>purelax oral powder in packet</i>	5	ACA; OTC
RECTIV RECTAL OINTMENT	2	
REGLAN ORAL TABLET	3	ST
RELISTOR ORAL TABLET	2	PA
RELISTOR SUBCUTANEOUS SOLUTION	2	PA
RELISTOR SUBCUTANEOUS SYRINGE	2	PA
RENAGEL ORAL TABLET 800 MG	3	
RENVELA ORAL POWDER IN PACKET	3	
RENVELA ORAL TABLET	3	
ROWASA RECTAL ENEMA KIT	3	
SANCUSO TRANSDERMAL PATCH WEEKLY	3	QL
<i>scopolamine base transdermal patch 3 day</i>	1	
<i>sevelamer carbonate oral powder in packet</i>	1	
<i>sevelamer carbonate oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>sevelamer hcl oral tablet</i>	1	
SFROWASA RECTAL ENEMA	3	
<i>smoothlax oral powder</i>	5	ACA; OTC
<i>smoothlax oral powder in packet</i>	5	ACA; OTC
<i>sodium polystyrene (sorb free) oral suspension</i>	1	
<i>sodium polystyrene sulfonate oral powder</i>	1	
SOLESTA IMPLANT GEL FOR IMPLANT IN SYRINGE	4	LA
<i>sps (with sorbitol) oral suspension</i>	1	
<i>sps (with sorbitol) rectal enema</i>	1	
SUCRAID ORAL SOLUTION	4	LA
<i>sulfasalazine oral tablet</i>	1	
<i>sulfasalazine oral tablet, delayed release (dr/ec)</i>	1	
SUPREP BOWEL PREP KIT ORAL RECON SOLN	5	ACA
SUSTOL SUBCUTANEOUS LIQUID, EXTENDED RELEASE SYRINGE	3	
SYMPROIC ORAL TABLET	2	PA

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Drug Name	Drug Tier	Requirements / Limits
SYNDROS ORAL SOLUTION	3	
TIGAN INTRAMUSCULAR SOLUTION	3	
TIGAN ORAL CAPSULE 300 MG	3	
TRANSDERM-SCOP TRANSDERMAL PATCH 3 DAY	3	
<i>trilyte with flavor packets oral recon soln</i>	5	ACA
<i>trimethobenzamide oral capsule</i>	1	
TRULANCE ORAL TABLET	2	PA
UCERIS ORAL TABLET,DELAYED AND EXT.RELEASE	3	
UCERIS RECTAL FOAM	2	
URSO 250 ORAL TABLET	3	
URSO FORTE ORAL TABLET	3	
<i>ursodiol oral capsule</i>	1	
<i>ursodiol oral tablet</i>	1	
VARUBI ORAL TABLET	2	QL
VELPHORO ORAL TABLET,CHEWABLE	2	
VELTASSA ORAL POWDER IN PACKET	3	QL

Drug Name	Drug Tier	Requirements / Limits
VIBERZI ORAL TABLET	2	PA
VIOKACE ORAL TABLET	2	
<i>women's gentle laxative(bisac) oral tablet,delayed release (dr/ec)</i>	5	ACA; OTC
<i>women's laxative (bisacodyl) oral tablet</i>	5	ACA; OTC
<i>women's laxative (bisacodyl) oral tablet,delayed release (dr/ec)</i>	5	ACA; OTC
ZELNORM ORAL TABLET	3	PA
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 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	2	
ZOFRAN ORAL TABLET 4 MG	3	QL
ZUPLENZ ORAL FILM	3	QL

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You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
ACIPHEX ORAL TABLET,DELAYED RELEASE (DR/EC)	3	ST
ACIPHEX SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE	3	ST; QL
<i>amoxicil-clarithromy-lansopraz oral combo pack</i>	1	QL
CARAFATE ORAL SUSPENSION	3	
CARAFATE ORAL TABLET	3	
<i>cimetidine hcl oral solution</i>	1	
<i>cimetidine oral tablet</i>	1	
CYTOTEC ORAL TABLET	3	
DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 30 MG	3	ST; QL
DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 60 MG	3	ST
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg</i>	1	ST; QL
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg</i>	1	ST

Drug Name	Drug Tier	Requirements / Limits
<i>esomeprazole magnesium oral granules dr for susp in packet 10 mg, 20 mg</i>	1	ST; QL
<i>esomeprazole magnesium oral granules dr for susp in packet 40 mg</i>	1	ST
<i>esomeprazole sodium intravenous recon soln</i>	1	
ESOMEPRAZOLE STRONTIUM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 49.3 MG	3	ST
<i>famotidine (pf) intravenous solution</i>	1	
<i>famotidine (pf)-nacl (iso-os) intravenous piggyback</i>	1	
FAMOTIDINE IN 0.9 % NACL INTRAVENOUS SYRINGE 20 MG/10 ML	3	
<i>famotidine intravenous solution</i>	1	
<i>famotidine oral suspension</i>	1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	
HELIDAC ORAL COMBO PACK	3	
<i>lansoprazole oral capsule,delayed release(dr/ec) 15 mg</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>lansoprazole oral capsule, delayed release(dr/ec) 30 mg</i>	1	
<i>lansoprazole oral tablet, disintegrat, delay rel 15 mg</i>	1	QL
<i>lansoprazole oral tablet, disintegrat, delay rel 30 mg</i>	1	
<i>misoprostol oral tablet</i>	1	
NEXIUM IV INTRAVENOUS RECON SOLN 40 MG	3	
NEXIUM ORAL CAPSULE, DELAYED RELEASE(DR/EC) 20 MG	3	ST; QL
NEXIUM ORAL CAPSULE, DELAYED RELEASE(DR/EC) 40 MG	3	ST
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG	3	ST; QL
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	3	ST
<i>nizatidine oral capsule</i>	1	
<i>nizatidine oral solution</i>	1	

Drug Name	Drug Tier	Requirements / Limits
OMECLAMOX-PAK ORAL COMBO PACK	3	QL
<i>omeprazole oral capsule, delayed release(dr/ec) 10 mg</i>	1	QL
<i>omeprazole oral capsule, delayed release(dr/ec) 20 mg, 40 mg</i>	1	
<i>omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram</i>	1	ST; QL
<i>omeprazole-sodium bicarbonate oral capsule 40-1.1 mg-gram</i>	1	ST
<i>omeprazole-sodium bicarbonate oral packet 20-1,680 mg</i>	1	ST; QL
<i>omeprazole-sodium bicarbonate oral packet 40-1,680 mg</i>	1	ST
<i>pantoprazole intravenous recon soln</i>	1	
<i>pantoprazole oral granules dr for susp in packet</i>	1	
<i>pantoprazole oral tablet, delayed release (dr/ec) 20 mg</i>	1	QL
<i>pantoprazole oral tablet, delayed release (dr/ec) 40 mg</i>	1	
PEPCID ORAL TABLET	3	

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Drug Name	Drug Tier	Requirements / Limits
PREVACID ORAL CAPSULE,DELAYED RELEASE(DR/EC) 15 MG	3	ST; QL
PREVACID ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 MG	3	ST
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG	3	ST; QL
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 30 MG	3	ST
PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON	3	ST; QL
PROTONIX INTRAVENOUS RECON SOLN	3	
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET	3	ST
PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 20 MG	3	ST; QL
PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 40 MG	3	ST
PYLERA ORAL CAPSULE	3	

Drug Name	Drug Tier	Requirements / Limits
RABEPRAZOLE ORAL CAPSULE, DELAYED REL SPRINKLE	3	ST; QL
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	1	ST
<i>ranitidine hcl injection solution</i>	1	
<i>ranitidine hcl oral capsule</i>	1	
<i>ranitidine hcl oral syrup</i>	1	
<i>ranitidine hcl oral tablet 150 mg, 300 mg</i>	1	
<i>sucralfate oral suspension</i>	1	
<i>sucralfate oral tablet</i>	1	
TALICIA ORAL CAPSULE,IR - DELAY REL,BIPHASE	2	QL
ZANTAC INJECTION SOLUTION	3	
ZEGERID ORAL CAPSULE 20-1.1 MG-GRAM	3	ST; QL
ZEGERID ORAL CAPSULE 40-1.1 MG-GRAM	3	ST
ZEGERID ORAL PACKET 20-1,680 MG	3	ST; QL
ZEGERID ORAL PACKET 40-1,680 MG	3	ST

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Drug Name	Drug Tier	Requirements / Limits
IMMUNOLOGY, VACCINES & BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	4	PA; LA
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	4	PA; LA
EPOGEN INJECTION SOLUTION 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	4	PA; LA
FULPHILA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
GRANIX SUBCUTANEOUS SOLUTION	4	PA; LA
GRANIX SUBCUTANEOUS SYRINGE	4	PA; LA
LEUKINE INJECTION RECON SOLN	4	PA; LA
MACRILEN ORAL RECON SOLN	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
MIRCERA INJECTION SYRINGE	4	PA; LA
MOZOBIL SUBCUTANEOUS SOLUTION	4	LA
NEULASTA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
NEULASTA SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR	4	PA; LA; QL
NEUPOGEN INJECTION SOLUTION	4	PA; LA
NEUPOGEN INJECTION SYRINGE	4	PA; LA
NIVESTYM INJECTION SOLUTION	4	PA; LA
NIVESTYM SUBCUTANEOUS SYRINGE	4	PA; LA
PROCRIT INJECTION SOLUTION	4	PA; LA
REBLOZYL SUBCUTANEOUS RECON SOLN	4	PA; LA
RETACRIT INJECTION SOLUTION	4	PA; LA
UDENYCA SUBCUTANEOUS SYRINGE	4	PA; LA; QL

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Drug Name	Drug Tier	Requirements / Limits
ZARXIO INJECTION SYRINGE	4	PA; LA
ZIEXTENZO SUBCUTANEOUS SYRINGE	4	PA; LA
GROWTH HORMONES		
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	4	PA; LA
EGRIFTA SV SUBCUTANEOUS RECON SOLN	4	PA; LA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE	4	PA; LA
GENOTROPIN SUBCUTANEOUS CARTRIDGE	4	PA; LA
HUMATROPE INJECTION CARTRIDGE	4	PA; LA
HUMATROPE INJECTION RECON SOLN	4	PA; LA
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR	4	PA; LA
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR	4	PA; LA
OMNITROPE SUBCUTANEOUS CARTRIDGE	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
OMNITROPE SUBCUTANEOUS RECON SOLN	4	PA; LA
SAIZEN SAIZENPREP SUBCUTANEOUS CARTRIDGE	4	PA; LA
SAIZEN SUBCUTANEOUS RECON SOLN	4	PA; LA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	4	PA; LA
ZOMACTON SUBCUTANEOUS RECON SOLN	4	PA; LA
ZORBTIVE SUBCUTANEOUS RECON SOLN	4	PA; LA
INTERFERONS		
AUBAGIO ORAL TABLET	4	PA; LA
AVONEX (WITH ALBUMIN) INTRAMUSCULAR KIT	4	PA; LA; QL
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	4	PA; LA; QL
AVONEX INTRAMUSCULAR SYRINGE KIT	4	PA; LA; QL
BAFIERTAM ORAL CAPSULE, DELAYED RELEASE (DR/EC)	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
BETASERON SUBCUTANEOUS KIT	4	PA; LA; QL
COPAXONE SUBCUTANEOUS SYRINGE	4	PA; LA; QL
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 240 mg</i>	4	PA; LA
EXTAVIA SUBCUTANEOUS KIT	4	PA; LA; QL
EXTAVIA SUBCUTANEOUS RECON SOLN	4	PA; LA; QL
GILENYA ORAL CAPSULE 0.5 MG	4	PA; LA
<i>glatiramer subcutaneous syringe</i>	4	PA; LA; QL
<i>glatopa subcutaneous syringe</i>	4	PA; LA; QL
KESIMPTA PEN SUBCUTANEOUS PEN INJECTOR	4	PA; LA
MAVENCLAD (10 TABLET PACK) ORAL TABLET	4	PA; LA; QL
MAVENCLAD (4 TABLET PACK) ORAL TABLET	4	PA; LA; QL
MAVENCLAD (5 TABLET PACK) ORAL TABLET	4	PA; LA; QL
MAVENCLAD (6 TABLET PACK) ORAL TABLET	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
MAVENCLAD (7 TABLET PACK) ORAL TABLET	4	PA; LA; QL
MAVENCLAD (8 TABLET PACK) ORAL TABLET	4	PA; LA; QL
MAVENCLAD (9 TABLET PACK) ORAL TABLET	4	PA; LA; QL
MAYZENT ORAL TABLET	4	PA; LA; QL
OCREVUS INTRAVENOUS SOLUTION	4	PA; LA
PEGASYS SUBCUTANEOUS SOLUTION	4	LA; QL
PEGASYS SUBCUTANEOUS SYRINGE	4	LA; QL
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML	4	LA; QL
PLEGRIDY SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
PLEGRIDY SUBCUTANEOUS SYRINGE	4	PA; LA; QL
POMALYST ORAL CAPSULE	4	PA; LA
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE	4	PA; LA; QL
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL

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Drug Name	Drug Tier	Requirements / Limits
REBIF TITRATION PACK SUBCUTANEOUS SYRINGE	4	PA; LA; QL
REVLIMID ORAL CAPSULE	4	PA; LA
<i>ribasphere oral capsule</i>	4	LA
<i>ribasphere oral tablet 600 mg</i>	4	LA
<i>ribasphere ribapak oral tablets, dose pack 600 mg (7)-400 mg (7), 600 mg (7)- 600 mg (7), 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)</i>	4	LA
<i>ribavirin oral capsule</i>	4	LA
<i>ribavirin oral tablet 200 mg</i>	4	LA
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG	4	PA; LA
TECFIDERA ORAL CAPSULE,DELAY ED RELEASE(DR/EC)	4	PA; LA
VUMERITY ORAL CAPSULE,DELAY ED RELEASE(DR/EC)	4	PA; LA
ZEPOSIA ORAL CAPSULE	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
ZEPOSIA STARTER KIT ORAL CAPSULE,DOSE PACK	4	PA; LA
ZEPOSIA STARTER PACK ORAL CAPSULE,DOSE PACK	4	PA; LA
INTERLEUKINS		
ACTIMMUNE SUBCUTANEOUS SOLUTION	4	LA
ALDARA TOPICAL CREAM IN PACKET	3	ST
ALFERON N INJECTION SOLUTION	2	
ARCALYST SUBCUTANEOUS RECON SOLN	4	LA
ILARIS (PF) SUBCUTANEOUS SOLUTION	4	PA; LA
IMIQUIMOD TOPICAL CREAM IN METERED-DOSE PUMP	3	ST
<i>imiquimod topical cream in packet</i>	1	
INTRON A INJECTION RECON SOLN	4	LA
INTRON A INJECTION SOLUTION	4	LA

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Drug Name	Drug Tier	Requirements / Limits
KINERET SUBCUTANEOUS SYRINGE	4	PA; LA; QL
PROLEUKIN INTRAVENOUS RECON SOLN	4	LA
ZYCLARA TOPICAL CREAM IN METERED- DOSE PUMP	3	ST
ZYCLARA TOPICAL CREAM IN PACKET	3	ST
VACCINES & MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF) INTRAMUSCULA R RECON SOLN	5	ACA
ADACEL(TDAP ADOLESN/ADULT) (PF) INTRAMUSCULA R SUSPENSION	5	ACA
ADACEL(TDAP ADOLESN/ADULT) (PF) INTRAMUSCULA R SYRINGE	5	ACA
AFLURIA QD 2019-20(3YR UP)(PF) INTRAMUSCULA R SYRINGE	5	ACA
AFLURIA QD 2019-20(6- 35MO)(PF) INTRAMUSCULA R SYRINGE	5	ACA

Drug Name	Drug Tier	Requirements / Limits
AFLURIA QD 2020-21(3YR UP)(PF) INTRAMUSCULA R SYRINGE	5	ACA
AFLURIA QD 2020-21(6- 35MO)(PF) INTRAMUSCULA R SYRINGE	5	ACA
AFLURIA QUAD 2019-20(6MO UP) INTRAMUSCULA R SUSPENSION	5	ACA
AFLURIA QUAD 2020-2021(6MO UP) INTRAMUSCULA R SUSPENSION	5	ACA
ASCENIV INTRAVENOUS SOLUTION	4	LA
ATGAM INTRAVENOUS SOLUTION	2	
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTIO N	2	
BEXSERO INTRAMUSCULA R SYRINGE	5	ACA
BOOSTRIX TDAP INTRAMUSCULA R SUSPENSION	5	ACA
BOOSTRIX TDAP INTRAMUSCULA R SYRINGE	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
BOTOX INJECTION RECON SOLN	4	PA; LA
CUTAQUIG SUBCUTANEOUS SOLUTION	4	PA; LA
CUVITRU SUBCUTANEOUS SOLUTION 10 GRAM/50 ML (20 %)	4	PA; LA
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULAR SUSPENSION	5	ACA
DYSPORT INTRAMUSCULAR RECON SOLN	4	PA; LA
ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION	5	ACA
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	5	ACA
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUAD 2019-2020 (65 YR UP)(PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUAD 2020-2021 (65 YR UP)(PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUAD QUAD 2020-21(65Y UP)(PF) INTRAMUSCULAR SYRINGE	5	ACA

Drug Name	Drug Tier	Requirements / Limits
FLUARIX QUAD 2019-2020 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUARIX QUAD 2020-2021 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUBLOK QUAD 2019-2020 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUBLOK QUAD 2020-2021 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUCELVAX QUAD 2019-2020 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUCELVAX QUAD 2019-2020 INTRAMUSCULAR SUSPENSION	5	ACA
FLUCELVAX QUAD 2020-2021 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUCELVAX QUAD 2020-2021 INTRAMUSCULAR SUSPENSION	5	ACA
FLULAVAL QUAD 2019-2020 (PF) INTRAMUSCULAR SYRINGE	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
FLULAVAL QUAD 2019-2020 INTRAMUSCULAR SUSPENSION	5	ACA
FLULAVAL QUAD 2020-2021 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUMIST QUAD 2019-2020 NASAL NASAL SPRAY SYRINGE	5	ACA
FLUMIST QUAD 2020-2021 NASAL NASAL SPRAY SYRINGE	5	ACA
FLUZONE HIGH-DOSE 2019-20 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUZONE HIGHDOSE QUAD 20-21 PF INTRAMUSCULAR SYRINGE	5	ACA
FLUZONE QUAD 2019-2020 (PF) INTRAMUSCULAR SUSPENSION	5	ACA
FLUZONE QUAD 2019-2020 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUZONE QUAD 2019-2020 INTRAMUSCULAR SUSPENSION	5	ACA
FLUZONE QUAD 2020-2021 (PF) INTRAMUSCULAR SUSPENSION	5	ACA

Drug Name	Drug Tier	Requirements / Limits
FLUZONE QUAD 2020-2021 (PF) INTRAMUSCULAR SYRINGE	5	ACA
FLUZONE QUAD 2020-2021 INTRAMUSCULAR SUSPENSION	5	ACA
FLUZONE QUAD PEDI 2019-20 (PF) INTRAMUSCULAR SYRINGE	5	ACA
GAMASTAN INTRAMUSCULAR SOLUTION	4	LA
GAMASTAN S/D INTRAMUSCULAR SOLUTION	4	LA
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION	5	ACA
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE	5	ACA
GRASTEK SUBLINGUAL TABLET	2	PA
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	5	ACA
HAVRIX (PF) INTRAMUSCULAR SYRINGE	5	ACA
HEPAGAM B INJECTION SOLUTION	2	

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Drug Name	Drug Tier	Requirements / Limits
HEPLISAV-B (PF) INTRAMUSCULAR SOLUTION	5	ACA
HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE	5	ACA
HIBERIX (PF) INTRAMUSCULAR RECON SOLN	5	ACA
HIZENTRA SUBCUTANEOUS SYRINGE	4	PA; LA
HYPERHEP B S/D INTRAMUSCULAR SOLUTION	2	
HYPERHEP B S/D INTRAMUSCULAR SYRINGE	2	
HYPERHEP B S-D NEONATAL INTRAMUSCULAR SYRINGE	2	
HYPERRAB (PF) INTRAMUSCULAR SOLUTION	2	
HYPERRAB S/D (PF) INTRAMUSCULAR SOLUTION	2	
HYPERTET S/D (PF) INTRAMUSCULAR SYRINGE	2	
IMOGAM RABIES-HT (PF) INTRAMUSCULAR SOLUTION	2	

Drug Name	Drug Tier	Requirements / Limits
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN	2	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	5	ACA
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	5	ACA
IPOLE INJECTION SUSPENSION	5	ACA
IXIARO (PF) INTRAMUSCULAR SYRINGE	2	
KEDRAB (PF) INTRAMUSCULAR SOLUTION	3	
KINRIX (PF) INTRAMUSCULAR SUSPENSION	5	ACA
KINRIX (PF) INTRAMUSCULAR SYRINGE	5	ACA
MENACTRA (PF) INTRAMUSCULAR SOLUTION	5	ACA
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	5	ACA
M-M-R II (PF) SUBCUTANEOUS RECON SOLN	5	ACA
MYOBLOC INTRAMUSCULAR SOLUTION	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
NABI-HB INTRAMUSCULAR SOLUTION	3	
ODACTRA SUBLINGUAL TABLET	2	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	4	PA; LA
PALFORZIA (LEVEL 1) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 2) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 3) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 4) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 5) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 6) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 7) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
PALFORZIA (LEVEL 8) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 9) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA (LEVEL 10) ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA INITIAL DOSE ORAL CAPSULE, SPRINKLE	4	PA; LA; QL
PALFORZIA LEVEL 11 MAINTENANCE ORAL POWDER IN PACKET	4	PA; LA; QL
PEDIARIX (PF) INTRAMUSCULAR SYRINGE	5	ACA
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION	5	ACA
PENTACEL (PF) INTRAMUSCULAR KIT	5	ACA
PENTACEL ACTHIB COMPONENT (PF) INTRAMUSCULAR RECON SOLN	5	ACA
PNEUMOVAX-23 INJECTION SOLUTION	5	ACA
PNEUMOVAX-23 INJECTION SYRINGE	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
PREVNAR 13 (PF) INTRAMUSCULAR SYRINGE	5	ACA
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	5	ACA
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION	5	ACA
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	2	
RAGWITEK SUBLINGUAL TABLET	2	PA
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION	5	ACA
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	5	ACA
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION	5	ACA
ROTATEQ VACCINE ORAL SOLUTION	5	ACA
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	5	ACA; QL

Drug Name	Drug Tier	Requirements / Limits
STAMARIL (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	2	
TDVAX INTRAMUSCULAR SUSPENSION	5	ACA
TENIVAC (PF) INTRAMUSCULAR SUSPENSION	5	ACA
TENIVAC (PF) INTRAMUSCULAR SYRINGE	5	ACA
TETANUS,DIPHTHERIA TOX PED(PF) INTRAMUSCULAR SUSPENSION	5	ACA
THYMOGLOBULIN INTRAVENOUS RECON SOLN	4	
TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION	2	
TRUMENBA INTRAMUSCULAR SYRINGE	5	ACA
TWINRIX (PF) INTRAMUSCULAR SYRINGE	5	ACA
TYPHIM VI INTRAMUSCULAR SOLUTION	2	
TYPHIM VI INTRAMUSCULAR SYRINGE	2	

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Drug Name	Drug Tier	Requirements / Limits
VAQTA (PF) INTRAMUSCULAR SUSPENSION	5	ACA
VAQTA (PF) INTRAMUSCULAR SYRINGE	5	ACA
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	5	ACA
VARIZIG INTRAMUSCULAR SOLUTION	2	
VAXCHORA VACCINE ORAL SUSPENSION FOR RECONSTITUTION	2	
VIVOTIF ORAL CAPSULE, DELAYED RELEASE (DR/EC)	2	
XEMBIFY SUBCUTANEOUS SOLUTION	4	PA; LA
XEOMIN INTRAMUSCULAR RECON SOLN	4	PA; LA
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	2	
ZINPLAVA INTRAVENOUS SOLUTION	3	

Drug Name	Drug Tier	Requirements / Limits
ZOSTAVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	5	ACA
MUSCULOSKELETAL & RHEUMATOLOGY		
GOUT THERAPY		
<i>allopurinol oral tablet</i>	1	
<i>allopurinol sodium intravenous recon soln</i>	1	
<i>aloprim intravenous recon soln</i>	1	
COLCHICINE ORAL CAPSULE	3	
<i>colchicine oral tablet</i>	1	
COLCRYS ORAL TABLET	3	
<i>febuxostat oral tablet</i>	1	ST
GLOPERBA ORAL SOLUTION	3	
MITIGARE ORAL CAPSULE	2	
<i>probenecid oral tablet</i>	1	
<i>probenecid-colchicine oral tablet</i>	1	
ULORIC ORAL TABLET	3	ST
ZYLOPRIM ORAL TABLET	3	

OSTEOPOROSIS THERAPY

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Drug Name	Drug Tier	Requirements / Limits
ACTONEL ORAL TABLET 150 MG, 35 MG, 5 MG	3	ST; QL
<i>alendronate oral solution</i>	1	QL
<i>alendronate oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	1	QL
ATELVIA ORAL TABLET, DELAYED RELEASE (DR/EC)	3	ST; QL
BINOSTO ORAL TABLET, EFFERVESCENT	3	ST; QL
BONIVA INTRAVENOUS SYRINGE	4	LA
BONIVA ORAL TABLET	3	ST; QL
EVENITY SUBCUTANEOUS SYRINGE	4	PA; LA; QL
EVISTA ORAL TABLET	3	
FORTEO SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
FOSAMAX ORAL TABLET 70 MG	3	ST; QL
FOSAMAX PLUS D ORAL TABLET	3	ST; QL
<i>ibandronate intravenous solution</i>	4	LA
<i>ibandronate intravenous syringe</i>	4	LA
<i>ibandronate oral tablet</i>	1	QL

Drug Name	Drug Tier	Requirements / Limits
PROLIA SUBCUTANEOUS SYRINGE	4	LA
<i>raloxifene oral tablet</i>	1	ACA
<i>risedronate oral tablet 150 mg, 35 mg, 5 mg</i>	1	QL
<i>risedronate oral tablet, delayed release (dr/ec)</i>	1	QL
TERIPARATIDE SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
TYMLOS SUBCUTANEOUS PEN INJECTOR	4	LA; QL
OTHER RHEUMATOLOGICALS		
ACTEMRA ACTPEN SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
ACTEMRA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
ARAVA ORAL TABLET	3	QL
CUPRIMINE ORAL CAPSULE	3	PA
DEPEN TITRATABS ORAL TABLET	3	
ENBREL MINI SUBCUTANEOUS CARTRIDGE	4	PA; LA; QL
ENBREL SUBCUTANEOUS RECON SOLN	4	PA; LA; QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
ENBREL SUBCUTANEOUS SOLUTION	4	PA; LA; QL
ENBREL SUBCUTANEOUS SYRINGE	4	PA; LA; QL
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT	4	PA; LA; QL
HUMIRA PEN PSOR-UVEITS-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT	4	PA; LA; QL
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT	4	PA; LA; QL
HUMIRA SUBCUTANEOUS SYRINGE KIT	4	PA; LA; QL
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT	4	PA; LA; QL
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT	4	PA; LA; QL
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	4	PA; LA; QL
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT	4	PA; LA; QL
KEVZARA SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL
KEVZARA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
<i>leflunomide oral tablet</i>	1	QL
OLUMIANT ORAL TABLET	4	PA; LA; QL
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA; QL
ORENCIA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
OTEZLA ORAL TABLET	4	PA; LA; QL
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	4	PA; LA; QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML	2	ST
<i>penicillamine oral capsule</i>	1	PA
<i>penicillamine oral tablet</i>	1	
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	2	ST
RIDAURA ORAL CAPSULE	2	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR	4	PA; LA; QL
SAVELLA ORAL TABLET	2	ST; QL
SAVELLA ORAL TABLETS,DOSE PACK	2	ST; QL
SIMPONI SUBCUTANEOUS PEN INJECTOR	4	PA; LA; QL

Drug Name	Drug Tier	Requirements / Limits
SIMPONI SUBCUTANEOUS SYRINGE	4	PA; LA; QL
XELJANZ ORAL TABLET	4	PA; LA; QL
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR	4	PA; LA; QL
OBSTETRICS & GYNECOLOGY		
DIAPHRAGMS AND OTHER NON- ORAL CONTRACEPTIVES		
CAYA CONTOURED VAGINAL DIAPHRAGM	5	ACA
FC2 FEMALE CONDOM	5	ACA; OTC
FEMCAP VAGINAL DEVICE 22 MM	5	ACA
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE	5	ACA; LA
LILETTA INTRAUTERINE INTRAUTERINE DEVICE	5	ACA; LA
MIRENA INTRAUTERINE INTRAUTERINE DEVICE	5	ACA; LA
PARAGARD T 380A INTRAUTERINE INTRAUTERINE DEVICE	5	ACA; LA

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Drug Name	Drug Tier	Requirements / Limits
SKYLA INTRAUTERINE INTRAUTERINE DEVICE	5	ACA; LA
WIDE-SEAL DIAPHRAGM	5	ACA
ESTROGENS & PROGESTINS		
ACTIVELLA ORAL TABLET	3	
ALORA TRANSDERMAL PATCH SEMIWEEKLY	3	QL
<i>amabelz oral tablet</i>	1	
ANGELIQ ORAL TABLET	3	
AYGESTIN ORAL TABLET	3	
BIJUVA ORAL CAPSULE	3	
<i>camila oral tablet</i>	5	ACA
CLIMARA PRO TRANSDERMAL PATCH WEEKLY	3	ST; QL
CLIMARA TRANSDERMAL PATCH WEEKLY	3	QL
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY	2	
<i>covaryx h.s. oral tablet</i>	1	
<i>covaryx oral tablet</i>	1	
CRINONE VAGINAL GEL 4 %	3	

Drug Name	Drug Tier	Requirements / Limits
CRINONE VAGINAL GEL 8 %	4	LA
<i>deblitane oral tablet</i>	5	ACA
DELESTROGEN INTRAMUSCULAR OIL	3	
DEPO-ESTRADIOL INTRAMUSCULAR OIL	2	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	3	QL
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	2	
DEPO-PROVERA INTRAMUSCULAR SYRINGE	3	QL
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE	5	ACA; QL
DIVIGEL TRANSDERMAL GEL IN PACKET 0.25 MG/0.25 GRAM (0.1 %), 0.5 MG/0.5 GRAM (0.1 %), 0.75 MG/0.75 GRAM (0.1%), 1 MG/GRAM (0.1 %)	2	QL
DIVIGEL TRANSDERMAL GEL IN PACKET 1.25 MG/1.25 GRAM (0.1 %)	2	
<i>dotti transdermal patch semiweekly</i>	1	QL

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Drug Name	Drug Tier	Requirements / Limits
DUAVEE ORAL TABLET	2	
<i>eemt hs oral tablet</i>	1	
<i>eemt oral tablet</i>	1	
ELESTRIN TRANSDERMAL GEL IN METERED-DOSE PUMP	3	ST; QL
ENDOMETRIN VAGINAL INSERT	4	LA
<i>errin oral tablet</i>	5	ACA
ESTRACE ORAL TABLET	3	
ESTRACE VAGINAL CREAM	3	
<i>estradiol oral tablet</i>	1	
<i>estradiol transdermal patch semiweekly</i>	1	QL
<i>estradiol transdermal patch weekly</i>	1	QL
<i>estradiol vaginal cream</i>	1	
<i>estradiol vaginal tablet</i>	1	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	1	
<i>estradiol-norethindrone acet oral tablet</i>	1	
ESTRING VAGINAL RING	2	

Drug Name	Drug Tier	Requirements / Limits
ESTROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP	3	ST; QL
<i>estrogens-methyltestosterone oral tablet</i>	1	
EVAMIST TRANSDERMAL SPRAY, NON-AEROSOL	3	QL
FEMHRT LOW DOSE ORAL TABLET	3	
FEMRING VAGINAL RING	3	
<i>fyavolv oral tablet</i>	1	
<i>heather oral tablet</i>	5	ACA
<i>hydroxyprogesterone (pf)(p reg presv) intramuscular oil</i>	4	LA; QL
<i>hydroxyprogesterone cap(ppres) intramuscular oil</i>	4	LA; QL
<i>hydroxyprogesterone caproate intramuscular oil</i>	1	
IMVEXXY MAINTENANCE PACK VAGINAL INSERT	3	PA; QL
IMVEXXY STARTER PACK VAGINAL INSERT, DOSE PACK	3	PA; QL
<i>incassia oral tablet</i>	5	ACA
<i>jencycla oral tablet</i>	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
<i>jinteli oral tablet</i>	1	
<i>lopreeza oral tablet</i>	1	
<i>lyza oral tablet</i>	5	ACA
MAKENA (PF) SUBCUTANEOUS AUTO-INJECTOR	4	LA; QL
MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)	4	LA; QL
<i>medroxyprogesterone intramuscular suspension</i>	5	ACA; QL
<i>medroxyprogesterone intramuscular syringe</i>	5	ACA; QL
<i>medroxyprogesterone oral tablet</i>	1	
MENEST ORAL TABLET	3	
MENOSTAR TRANSDERMAL PATCH WEEKLY	3	QL
<i>mimvey lo oral tablet</i>	1	
<i>mimvey oral tablet</i>	1	
MINIVELLE TRANSDERMAL PATCH SEMIWEEKLY	3	QL
<i>nora-be oral tablet</i>	5	ACA
<i>norethindrone (contraceptive) oral tablet</i>	5	ACA
<i>norethindrone acetate oral tablet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	
<i>norlyda oral tablet</i>	5	ACA
PREFEST ORAL TABLET	3	
PREMARIN INJECTION RECON SOLN	2	
PREMARIN ORAL TABLET	2	
PREMARIN VAGINAL CREAM	2	
PREMPHASE ORAL TABLET	2	
PREMPRO ORAL TABLET	2	
<i>progesterone intramuscular oil</i>	4	LA
<i>progesterone micronized oral capsule</i>	1	
PROVERA ORAL TABLET	3	
<i>sharobel oral tablet</i>	5	ACA
<i>tulana oral tablet</i>	5	ACA
VAGIFEM VAGINAL TABLET	3	
VIVELLE-DOT TRANSDERMAL PATCH SEMIWEEKLY	3	QL
<i>yuvafem vaginal tablet</i>	1	

MISCELLANEOUS OB/GYN

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Drug Name	Drug Tier	Requirements / Limits
ANNOVERA VAGINAL RING	5	ACA; QL
AVC VAGINAL VAGINAL CREAM	3	
CERVIDIL VAGINAL INSERT, EXTENDED RELEASE	3	
CLEOCIN VAGINAL CREAM	3	
CLEOCIN VAGINAL SUPPOSITORY	3	
<i>clindamycin phosphate vaginal cream</i>	1	
CLINDESSE VAGINAL CREAM, EXTENDED RELEASE	3	
<i>eluryng vaginal ring</i>	5	ACA
<i>etonogestrel-ethinyl estradiol vaginal ring</i>	5	ACA
GYNAZOLE-1 VAGINAL CREAM	3	
<i>gynol ii vaginal gel</i>	5	ACA; OTC
INTRAROSA VAGINAL INSERT	3	PA
LUPANETA PACK (1 MONTH) KIT. SYRINGE AND TABLET	4	PA; LA
LUPANETA PACK (3 MONTH) KIT. SYRINGE AND TABLET	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
LYSTEDA ORAL TABLET	3	
METROGEL VAGINAL VAGINAL GEL	3	
<i>metronidazole vaginal gel</i>	1	
<i>miconazole-3 vaginal suppository</i>	1	
NEXPLANON SUBDERMAL IMPLANT	5	ACA; LA
NUVARING VAGINAL RING	3	
NUVESSA VAGINAL GEL	3	
ORIAHNN ORAL CAPSULE, SEQUENTIAL	3	PA
OSPHENA ORAL TABLET	3	PA
PHEXXI VAGINAL GEL	3	
PREPIDIL VAGINAL GEL	3	
PROSTIN E2 VAGINAL SUPPOSITORY	3	
<i>terconazole vaginal cream</i>	1	
<i>terconazole vaginal suppository</i>	1	
TODAY CONTRACEPTIVE SPONGE VAGINAL CONTRACEPTIVE SPONGE	5	ACA; OTC

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Drug Name	Drug Tier	Requirements / Limits
<i>tranexamic acid oral tablet</i>	1	
TWIRLA TRANSDERMAL PATCH WEEKLY	5	ST; ACA
<i>vaginal contraceptive foam vaginal foam</i>	5	ACA; OTC
<i>vandazole vaginal gel</i>	1	
VCF CONTRACEPTIVE FILM VAGINAL FILM	5	ACA; OTC
VCF CONTRACEPTIVE GEL VAGINAL GEL	5	ACA; OTC
<i>xulane transdermal patch weekly</i>	5	ACA
ORAL CONTRACEPTIVES & RELATED AGENTS		
<i>afirmelle oral tablet</i>	5	ACA
<i>altavera (28) oral tablet</i>	5	ACA
<i>alyacen 1/35 (28) oral tablet</i>	5	ACA
<i>alyacen 7/7/7 (28) oral tablet</i>	5	ACA
<i>amethia lo oral tablets,dose pack,3 month</i>	5	ACA
<i>amethia oral tablets,dose pack,3 month</i>	5	ACA
<i>amethyst (28) oral tablet</i>	5	ACA
<i>apri oral tablet</i>	5	ACA

Drug Name	Drug Tier	Requirements / Limits
<i>aranelle (28) oral tablet</i>	5	ACA
<i>ashlyna oral tablets,dose pack,3 month</i>	5	ACA
<i>aubra eq oral tablet</i>	5	ACA
<i>aubra oral tablet</i>	5	ACA
<i>aurovela 1.5/30 (21) oral tablet</i>	5	ACA
<i>aurovela 1/20 (21) oral tablet</i>	5	ACA
<i>aurovela 24 fe oral tablet</i>	5	ACA
<i>aurovela fe 1.5/30 (28) oral tablet</i>	5	ACA
<i>aurovela fe 1-20 (28) oral tablet</i>	5	ACA
<i>aviane oral tablet</i>	5	ACA
<i>ayuna oral tablet</i>	5	ACA
<i>azurette (28) oral tablet</i>	5	ACA
BALCOLTRA ORAL TABLET	5	ST; ACA
<i>balziva (28) oral tablet</i>	5	ACA
<i>bekyree (28) oral tablet</i>	5	ACA
BEYAZ ORAL TABLET	3	ST
<i>blisovi 24 fe oral tablet</i>	5	ACA
<i>blisovi fe 1.5/30 (28) oral tablet</i>	5	ACA
<i>blisovi fe 1/20 (28) oral tablet</i>	5	ACA
<i>briellyn oral tablet</i>	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
<i>camrese lo oral tablets,dose pack,3 month</i>	5	ACA
<i>camrese oral tablets,dose pack,3 month</i>	5	ACA
<i>caziant (28) oral tablet</i>	5	ACA
<i>charlotte 24 fe oral tablet,chewable</i>	5	ACA
<i>chateal eq (28) oral tablet</i>	5	ACA
<i>cryselle (28) oral tablet</i>	5	ACA
<i>cyclafem 1/35 (28) oral tablet</i>	5	ACA
<i>cyclafem 7/7/7 (28) oral tablet</i>	5	ACA
<i>cyred eq oral tablet</i>	5	ACA
<i>cyred oral tablet</i>	5	ACA
<i>dasetta 1/35 (28) oral tablet</i>	5	ACA
<i>dasetta 7/7/7 (28) oral tablet</i>	5	ACA
<i>daysee oral tablets,dose pack,3 month</i>	5	ACA
<i>desog-e.estradiol/e.estradiol oral tablet</i>	5	ACA
<i>desogestrel-ethinyl estradiol oral tablet</i>	5	ACA
<i>drospirenone-e.estradiol-lm.fa oral tablet</i>	5	ACA
<i>drospirenone-ethinyl estradiol oral tablet</i>	5	ACA

Drug Name	Drug Tier	Requirements / Limits
<i>econtra ez oral tablet</i>	5	ACA; OTC; QL
<i>econtra one-step oral tablet</i>	5	ACA; OTC; QL
<i>elinest oral tablet</i>	5	ACA
ELLA ORAL TABLET	5	ACA; QL
<i>emoquette oral tablet</i>	5	ACA
<i>enpresse oral tablet</i>	5	ACA
<i>enskyce oral tablet</i>	5	ACA
<i>estarylla oral tablet</i>	5	ACA
ESTROSTEP FE-28 ORAL TABLET	3	ST
<i>ethynodiol diac-eth estradiol oral tablet</i>	5	ACA
<i>falmina (28) oral tablet</i>	5	ACA
<i>fayosim oral tablets,dose pack,3 month</i>	5	ACA
<i>femynor oral tablet</i>	5	ACA
GENERESS FE ORAL TABLET,CHEWABLE	3	ST
<i>gianvi (28) oral tablet</i>	5	ACA
<i>hailey 24 fe oral tablet</i>	5	ACA
<i>hailey fe 1.5/30 (28) oral tablet</i>	5	ACA
<i>hailey fe 1/20 (28) oral tablet</i>	5	ACA
<i>hailey oral tablet</i>	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
<i>introvale oral tablets,dose pack,3 month</i>	5	ACA
<i>isibloom oral tablet</i>	5	ACA
<i>jaimiess oral tablets,dose pack,3 month</i>	5	ACA
<i>jasmiel (28) oral tablet</i>	5	ACA
<i>jolessa oral tablets,dose pack,3 month</i>	5	ACA
<i>juleber oral tablet</i>	5	ACA
<i>junel 1.5/30 (21) oral tablet</i>	5	ACA
<i>junel 1/20 (21) oral tablet</i>	5	ACA
<i>junel fe 1.5/30 (28) oral tablet</i>	5	ACA
<i>junel fe 1/20 (28) oral tablet</i>	5	ACA
<i>junel fe 24 oral tablet</i>	5	ACA
<i>kaitlib fe oral tablet,chewable</i>	5	ACA
<i>kalliga oral tablet</i>	5	ACA
<i>kariva (28) oral tablet</i>	5	ACA
<i>kelnor 1/35 (28) oral tablet</i>	5	ACA
<i>kelnor 1-50 oral tablet</i>	5	ACA
<i>kurvelo (28) oral tablet</i>	5	ACA
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month</i>	5	ACA

Drug Name	Drug Tier	Requirements / Limits
<i>larin 1.5/30 (21) oral tablet</i>	5	ACA
<i>larin 1/20 (21) oral tablet</i>	5	ACA
<i>larin 24 fe oral tablet</i>	5	ACA
<i>larin fe 1.5/30 (28) oral tablet</i>	5	ACA
<i>larin fe 1/20 (28) oral tablet</i>	5	ACA
<i>larissia oral tablet</i>	5	ACA
<i>layolis fe oral tablet,chewable</i>	5	ACA
<i>leena 28 oral tablet</i>	5	ACA
<i>lessina oral tablet</i>	5	ACA
<i>levonest (28) oral tablet</i>	5	ACA
<i>levonorgestrel oral tablet 1.5 mg</i>	5	ACA; OTC; QL
<i>levonorgestrel-ethinyl estrad oral tablet</i>	5	ACA
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	5	ACA
<i>levonorg-eth estrad triphasic oral tablet</i>	5	ACA
<i>levora-28 oral tablet</i>	5	ACA
<i>lillow (28) oral tablet</i>	5	ACA
LO LOESTRIN FE ORAL TABLET	5	ST; ACA
LOESTRIN 1.5/30 (21) ORAL TABLET	3	ST

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Drug Name	Drug Tier	Requirements / Limits
LOESTRIN 1/20 (21) ORAL TABLET	3	ST
LOESTRIN FE 1.5/30 (28-DAY) ORAL TABLET	3	ST
LOESTRIN FE 1/20 (28-DAY) ORAL TABLET	3	ST
<i>lojaimiess oral tablets,dose pack,3 month</i>	5	ACA
<i>loryna (28) oral tablet</i>	5	ACA
LOSEASONIQUE ORAL TABLETS,DOSE PACK,3 MONTH	3	ST
<i>low-ogestrel (28) oral tablet</i>	5	ACA
<i>lo-zumandimine (28) oral tablet</i>	5	ACA
<i>lutra (28) oral tablet</i>	5	ACA
<i>marlissa (28) oral tablet</i>	5	ACA
<i>melodetta 24 fe oral tablet,chewable</i>	5	ACA
<i>mibelas 24 fe oral tablet,chewable</i>	5	ACA
<i>microgestin 1.5/30 (21) oral tablet</i>	5	ACA
<i>microgestin 1/20 (21) oral tablet</i>	5	ACA
<i>microgestin fe 1.5/30 (28) oral tablet</i>	5	ACA
<i>microgestin fe 1/20 (28) oral tablet</i>	5	ACA

Drug Name	Drug Tier	Requirements / Limits
<i>mili oral tablet</i>	5	ACA
MINASTRIN 24 FE ORAL TABLET,CHEWABLE	3	ST
MIRCETTE (28) ORAL TABLET	3	ST
<i>mono-lynyah oral tablet</i>	5	ACA
<i>my choice oral tablet</i>	5	ACA; OTC; QL
<i>my way oral tablet</i>	5	ACA; OTC; QL
NATAZIA ORAL TABLET	5	ST; ACA
<i>necon 0.5/35 (28) oral tablet</i>	5	ACA
<i>new day oral tablet</i>	5	ACA; OTC; QL
<i>nikki (28) oral tablet</i>	5	ACA
<i>noreth-ethinyl estradiol-iron oral tablet,chewable</i>	5	ACA
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	5	ACA
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1.5 mg-30 mcg (21)/75 mg (7)</i>	5	ACA
<i>norethindrone-e.estradiol-iron oral tablet,chewable</i>	5	ACA
<i>norgestimate-ethinyl estradiol oral tablet</i>	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
<i>nortrel 0.5/35 (28) oral tablet</i>	5	ACA
<i>nortrel 1/35 (21) oral tablet</i>	5	ACA
<i>nortrel 1/35 (28) oral tablet</i>	5	ACA
<i>nortrel 7/7/7 (28) oral tablet</i>	5	ACA
<i>ocella oral tablet</i>	5	ACA
<i>ogestrel (28) oral tablet</i>	5	ACA
<i>opcicon one-step oral tablet</i>	5	ACA; OTC; QL
<i>option-2 oral tablet</i>	5	ACA; OTC; QL
<i>orsythia oral tablet</i>	5	ACA
<i>philith oral tablet</i>	5	ACA
<i>pimtrea (28) oral tablet</i>	5	ACA
<i>pirmella oral tablet</i>	5	ACA
PLAN B ONE-STEP ORAL TABLET	2	OTC; QL
<i>portia 28 oral tablet</i>	5	ACA
<i>previfem oral tablet</i>	5	ACA
QUARTETTE ORAL TABLETS,DOSE PACK,3 MONTH	3	ST
<i>reclipsen (28) oral tablet</i>	5	ACA
<i>rivelsa oral tablets,dose pack,3 month</i>	5	ACA
SAFYRAL ORAL TABLET	3	ST

Drug Name	Drug Tier	Requirements / Limits
SEASONIQUE ORAL TABLETS,DOSE PACK,3 MONTH	3	ST
<i>setlakin oral tablets,dose pack,3 month</i>	5	ACA
<i>simliya (28) oral tablet</i>	5	ACA
<i>simpesse oral tablets,dose pack,3 month</i>	5	ACA
SLYND ORAL TABLET	5	ST; ACA
<i>sprintec (28) oral tablet</i>	5	ACA
<i>sronyx oral tablet</i>	5	ACA
<i>syeda oral tablet</i>	5	ACA
<i>tarina 24 fe oral tablet</i>	5	ACA
<i>tarina fe 1/20 (28) oral tablet</i>	5	ACA
TAYTULLA ORAL CAPSULE	5	ST; ACA
<i>tilia fe oral tablet</i>	5	ACA
<i>tri femynor oral tablet</i>	5	ACA
<i>tri-estarylla oral tablet</i>	5	ACA
<i>tri-legest fe oral tablet</i>	5	ACA
<i>tri-linyah oral tablet</i>	5	ACA
<i>tri-lo-estarylla oral tablet</i>	5	ACA
<i>tri-lo-marzia oral tablet</i>	5	ACA
<i>tri-lo-mili oral tablet</i>	5	ACA

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Drug Name	Drug Tier	Requirements / Limits
<i>tri-lo-sprintec oral tablet</i>	5	ACA
<i>tri-mili oral tablet</i>	5	ACA
<i>tri-previfem (28) oral tablet</i>	5	ACA
<i>tri-sprintec (28) oral tablet</i>	5	ACA
<i>trivora (28) oral tablet</i>	5	ACA
<i>tri-vylibra lo oral tablet</i>	5	ACA
<i>tri-vylibra oral tablet</i>	5	ACA
<i>tydemy oral tablet</i>	5	ACA
<i>velivet triphasic regimen (28) oral tablet</i>	5	ACA
<i>vienva oral tablet</i>	5	ACA
<i>viorele (28) oral tablet</i>	5	ACA
<i>volnea (28) oral tablet</i>	5	ACA
<i>vyfemla (28) oral tablet</i>	5	ACA
<i>vylibra oral tablet</i>	5	ACA
<i>wera (28) oral tablet</i>	5	ACA
<i>wymzya fe oral tablet, chewable</i>	5	ACA
YASMIN (28) ORAL TABLET	3	ST
YAZ (28) ORAL TABLET	3	ST
<i>zarah oral tablet</i>	5	ACA
<i>zovia 1/35e (28) oral tablet</i>	5	ACA

Drug Name	Drug Tier	Requirements / Limits
<i>zumandimine (28) oral tablet</i>	5	ACA
OXYTOCICS		
<i>methergine oral tablet</i>	1	QL
<i>methylergonovine oral tablet</i>	1	QL
<i>oxytocin injection solution</i>	1	
OPHTHALMOLOGY		
ANTIBIOTICS		
<i>ak-poly-bac ophthalmic (eye) ointment</i>	1	
AZASITE OPHTHALMIC (EYE) DROPS	2	
BACIGUENT OPHTHALMIC (EYE) OINTMENT	3	
<i>bacitracin ophthalmic (eye) ointment</i>	1	
<i>bacitracin-polymyxin b ophthalmic (eye) ointment</i>	1	
BESIVANCE OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
BETADINE OPHTHALMIC PREP OPHTHALMIC (EYE) SOLUTION	3	

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Drug Name	Drug Tier	Requirements / Limits
CEFUROXIME (PF) IN 0.9% NACL INTRAVITREAL SOLUTION	3	
CILOXAN OPHTHALMIC (EYE) DROPS	3	
CILOXAN OPHTHALMIC (EYE) OINTMENT	3	
<i>ciprofloxacin hcl ophthalmic (eye) drops</i>	1	
<i>erythromycin ophthalmic (eye) ointment</i>	1	
<i>gatifloxacin ophthalmic (eye) drops</i>	1	
<i>gentak ophthalmic (eye) ointment</i>	1	
<i>gentamicin ophthalmic (eye) drops</i>	1	
<i>levofloxacin ophthalmic (eye) drops</i>	1	
MOXEZA OPHTHALMIC (EYE) DROPS, VISCOUS	3	
MOXIFLOXACIN (PF)-BSS INTRAVITREAL SOLUTION	3	
<i>moxifloxacin ophthalmic (eye) drops</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>moxifloxacin ophthalmic (eye) drops, viscous</i>	1	
MOXIFLOXACIN-SOD CHLOR,ISO(PF) INTRAOCULAR SOLUTION 0.8 MG/0.8 ML, 5 MG/ML	3	
MOXIFLOXACIN-SOD CHLOR,ISO(PF) INTRAOCULAR SYRINGE	3	
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION	2	
<i>neomycin-bacitracin-polymyxin ophthalmic (eye) ointment</i>	1	
<i>neomycin-polymyxin-gramicidin ophthalmic (eye) drops</i>	1	
<i>neo-polycin ophthalmic (eye) ointment</i>	1	
OCUFLOX OPHTHALMIC (EYE) DROPS	3	
<i>ofloxacin ophthalmic (eye) drops</i>	1	
<i>polycin ophthalmic (eye) ointment</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops</i>	1	
POLYTRIM OPTHALMIC (EYE) DROPS	3	
<i>tobramycin ophthalmic (eye) drops</i>	1	
TOBREX OPTHALMIC (EYE) DROPS	3	
TOBREX OPTHALMIC (EYE) OINTMENT	3	
VIGAMOX OPTHALMIC (EYE) DROPS	3	
ZYMAXID OPTHALMIC (EYE) DROPS	3	
ANTIVIRALS		
<i>trifluridine ophthalmic (eye) drops</i>	1	
ZIRGAN OPTHALMIC (EYE) GEL	3	
BETA-BLOCKERS		
<i>betaxolol ophthalmic (eye) drops</i>	1	
BETIMOL OPTHALMIC (EYE) DROPS	3	

Drug Name	Drug Tier	Requirements / Limits
BETOPTIC S OPTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>carteolol ophthalmic (eye) drops</i>	1	
ISTALOL OPTHALMIC (EYE) DROPS, ONCE DAILY	3	ST
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	1	
<i>timolol maleate ophthalmic (eye) drops</i>	1	
<i>timolol maleate ophthalmic (eye) drops, once daily</i>	1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	1	
TIMOPTIC OCUDOSE (PF) OPTHALMIC (EYE) DROPPERETTE	3	ST
TIMOPTIC OPTHALMIC (EYE) DROPS	3	ST
TIMOPTIC-XE OPTHALMIC (EYE) GEL FORMING SOLUTION	3	ST
CHOLINESTERASE INHIBITOR MIOTICS		

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Drug Name	Drug Tier	Requirements / Limits
PHOSPHOLINE IODIDE OPHTHALMIC (EYE) DROPS	2	
CYCLOPLEGIC MYDRIATICS		
ATROPINE IN 0.9 % SOD CHLORIDE OPHTHALMIC (EYE) DROPS	3	
<i>atropine ophthalmic (eye) drops</i>	1	
ATROPINE OPHTHALMIC (EYE) DROPS, EMULSION	3	
<i>atropine ophthalmic (eye) ointment</i>	1	
CYCLOGYL OPHTHALMIC (EYE) DROPS	3	
<i>cyclopentolate ophthalmic (eye) drops</i>	1	
ISOPTO ATROPINE OPHTHALMIC (EYE) DROPS	3	
MYDRIACYL OPHTHALMIC (EYE) DROPS	3	
PAREMYD OPHTHALMIC (EYE) DROPS	3	
PHENYLEPH-TROPICAMIDE IN WATER OPHTHALMIC (EYE) DROPS	3	

Drug Name	Drug Tier	Requirements / Limits
<i>tropicamide ophthalmic (eye) drops</i>	1	
DIRECT ACTING MIOTICS		
ISOPTO CARPINE OPHTHALMIC (EYE) DROPS	3	
MIOCHOL-E INTRAOCULAR KIT	3	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	1	
MISCELLANEOUS OPHTHALMOLOGICS		
AKTEN (PF) OPHTHALMIC (EYE) GEL	3	
ALCAINE OPHTHALMIC (EYE) DROPS	3	
ALOCRIAL OPHTHALMIC (EYE) DROPS	3	
ALOMIDE OPHTHALMIC (EYE) DROPS	3	
ALTAFLUOR BENOX OPHTHALMIC (EYE) DROPS	3	
<i>azelastine ophthalmic (eye) drops</i>	1	
BEPREVE OPHTHALMIC (EYE) DROPS	3	ST

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Drug Name	Drug Tier	Requirements / Limits
CEQUA OPTHALMIC (EYE) DROPPERETTE	3	PA
<i>cromolyn ophthalmic (eye) drops</i>	1	
CYSTADROPS OPTHALMIC (EYE) DROPS	4	LA
CYSTARAN OPTHALMIC (EYE) DROPS	4	LA
<i>epinastine ophthalmic (eye) drops</i>	1	
JETREA (PF) INTRAVITREAL SOLUTION 0.125 MG/0.1 ML (1.25 MG/ML)	4	LA
KLARITY-A (AZITHRO-CHONDR)(PF) OPTHALMIC (EYE) DROPS	3	
KLARITY-B (BETAMETH-CHOND)(PF) OPTHALMIC (EYE) DROPS	3	
KLARITY-L (LOTEPRED-CHOND)(PF) OPTHALMIC (EYE) DROPS	3	
LACRISERT OPTHALMIC (EYE) INSERT	3	

Drug Name	Drug Tier	Requirements / Limits
LASTACAFT OPTHALMIC (EYE) DROPS	3	ST
LIDOCAINE-PHENYLEPHRIN-BSS(PF) INTRAOCULAR SYRINGE	3	
OMIDRIA INTRAOCULAR CONCENTRATE	3	
OXERVATE OPTHALMIC (EYE) DROPS	4	PA; LA
PAZEO OPTHALMIC (EYE) DROPS	2	ST
PHOTREXA CROSS-LINKING KIT OPTHALMIC (EYE) COMBO, DROPS AND DROPS VISCOUS	3	
PHOTREXA VISCOUS OPTHALMIC (EYE) DROPS, VISCOUS	3	
PREDNISOL ACE-GATIFLOX-BROMFEN OPTHALMIC (EYE) DROPS,SUSPENSION	3	
PREDNISOLN SP-MOXIFLOX-BROMFEN OPTHALMIC (EYE) DROPS	3	

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Drug Name	Drug Tier	Requirements / Limits
PREDNISOLONE ACETATE-NEPAFENAC OPTHALMIC (EYE) DROPS,SUSPENSION	3	
PREDNISOLONE-MOXIFLO-NEPAFENAC OPTHALMIC (EYE) DROPS,SUSPENSION	3	
PREDNISOLONE-MOXIFLOX-BROMFEN OPTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>proparacaine ophthalmic (eye) drops</i>	1	
RACEPINEPH-LIDOCAINE-BSS 7(PF) INTRAOCULAR SOLUTION	3	
RESTASIS MULTIDOSE OPTHALMIC (EYE) DROPS	2	PA; QL
RESTASIS OPTHALMIC (EYE) DROPPERETTE	2	PA; QL
<i>tetacaine ophthalmic (eye) drops</i>	1	

Drug Name	Drug Tier	Requirements / Limits
TETRACAINE HCL (PF) OPTHALMIC (EYE) DROPS	3	
<i>tetracaine hcl ophthalmic (eye) drops</i>	1	
VISUDYNE INTRAVENOUS RECON SOLN	4	LA
VITRASE INJECTION SOLUTION	3	
XIIDRA OPTHALMIC (EYE) DROPPERETTE	2	PA; QL
ZERVIAE OPTHALMIC (EYE) DROPPERETTE	2	ST
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
ACULAR LS OPTHALMIC (EYE) DROPS	3	ST
ACULAR OPTHALMIC (EYE) DROPS	3	ST
ACUVAIL (PF) OPTHALMIC (EYE) DROPPERETTE	3	ST
<i>bromfenac ophthalmic (eye) drops</i>	1	
BROMSITE OPTHALMIC (EYE) DROPS	3	

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Drug Name	Drug Tier	Requirements / Limits
<i>flurbiprofen sodium ophthalmic (eye) drops</i>	1	
ILEVRO OPTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>ketorolac ophthalmic (eye) drops</i>	1	
NEVANAC OPTHALMIC (EYE) DROPS,SUSPENSION	3	ST
PROLENSA OPTHALMIC (EYE) DROPS	3	
ORAL DRUGS FOR GLAUCOMA		
<i>acetazolamide oral capsule, extended release</i>	1	
<i>acetazolamide oral tablet</i>	1	
<i>acetazolamide sodium injection recon soln</i>	1	
<i>methazolamide oral tablet</i>	1	
OTHER GLAUCOMA DRUGS		
AZOPT OPTHALMIC (EYE) DROPS,SUSPENSION	2	
<i>bimatoprost ophthalmic (eye) drops</i>	1	

Drug Name	Drug Tier	Requirements / Limits
BRIMONIDINE-DORZOLAMIDE (PF) OPTHALMIC (EYE) DROPS	3	
COMBIGAN OPTHALMIC (EYE) DROPS	2	
COSOPT (PF) OPTHALMIC (EYE) DROPPERETTE	3	
COSOPT OPTHALMIC (EYE) DROPS	3	ST
DORZOLAMIDE (PF) OPTHALMIC (EYE) DROPS	3	
<i>dorzolamide ophthalmic (eye) drops</i>	1	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	1	
DORZOLAMIDE-TIMOLOL (PF) OPTHALMIC (EYE) DROPS	3	
<i>dorzolamide-timolol ophthalmic (eye) drops</i>	1	
DURYSTA INTRACAMERAL IMPLANT	4	ST; LA
LATANOPROST (PF) OPTHALMIC (EYE) DROPS	3	

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Drug Name	Drug Tier	Requirements / Limits
<i>latanoprost ophthalmic (eye) drops</i>	1	
LUMIGAN OPTHALMIC (EYE) DROPS 0.01 %	2	
<i>miostat intraocular solution</i>	1	
MITOSOL OPTHALMIC (EYE) KIT	3	
RHOPRESSA OPTHALMIC (EYE) DROPS	2	
ROCKLATAN OPTHALMIC (EYE) DROPS	3	ST
SIMBRINZA OPTHALMIC (EYE) DROPS,SUSPENSION	3	
TIMOL-BRIMON-DORZO-LATANOP(PF) OPTHALMIC (EYE) DROPS	3	
TIMOLOL-BRIMONIDI-DORZOLAM(PF) OPTHALMIC (EYE) DROPS	3	
TIMOLOL-DORZOLAMID-LATANOP(PF) OPTHALMIC (EYE) DROPS	3	

Drug Name	Drug Tier	Requirements / Limits
TIMOLOL-LATANOPROST(PF) OPTHALMIC (EYE) DROPS	3	
TRAVATAN Z OPTHALMIC (EYE) DROPS	3	
<i>travoprost ophthalmic (eye) drops</i>	1	
TRUSOPT OPTHALMIC (EYE) DROPS	3	ST
VYZULTA OPTHALMIC (EYE) DROPS	3	ST
XALATAN OPTHALMIC (EYE) DROPS	3	ST
XELPROS OPTHALMIC (EYE) DROPS, EMULSION	3	ST
ZIOPTAN (PF) OPTHALMIC (EYE) DROPPERETTE	2	ST
STEROID-ANTIBIOTIC COMBINATIONS		
MAXITROL OPTHALMIC (EYE) DROPS,SUSPENSION	3	
MAXITROL OPTHALMIC (EYE) OINTMENT	3	

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Drug Name	Drug Tier	Requirements / Limits
<i>neomycin-bacitracin-poly-hc ophthalmic (eye) ointment</i>	1	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension</i>	1	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment</i>	1	
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension</i>	1	
<i>neo-polycin hc ophthalmic (eye) ointment</i>	1	
PRED-G OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
PRED-G S.O.P. OPHTHALMIC (EYE) OINTMENT	3	
PREDNISOLONE SOD PH-MOXIFLOX OPHTHALMIC (EYE) DROPS	3	
PREDNISOLONE-MOXIFLOXACIN HCL OPHTHALMIC (EYE) DROPS,SUSPENSION	3	

Drug Name	Drug Tier	Requirements / Limits
TOBRADEX OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	2	
TOBRADEX ST OPHTHALMIC (EYE) DROPS,SUSPENSION	2	
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension</i>	1	
ZYLET OPHTHALMIC (EYE) DROPS,SUSPENSION	2	
STERIODS		
ALREX OPHTHALMIC (EYE) DROPS,SUSPENSION	3	ST
<i>dexamethasone sodium phosphate ophthalmic (eye) drops</i>	1	
DEXTENZA INTRACANALICULAR INSERT	3	
DEXYCU (PF) INTRAOCULAR SUSPENSION	3	
DUREZOL OPHTHALMIC (EYE) DROPS	3	

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Drug Name	Drug Tier	Requirements / Limits
FLAREX OPHTHALMIC (EYE) DROPS,SUSPENSION	3	ST
<i>fluorometholone ophthalmic (eye) drops,suspension</i>	1	
FML FORTE OPHTHALMIC (EYE) DROPS,SUSPENSION	3	ST
FML LIQUIFILM OPHTHALMIC (EYE) DROPS,SUSPENSION	3	ST
FML S.O.P. OPHTHALMIC (EYE) OINTMENT	3	ST
ILUVIEN INTRAVITREAL IMPLANT	4	LA
INVELTYS OPHTHALMIC (EYE) DROPS,SUSPENSION	2	ST
LOTEMAX OPHTHALMIC (EYE) DROPS,GEL	2	
LOTEMAX OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
LOTEMAX OPHTHALMIC (EYE) OINTMENT	2	

Drug Name	Drug Tier	Requirements / Limits
LOTEMAX SM OPHTHALMIC (EYE) DROPS,GEL	2	
<i>loteprednol etabonate ophthalmic (eye) drops,suspension</i>	1	
MAXIDEX OPHTHALMIC (EYE) DROPS,SUSPENSION	3	ST
OZURDEX INTRAVITREAL IMPLANT	4	LA
PRED FORTE OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
PRED MILD OPHTHALMIC (EYE) DROPS,SUSPENSION	3	ST
PREDNISOLONE ACETATE (PF) OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>prednisolone acetate ophthalmic (eye) drops,suspension</i>	1	
<i>prednisolone sodium phosphate ophthalmic (eye) drops</i>	1	
RETISERT INTRAVITREAL IMPLANT	4	LA

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Drug Name	Drug Tier	Requirements / Limits
YUTIQ INTRAVITREAL IMPLANT	4	LA
STEROID-SULFONAMIDE COMBINATIONS		
BLEPHAMIDE OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
BLEPHAMIDE S.O.P. OPHTHALMIC (EYE) OINTMENT	3	
<i>sulfacetamide- prednisolone ophthalmic (eye) drops</i>	1	
SULFONAMIDES		
BLEPH-10 OPHTHALMIC (EYE) DROPS	3	
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	1	
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	1	
SYMPATHOMIMETICS		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	2	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.15 %	3	ST
<i>apraclonidine ophthalmic (eye) drops</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>brimonidine ophthalmic (eye) drops</i>	1	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	3	ST
VASOCONSTRICTOR DECONGESTANTS		
CYCLOMYDRIL OPHTHALMIC (EYE) DROPS	3	
<i>phenylephrine hcl ophthalmic (eye) drops</i>	1	
UPNEEQ OPHTHALMIC (EYE) DROPPERETTE	3	
RESPIRATORY, ALLERGY, COUGH & COLD		
ANTI-HISTAMINE & ANTI-ALLERGENIC AGENTS		
<i>adrenalin injection solution</i>	1	
AUVI-Q INJECTION AUTO- INJECTOR	3	PA; QL
<i>carbinoxamine maleate oral liquid</i>	1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	
<i>cetirizine oral solution 1 mg/ml</i>	1	
CLARINEX ORAL TABLET	3	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>clemastine oral tablet 2.68 mg</i>	1	
<i>cyproheptadine oral syrup</i>	1	
<i>cyproheptadine oral tablet</i>	1	
<i>desloratadine oral tablet</i>	1	QL
<i>desloratadine oral tablet, disintegrating</i>	1	QL
DIPHEN ORAL ELIXIR	3	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	1	
<i>diphenhydramine hcl injection syringe</i>	1	
EPINEPHRINE HCL (PF) INJECTION SOLUTION	3	
EPINEPHRINE INJECTION 0.15 MG AUTO-INJECTOR (IMPAX, LINEAGE GENERIC) 0.15 MG/0.15 ML	3	ST; QL
<i>epinephrine injection auto-injector (mylan generic) 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	1	QL
EPIPEN 2-PAK INJECTION AUTO-INJECTOR	2	ST; QL
EPIPEN JR 2-PAK INJECTION AUTO-INJECTOR	2	ST; QL

Drug Name	Drug Tier	Requirements / Limits
<i>hydroxyzine hcl intramuscular solution</i>	1	
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	1	
<i>hydroxyzine hcl oral tablet</i>	1	
<i>hydroxyzine pamoate oral capsule</i>	1	
KARBINAL ER ORAL SUSPENSION, EXTENDED REL 12 HR	3	
<i>levocetirizine oral solution</i>	1	
<i>levocetirizine oral tablet</i>	1	QL
<i>phenadoz rectal suppository</i>	1	
PHENERGAN INJECTION SOLUTION	3	
<i>promethazine injection solution</i>	1	
<i>promethazine oral syrup</i>	1	
<i>promethazine oral tablet</i>	1	
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	1	
<i>promethegan rectal suppository</i>	1	
QUZYTIR INTRAVENOUS SOLUTION	3	
RYCLORA ORAL SOLUTION	3	

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Drug Name	Drug Tier	Requirements / Limits
SYMJEPI INJECTION SYRINGE	2	QL
VISTARIL ORAL CAPSULE	3	
COUGH & COLD THERAPY		
<i>benzonatate oral capsule</i>	1	
BROMFED DM ORAL SYRUP	3	
<i>brompheniramine-pseudoeph-dm oral syrup</i>	1	
CAPCOF ORAL LIQUID	3	
CLARINEX-D 12 HOUR ORAL TABLET, ER MULTIPHASE 12 HR	3	QL
<i>codeine-guaifenesin oral liquid</i>	1	
CODITUSSIN AC ORAL LIQUID	3	
CODITUSSIN DAC ORAL LIQUID	3	
<i>g tussin ac oral liquid</i>	1	
<i>guaiaatussin ac oral liquid</i>	1	
HISTEX-AC ORAL SYRUP	3	
<i>hydrocodone-chlorpheniramine oral suspension, extended rel 12 hr</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>hydrocodone-homatropine oral syrup 5-1.5 mg/5 ml</i>	1	
<i>hydrocodone-homatropine oral tablet</i>	1	
<i>hydromet oral syrup</i>	1	
<i>lortuss ex oral syrup</i>	1	
MAR-COF CG ORAL LIQUID	3	
<i>maxi-tuss ac oral liquid</i>	1	
MAXI-TUSS CD ORAL LIQUID	3	
<i>m-clear wc oral liquid</i>	1	
M-END PE ORAL LIQUID	3	
NINJACOF-XG ORAL LIQUID	3	
OBREDON ORAL SOLUTION	3	ST
<i>pe-guai oral drops</i>	1	
POLY-TUSSIN AC ORAL LIQUID 4-10-10 MG/5 ML	3	
<i>promethazine-codeine oral syrup</i>	1	
<i>promethazine-dm oral syrup</i>	1	
<i>promethazine-phenyleph-codeine oral syrup</i>	1	
<i>promethazine-phenylephrine oral syrup</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
RESPA-AR ORAL TABLET EXTENDED RELEASE 12 HR	3	
SEMPREX-D ORAL CAPSULE	3	
TESSALON PERLES ORAL CAPSULE	3	
TUSSICAPS ORAL CAPSULE,EXTENDED RELEASE 12 HR	3	ST
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HR	3	
TUZISTRA XR ORAL SUSPENSION,EXTENDED REL 12 HR	3	ST
<i>virtussin ac oral liquid</i>	1	
<i>virtussin dac oral syrup</i>	1	
ZODRYL AC 25 ORAL SUSPENSION	3	
ZODRYL AC 30 ORAL SUSPENSION	3	
ZODRYL AC 35 ORAL SUSPENSION	3	
ZODRYL AC 40 ORAL SUSPENSION	3	
ZODRYL AC 50 ORAL SUSPENSION	3	

Drug Name	Drug Tier	Requirements / Limits
ZODRYL AC 60 ORAL SUSPENSION	3	
ZODRYL AC 80 ORAL SUSPENSION	3	
ZODRYL DAC 25 ORAL SUSPENSION	3	
ZODRYL DAC 30 ORAL SUSPENSION	3	
ZODRYL DAC 35 ORAL SUSPENSION	3	
ZODRYL DAC 40 ORAL SUSPENSION	3	
ZODRYL DAC 50 ORAL SUSPENSION	3	
ZODRYL DAC 60 ORAL SUSPENSION	3	
ZODRYL DAC 80 ORAL SUSPENSION	3	
ZODRYL DEC 25 ORAL SUSPENSION	3	
ZODRYL DEC 30 ORAL SUSPENSION	3	
ZODRYL DEC 35 ORAL SUSPENSION	3	
ZODRYL DEC 40 ORAL SUSPENSION	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
ZODRYL DEC 50 ORAL SUSPENSION	3	
ZODRYL DEC 60 ORAL SUSPENSION	3	
ZODRYL DEC 80 ORAL SUSPENSION	3	
Z-TUSS AC ORAL LIQUID	3	
PULMONARY AGENTS		
ACCOLATE ORAL TABLET	3	
<i>acetylcysteine solution</i>	1	
ADCIRCA ORAL TABLET	4	PA; LA; QL
ADEMPAS ORAL TABLET	4	PA; LA
ADRENALIN NASAL SOLUTION	3	
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE	3	QL
ADVAIR HFA INHALATION HFA AEROSOL INHALER	2	QL
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR	3	QL

Drug Name	Drug Tier	Requirements / Limits
AIRDUO RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED	3	QL
<i>albuterol sulfate inhalation hfa aerosol inhaler</i>	1	QL
<i>albuterol sulfate inhalation solution for nebulization</i>	1	
<i>albuterol sulfate oral syrup</i>	1	
<i>albuterol sulfate oral tablet</i>	1	
<i>albuterol sulfate oral tablet extended release 12 hr</i>	1	
ALVESCO INHALATION HFA AEROSOL INHALER	3	ST; QL
<i>alyq oral tablet</i>	4	PA; LA; QL
<i>ambrisentan oral tablet</i>	4	PA; LA
<i>aminophylline intravenous solution 250 mg/10 ml</i>	1	
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE	2	QL
ARCAPTA NEOHALER INHALATION CAPSULE, W/INHALATION DEVICE	3	QL

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Drug Name	Drug Tier	Requirements / Limits
ARMONAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR	3	QL
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE	2	QL
ASMANEX HFA INHALATION HFA AEROSOL INHALER	2	QL
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (14), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	2	QL
ATROVENT HFA INHALATION HFA AEROSOL INHALER	3	QL
<i>azelastine-fluticasone nasal spray, non-aerosol</i>	1	QL
BECONASE AQ NASAL SPRAY, NON-AEROSOL	3	ST; QL

Drug Name	Drug Tier	Requirements / Limits
BERINERT INTRAVENOUS KIT	4	PA; LA
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER	2	QL
<i>bosentan oral tablet</i>	4	PA; LA
BREO ELLIPTA INHALATION BLISTER WITH DEVICE	2	QL
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER	2	PA
BROVANA INHALATION SOLUTION FOR NEBULIZATION	3	ST; QL
<i>budesonide inhalation suspension for nebulization</i>	1	QL
BUDESONIDE-FORMOTEROL INHALATION HFA AEROSOL INHALER	3	QL
CINRYZE INTRAVENOUS RECON SOLN	4	PA; LA
COMBIVENT RESPIMAT INHALATION MIST	2	QL
<i>cromolyn inhalation solution for nebulization</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
CUROSURF INTRATRACHEAL SUSPENSION	3	
DALIRESP ORAL TABLET 250 MCG	2	PA; QL
DALIRESP ORAL TABLET 500 MCG	2	PA
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED	3	QL
DULERA INHALATION HFA AEROSOL INHALER	2	QL
DYMISTA NASAL SPRAY, NON-AEROSOL	2	ST; QL
ELIXOPHYLLIN ORAL ELIXIR 80 MG/15 ML	3	
ESBRIET ORAL CAPSULE	4	PA; LA; QL
ESBRIET ORAL TABLET 267 MG	4	PA; LA; QL
ESBRIET ORAL TABLET 801 MG	4	PA; LA
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA
FASENRA SUBCUTANEOUS SYRINGE	4	PA; LA
FIRAZYR SUBCUTANEOUS SYRINGE	4	PA; LA

Drug Name	Drug Tier	Requirements / Limits
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE	2	QL
FLOVENT HFA INHALATION HFA AEROSOL INHALER	2	QL
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	1	QL
<i>fluticasone propionate nasal spray, suspension</i>	1	QL
FLUTICASONE PROPION-SALMETEROL INHALATION AEROSOL POWDR BREATH ACTIVATED	3	QL
<i>fluticasone propion-salmeterol inhalation blister with device</i>	1	QL
HAEGARDA SUBCUTANEOUS RECON SOLN	4	PA; LA
HYPER-SAL INHALATION SOLUTION FOR NEBULIZATION	3	
<i>icatibant subcutaneous syringe</i>	4	PA
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE	2	QL

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Drug Name	Drug Tier	Requirements / Limits
<i>ipratropium bromide inhalation solution</i>	1	
<i>ipratropium-albuterol inhalation solution for nebulization</i>	1	QL
KALBITOR SUBCUTANEOUS SOLUTION	4	PA; LA
KALYDECO ORAL GRANULES IN PACKET 25 MG	4	PA; LA
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	4	PA; LA; QL
KALYDECO ORAL TABLET	4	PA; LA; QL
LETAIRIS ORAL TABLET	4	PA; LA
<i>levalbuterol hcl inhalation solution for nebulization</i>	1	
LEVALBUTEROL TARTRATE INHALATION HFA AEROSOL INHALER	3	ST; QL
LONHALA MAGNAIR REFILL INHALATION SOLUTION FOR NEBULIZATION	3	QL
LONHALA MAGNAIR STARTER INHALATION SOLUTION FOR NEBULIZATION	3	QL

Drug Name	Drug Tier	Requirements / Limits
<i>metaproterenol oral syrup</i>	1	
<i>mometasone nasal spray,non-aerosol</i>	1	QL
<i>montelukast oral granules in packet</i>	1	
<i>montelukast oral tablet</i>	1	
<i>montelukast oral tablet,chewable</i>	1	
NASONEX NASAL SPRAY,NON-AEROSOL	3	ST; QL
<i>nebusal inhalation solution for nebulization 3 %</i>	1	
NEBUSAL INHALATION SOLUTION FOR NEBULIZATION 6 %	3	
NUCALA SUBCUTANEOUS AUTO-INJECTOR	4	PA; LA; QL
NUCALA SUBCUTANEOUS RECON SOLN	4	PA; LA; QL
NUCALA SUBCUTANEOUS SYRINGE	4	PA; LA; QL
OFEV ORAL CAPSULE	4	PA; LA; QL
OMNARIS NASAL SPRAY,NON-AEROSOL	3	ST; QL
OPSUMIT ORAL TABLET	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
ORKAMBI ORAL GRANULES IN PACKET	4	PA; LA; QL
ORKAMBI ORAL TABLET	4	PA; LA; QL
PERFOROMIST INHALATION SOLUTION FOR NEBULIZATION	2	QL
PROAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR	3	ST; QL
PROAIR HFA INHALATION HFA AEROSOL INHALER	3	ST; QL
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED	3	QL
PROVENTIL HFA INHALATION HFA AEROSOL INHALER	3	ST; QL
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED	2	QL
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION	3	QL

Drug Name	Drug Tier	Requirements / Limits
<i>pulmosal inhalation solution for nebulization</i>	1	
PULMOZYME INHALATION SOLUTION	4	LA
QNASL NASAL HFA AEROSOL INHALER	2	ST; QL
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED	2	QL
REVATIO INTRAVENOUS SOLUTION	4	PA; LA
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	4	PA; LA; QL
REVATIO ORAL TABLET	4	PA; LA; QL
RUCONEST INTRAVENOUS RECON SOLN	4	PA; LA
SEEBRI NEOHALER INHALATION CAPSULE, W/INHALATION DEVICE	3	QL
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE	2	QL
<i>sildenafil (pulm.hypertension) intravenous solution</i>	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution</i>	4	PA; LA; QL
<i>sildenafil (pulm.hypertension) oral tablet</i>	4	PA; LA; QL
SINGULAIR ORAL GRANULES IN PACKET	3	
SINGULAIR ORAL TABLET	3	
SINGULAIR ORAL TABLET,CHEWABLE	3	
SINUVA SINUS IMPLANT	4	PA; LA
<i>sodium chloride inhalation solution for nebulization</i>	1	
SPIRIVA RESPIMAT INHALATION MIST	2	QL
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE	2	QL
STIOLTO RESPIMAT INHALATION MIST	2	QL
STRIVERDI RESPIMAT INHALATION MIST	2	QL

Drug Name	Drug Tier	Requirements / Limits
SURFAXIN INTRATRACHEAL SUSPENSION	3	
SYMBICORT INHALATION HFA AEROSOL INHALER	2	QL
SYMDEKO ORAL TABLETS, SEQUENTIAL	4	PA; LA; QL
<i>tadalafil (pulm.hypertension) oral tablet</i>	4	PA; LA; QL
TAKHZYRO SUBCUTANEOUS SOLUTION	4	PA; LA; QL
<i>terbutaline oral tablet</i>	1	
<i>terbutaline subcutaneous solution</i>	1	
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR	3	
<i>theophylline oral elixir</i>	1	
<i>theophylline oral solution</i>	1	
<i>theophylline oral tablet extended release 12 hr</i>	1	
<i>theophylline oral tablet extended release 24 hr</i>	1	
TRACLEER ORAL TABLET	4	PA; LA

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Drug Name	Drug Tier	Requirements / Limits
TRACLEER ORAL TABLET FOR SUSPENSION	4	PA; LA
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG	2	QL
TRIKAFTA ORAL TABLETS, SEQUENTIAL	4	PA; LA
TYVASO INHALATION SOLUTION FOR NEBULIZATION	4	PA; LA
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION	4	PA; LA
TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION	4	PA; LA
UTIBRON NEOHALER INHALATION CAPSULE, W/INHALATION DEVICE	3	QL
VENTOLIN HFA INHALATION HFA AEROSOL INHALER	2	QL
<i>wixela inhub inhalation blister with device</i>	1	QL

Drug Name	Drug Tier	Requirements / Limits
XHANCE NASAL AEROSOL BREATH ACTIVATED	3	ST; QL
XOLAIR SUBCUTANEOUS RECON SOLN	4	PA; LA; QL
XOLAIR SUBCUTANEOUS SYRINGE	4	PA; LA; QL
XOPENEX CONCENTRATE INHALATION SOLUTION FOR NEBULIZATION	3	
XOPENEX HFA INHALATION HFA AEROSOL INHALER	3	ST; QL
XOPENEX INHALATION SOLUTION FOR NEBULIZATION	3	
YUPELRI INHALATION SOLUTION FOR NEBULIZATION	2	QL
<i>zafirlukast oral tablet</i>	1	
ZETONNA NASAL HFA AEROSOL INHALER	3	ST; QL
<i>zileuton oral tablet, er multiphase 12 hr</i>	1	ST
ZYFLO ORAL TABLET	3	ST

UROLOGICALS

ANTICHOLINERGICS & ANTISPASMODICS

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
<i>darifenacin oral tablet extended release 24 hr</i>	1	
DETROL LA ORAL CAPSULE, EXTENDED RELEASE 24HR	3	ST
DETROL ORAL TABLET	3	ST
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 5 MG	3	ST
ENABLEX ORAL TABLET EXTENDED RELEASE 24 HR	3	ST
<i>flavoxate oral tablet</i>	1	
GELNIQUE TRANSDERMAL GEL IN METERED-DOSE PUMP 100 MG/GRAM (10 %)	2	ST; QL
GELNIQUE TRANSDERMAL GEL IN PACKET	2	ST; QL
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	2	ST
<i>oxybutynin chloride oral syrup</i>	1	
<i>oxybutynin chloride oral tablet</i>	1	
<i>oxybutynin chloride oral tablet extended release 24hr</i>	1	

Drug Name	Drug Tier	Requirements / Limits
OXYTROL TRANSDERMAL PATCH SEMIWEEKLY	3	ST; QL
<i>solifenacin oral tablet</i>	1	
<i>tolterodine oral capsule, extended release 24hr</i>	1	
<i>tolterodine oral tablet</i>	1	
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR	2	ST
<i>trospium oral capsule, extended release 24hr</i>	1	
<i>trospium oral tablet</i>	1	
VESICARE ORAL TABLET	3	ST
BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY		
<i>alfuzosin oral tablet extended release 24 hr</i>	1	
AVODART ORAL CAPSULE	3	
CIALIS ORAL TABLET 2.5 MG, 5 MG	3	PA; QL
<i>dutasteride oral capsule</i>	1	
<i>dutasteride-tamsulosin oral capsule, er multiphase 24 hr</i>	1	
<i>finasteride oral tablet 5 mg</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
FLOMAX ORAL CAPSULE	3	
JALYN ORAL CAPSULE, ER MULTIPHASE 24 HR	3	
PROSCAR ORAL TABLET	3	
RAPAFLO ORAL CAPSULE	3	
<i>silodosin oral capsule</i>	1	
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1	PA; QL
<i>tamsulosin oral capsule</i>	1	
UROXATRAL ORAL TABLET EXTENDED RELEASE 24 HR	3	
CHOLINERGIC STIMULANTS		
<i>bethanechol chloride oral tablet</i>	1	
URECHOLINE ORAL TABLET 25 MG, 5 MG, 50 MG	3	
MISCELLANEOUS UROLOGICALS		
<i>alprostadil injection solution</i>	1	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT	2	QL
CAVERJECT INTRACAVERNOSAL RECON SOLN	2	QL

Drug Name	Drug Tier	Requirements / Limits
CAVERJECT INTRACAVERNOSAL SYRINGE	2	QL
CIALIS ORAL TABLET 10 MG, 20 MG	3	QL
CYSTAGON ORAL CAPSULE	4	LA
<i>cytra k crystals oral packet</i>	1	
EDEX INTRACAVERNOSAL KIT	3	QL
ELMIRON ORAL CAPSULE	2	
IFE-BIMIX 30/1 INTRACAVERNOSAL SOLUTION	3	QL
IFE-PG20 INTRACAVERNOSAL SOLUTION	3	QL
K-PHOS ORIGINAL ORAL TABLET,SOLUBLE	2	
LEVITRA ORAL TABLET 10 MG, 20 MG	3	ST; QL
MUSE INTRA-URETHRAL SUPPOSITORY	2	QL
PAPAV-PHENTOLAM-ALPROST-WATER INTRACAVERNOSAL SOLUTION	3	QL

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Drug Name	Drug Tier	Requirements / Limits
PAPAV-PHENTOLAMINE IN WATER INTRACAVERNOSAL SOLUTION	3	QL
<i>potassium citrate oral tablet extended release</i>	1	
PROCYSBI ORAL CAPSULE, DELAYED REL SPRINKLE	4	ST; LA
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	4	ST; LA
PROSTIN VR PEDIATRIC INJECTION SOLUTION	3	
RENACIDIN IRRIGATION SOLUTION 1980.6 MG-59.4 MG-980.4MG/30ML	2	
SHOHL'S MODIFIED ORAL SOLUTION	3	
<i>sildenafil oral tablet</i>	1	QL
STAXYN ORAL TABLET,DISINTEGRATING	3	ST; QL
STENDRA ORAL TABLET	3	ST; QL
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1	QL

Drug Name	Drug Tier	Requirements / Limits
TRI-MIX (PAPAVRN-PHNTLMN-PGE1) INTRACAVERNOSAL RECON SOLN	3	QL
<i>uretron d-s oral tablet 81.6-10.8-40.8 mg</i>	1	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE	3	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE	3	
UROCIT-K 5 ORAL TABLET EXTENDED RELEASE	3	
<i>uro-mp oral capsule</i>	1	
UROQID-ACID NO.2 ORAL TABLET	3	
<i>uryl oral tablet</i>	1	
<i>vardenafil oral tablet</i>	1	QL
<i>vardenafil oral tablet,disintegrating</i>	1	QL
VIAGRA ORAL TABLET	3	ST; QL
<i>vilamit mb oral capsule</i>	1	
URINARY ANESTHETICS		
PYRIDIUM ORAL TABLET	3	

VITAMINS, HEMATINICS & ELECTROLYTES

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
ELECTROLYTES		
CALCIUM GLUCONATE IN NAACL, ISO-Osm INTRAVENOUS SOLUTION	3	
<i>calcium gluconate in 0.9% nacl intravenous solution 1 gram/100 ml</i>	1	
CALCIUM GLUCONATE IN WATER INTRAVENOUS SYRINGE	3	
EFFER-K ORAL TABLET, EFFERVESCENT 20 MEQ	3	
<i>effe-k oral tablet, effervescent 25 meq</i>	1	
GALZIN ORAL CAPSULE	3	
<i>klor-con 10 oral tablet extended release</i>	1	
<i>klor-con 8 oral tablet extended release</i>	1	
<i>klor-con m10 oral tablet,er particles/crystals</i>	1	
<i>klor-con m15 oral tablet,er particles/crystals</i>	1	
<i>klor-con m20 oral tablet,er particles/crystals</i>	1	
<i>klor-con oral packet</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>klor-con/ef oral tablet, effervescent</i>	1	
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	3	
<i>k-tab oral tablet extended release 8 meq</i>	1	
<i>lugols oral solution</i>	1	
NORMOSOL-R INTRAVENOUS PARENTERAL SOLUTION	3	
POTABA ORAL CAPSULE	3	
<i>potassium chloride oral capsule, extended release</i>	1	
<i>potassium chloride oral liquid</i>	1	
<i>potassium chloride oral packet</i>	1	
<i>potassium chloride oral tablet extended release</i>	1	
<i>potassium chloride oral tablet,er particles/crystals</i>	1	
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	1	
<i>sodium chloride 0.45 % intravenous piggyback</i>	1	
<i>sodium chloride 3 % intravenous parenteral solution</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>sodium chloride 5 % intravenous parenteral solution</i>	1	
<i>sodium chloride intravenous parenteral solution</i>	1	
<i>strong iodine oral solution</i>	1	
MISCELLANEOUS VITAMINS, HEMATINICS, & ELECTROLYTES		
DOJOLVI ORAL LIQUID	4	PA; LA
ISOLYTE S PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	2	
ISOLYTE-S INTRAVENOUS PARENTERAL SOLUTION	2	
NORMOSOL-R PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	2	
PLASMA-LYTE 148 INTRAVENOUS PARENTERAL SOLUTION	2	
PLASMA-LYTE A INTRAVENOUS PARENTERAL SOLUTION	2	
VITAMINS & HEMATINICS		
ASCOR INTRAVENOUS SOLUTION	3	

Drug Name	Drug Tier	Requirements / Limits
<i>ascorbic acid (vitamin c) injection solution</i>	1	
<i>b complex 100 injection solution</i>	1	
BAL-CARE DHA ESSENTIAL ORAL COMBO PACK, TABLET AND CAP, DR	3	
<i>bal-care dha oral combo pack, tablet and cap, dr</i>	1	
CITRANATAL (DUAL-IRON) ORAL TABLET	3	
CITRANATAL 90 DHA (ALGAL OIL) ORAL COMBO PACK	3	
CITRANATAL ASSURE ORAL COMBO PACK 35 MG IRON-1 MG - 50 MG-300 MG	3	
CITRANATAL B-CALM (FE GLUC) ORAL TABLETS, SEQUENTIAL	3	
CITRANATAL DHA (ALGAL OIL) ORAL COMBO PACK	3	
CITRANATAL HARMONY (IRON FUM) ORAL CAPSULE	3	
<i>c-nate dha oral capsule</i>	1	

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Drug Name	Drug Tier	Requirements / Limits
<i>complete natal dha oral combo pack</i>	1	
CONCEPT DHA ORAL CAPSULE	3	
CONCEPT OB ORAL CAPSULE	3	
<i>cyanocobalamin (vitamin b-12) injection solution</i>	1	
DRISDOL ORAL CAPSULE	3	
DUET DHA BALANCED ORAL COMBO PACK 25 MG IRON-1 MG - 267 MG-233 MG	3	
DUET DHA WITH OMEGA-3 ORAL COMBO PACK 25 MG IRON-1 MG - 400 MG	3	
<i>elite-ob oral tablet</i>	1	
ENBRACE HR ORAL CAPSULE,IR - DELAY REL,BIPHASE	3	
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	1	
FERAHEME INTRAVENOUS SOLUTION	2	
<i>fluoride (sodium) oral drops</i>	5	ACA; OTC
<i>fluoride (sodium) oral tablet,chewable</i>	5	ACA; OTC

Drug Name	Drug Tier	Requirements / Limits
<i>fluoritab oral tablet,chewable</i>	5	ACA; OTC
FOLET ONE ORAL CAPSULE	3	
<i>folic acid injection solution</i>	1	
<i>folic acid oral tablet 1 mg</i>	1	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	5	ACA; OTC
<i>folivane-ob oral capsule</i>	1	
<i>hydroxocobalamin intramuscular solution</i>	1	
INFED INJECTION SOLUTION	2	
INFUVITE ADULT INTRAVENOUS SOLUTION	3	
INFUVITE PEDIATRIC INTRAVENOUS SOLUTION	2	
INJECTAFER INTRAVENOUS SOLUTION	3	
KOSHER PRENATAL PLUS IRON ORAL TABLET	3	
<i>ludent fluoride oral tablet,chewable</i>	5	ACA; OTC
<i>m.v.i. adult intravenous solution</i>	1	
M.V.I. PEDIATRIC INTRAVENOUS RECON SOLN	2	

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Drug Name	Drug Tier	Requirements / Limits
MARNATAL-F ORAL CAPSULE	3	
MECOBALAMIN (VITAMIN B12) INJECTION RECON SOLN	3	
<i>m-natal plus oral tablet</i>	1	
MONOFERRIC INTRAVENOUS SOLUTION	3	
<i>multi-vitamin with fluoride oral drops</i>	5	ACA; OTC
<i>multi-vitamin with fluoride oral tablet, chewable</i>	5	ACA; OTC
<i>multivitamins with fluoride oral tablet, chewable</i>	5	ACA; OTC
<i>mvc-fluoride oral tablet, chewable</i>	5	ACA; OTC
<i>mynatal advance oral tablet</i>	1	
<i>mynatal oral capsule</i>	1	
<i>mynatal oral tablet</i>	1	
<i>mynatal plus oral tablet</i>	1	
<i>mynatal-z oral tablet</i>	1	
<i>mynate 90 plus oral tablet extended release</i>	1	
NASCOBAL NASAL SPRAY, NON-AEROSOL	2	ST

Drug Name	Drug Tier	Requirements / Limits
NATACHEW (FE BIS-GLYCINATE) ORAL TABLET, CHEWABLE	3	
NEEVODHA (WITH ALGAL OIL) ORAL CAPSULE	3	
NESTABS ABC ORAL COMBO PACK	3	
NESTABS DHA ORAL COMBO PACK	3	
NESTABS ONE ORAL CAPSULE	3	
NESTABS ORAL TABLET	3	
<i>newgen oral tablet</i>	1	
NEXAVIR INJECTION SOLUTION	3	
OB COMPLETE ONE ORAL CAPSULE	3	
OB COMPLETE ORAL TABLET	3	
OB COMPLETE PETITE ORAL CAPSULE	3	
OB COMPLETE PREMIER ORAL TABLET	3	
OB COMPLETE WITH DHA ORAL CAPSULE	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
<i>obstetrix dha oral combo pack,tablet and cap,dr</i>	1	
OBSTETRIX EC ORAL TABLET,DELAYED RELEASE (DR/EC)	3	
OBSTETRIX ONE ORAL CAPSULE	3	
OBTREX DHA ORAL COMBO PACK, TABLET AND CAP, DR	3	
<i>pnv 29-1 oral tablet</i>	1	
<i>pnv-dha + docusate oral capsule</i>	1	
<i>pnv-dha oral capsule</i>	1	
<i>pnv-omega oral capsule</i>	1	
<i>pnv-select oral tablet</i>	1	
<i>pnv-vp-u oral capsule</i>	1	
<i>pr natal 400 ec oral combo pack,tablet and cap,dr</i>	1	
<i>pr natal 400 oral combo pack</i>	1	
<i>pr natal 430 ec oral combo pack,tablet and cap,dr</i>	1	
<i>pr natal 430 oral combo pack</i>	1	
PREGENNA ORAL TABLET	3	
<i>prenal chew oral tablet,chew,ir - dr,biphase</i>	1	

Drug Name	Drug Tier	Requirements / Limits
<i>prenal pearl oral capsule,ir - delay rel,biphase</i>	1	
<i>prenal true oral combo pack</i>	1	
<i>prenaissance oral capsule</i>	1	
<i>prenaissance plus oral capsule</i>	1	
PRENATA ORAL TABLET,CHEWABLE	3	
<i>prenatabs fa oral tablet</i>	1	
<i>prenatabs rx oral tablet</i>	1	
<i>prenatal plus (calcium carb) oral tablet</i>	1	
PRENATAL PLUS DHA ORAL COMBO PACK	3	
<i>prenatal plus oral tablet</i>	1	
<i>prenatal vitamin plus low iron oral tablet</i>	1	
<i>prenatal-u oral capsule</i>	1	
PRENATE AM ORAL TABLET	3	
PRENATE CHEWABLE ORAL TABLET,CHEWABLE	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
PRENATE DHA (FERR ASP GLYCIN) ORAL CAPSULE	3	
PRENATE ELITE (IRON ASP GLYC) ORAL TABLET	3	
PRENATE ENHANCE ORAL CAPSULE	3	
PRENATE ESSENTIAL(IRON-ASP-GL) ORAL CAPSULE	3	
PRENATE MINI (FERR ASP GLYCIN) ORAL CAPSULE	3	
PRENATE PIXIE ORAL CAPSULE	3	
PRENATE RESTORE ORAL CAPSULE	3	
PRENATE STAR ORAL TABLET	3	
<i>pretab oral tablet</i>	1	
PRIMACARE ORAL CAPSULE	3	
PROVIDA OB ORAL CAPSULE	3	
PUREFE OB PLUS ORAL CAPSULE	3	
R-NATAL OB ORAL CAPSULE	3	
SELECT-OB (FOLIC ACID) ORAL TABLET,CHEWABLE	3	

Drug Name	Drug Tier	Requirements / Limits
SELECT-OB + DHA ORAL COMBO PACK	3	
SELECT-OB ORAL TABLET,CHEWABLE	3	
<i>se-natal 19 chewable oral tablet,chewable</i>	1	
<i>se-natal-19 oral tablet</i>	2	
<i>taron-c dha oral capsule</i>	1	
<i>taron-prex prenatal-dha oral capsule</i>	1	
THRIVITE RX ORAL TABLET	3	
TRICARE ORAL TABLET	3	
TRIFERIC HEMODIALYSIS POWDER IN PACKET	3	
TRIFERIC HEMODIALYSIS SOLUTION	3	
<i>trinatal rx 1 oral tablet</i>	1	
<i>trinate oral tablet</i>	1	
TRISTART DHA ORAL CAPSULE	3	
<i>triveen-duo dha oral combo pack</i>	1	
<i>tri-vitamin with fluoride oral drops</i>	5	ACA; OTC
<i>trust natal dha oral combo pack</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

Drug Name	Drug Tier	Requirements / Limits
VENOFER INTRAVENOUS SOLUTION	2	
VINATE DHA RF ORAL CAPSULE	3	
<i>virt-c dha oral capsule</i>	1	
<i>virt-nate dha oral capsule</i>	1	
<i>virt-pn dha oral capsule</i>	1	
<i>virt-pn plus oral capsule</i>	1	
VITAFOL FE PLUS ORAL CAPSULE	3	
VITAFOL FE+ (WITH DOCUSATE) ORAL CAPSULE	3	
VITAFOL GUMMIES ORAL TABLET,CHEWAB LE	3	
VITAFOL NANO ORAL TABLET	3	
VITAFOL ULTRA ORAL CAPSULE	3	
VITAFOL-OB ORAL TABLET	3	
VITAFOL- OB+DHA ORAL COMBO PACK	3	

Drug Name	Drug Tier	Requirements / Limits
VITAFOL-ONE ORAL CAPSULE	3	
VITAMED MD ONE RX ORAL CAPSULE	3	
VITAMEDMD REDICHEW RX ORAL TABLET,CHEW,IR - DR,BIPHASE	3	
<i>vitamins a,c,d and fluoride oral drops</i>	5	ACA; OTC
VITAPEARL ORAL CAPSULE,IR - DELAY REL,BIPHASE	3	
VITATRUE ORAL COMBO PACK	3	
<i>vp-ch-pnv oral capsule</i>	1	
VP-PNV-DHA ORAL CAPSULE	3	
<i>zatean-pn dha oral capsule</i>	1	
<i>zatean-pn plus oral capsule</i>	1	
<i>zingiber oral tablet</i>	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table. Updated November 1, 2020.

MEDICAL MUTUAL

Resources/Tools

My Health Plan—It's All About You



With My Health Plan, our secure member portal, you can access all the tools you need to manage your health plan—and start being a healthier you.

My Health Plan Tools and Resources

- Access your Explanation of Benefits (EOB) forms to monitor the costs of doctor's visits and treatment you receive.
- Use Find a Provider tool to search for in-network doctors and hospitals covered by your plan to give you the most cost-effective coverage available.
- Order new identification (ID) cards or even print a temporary one.
- Access other tools and resources to help you manage your health plan.

Go Paperless!

Safely access claim information online and receive alerts as soon as claims are processed. Look for the Go Paperless icon to sign up. Alerts for paperless items are sent to your email. If you try electronic delivery and decide it's not for you, switch back to paper at any time.

Registration is Easy!

Step 1

To set up your personal My Health Plan account, simply visit our website, MedMutual.com, and click on Register Now on the right side of the page to get started.





Step 2

Enter your member identification number and date of birth. If you don't have your ID card handy, enter your Social Security number, date of birth and first and last name.

The screenshot shows the 'my Health Plan' registration interface. At the top, it says 'my Health Plan' and 'Register'. Below this, there are three progress steps: '1. Enter yourself', '2. Create account', and '3. Complete profile'. The current step is 'Step 1 - Identify Yourself'. The form contains two input fields: 'Member ID*' and 'Date of Birth*'. Below the 'Date of Birth' field is a link: 'Please see memberhelp@goi.com (610) 272-1822'. A green box highlights the 'Member ID' and 'Date of Birth' fields and the 'Continue' button. To the right, there is a 'Need Help?' section with the text 'If you are having trouble, please call our Technical Help Desk.' and a phone number '800.294.7500'. Below that is a 'Already Registered?' section with a 'Log in here' link.

Step 2

Step 3

Create a user name and password and enter your email address.

- Your username can be a combination of letters and numbers. It must contain between eight and 20 characters, not contain symbols and have at least one letter and one number.
Example: John22Smith
- Your password must be at least eight characters, include one uppercase letter, one lowercase letter and one number. We also recommend including at least one special character (@#%&).
Example: GreenTree2#3\$4!

Check the box to agree to the Terms and Conditions, then click Continue.

The screenshot shows the 'my Health Plan' registration interface for Step 3. At the top, it says 'my Health Plan' and 'Register'. Below this, there are three progress steps: '1. Enter yourself', '2. Create account', and '3. Complete profile'. The current step is 'Step 3 - Create Account'. The form contains four input fields: 'Username*', 'Create Password*', 'Confirm Password*', and 'Email Address*'. Below the 'Email Address' field is a link: 'View our privacy policy'. At the bottom of the form, there is a checkbox labeled 'I agree to the Terms and Conditions' and a link 'Show Terms and Conditions'. A green box highlights the 'Username', 'Create Password', 'Confirm Password', and 'Email Address' fields and the 'Continue' button. To the right, there is a 'Need Help?' section with the text 'If you are having trouble, please call our Technical Help Desk.' and a phone number '800.294.7500'. Below that is a 'Already Registered?' section with a 'Log in here' link.

Step 3

Your Health Plan Benefits at Your Fingertips

Download the MedMutual Mobile App

Get access to the important health insurance information you need wherever you are with the MedMutual mobile app. It makes it easy and convenient to manage your health insurance, whether you're at home, at your doctor's office or on the go.

Track Your Claims and Spending Information

Review your claims online, including details about the total amount billed, what Medical Mutual paid and what you are responsible for paying. You can also view other spending information, like your deductible, out-of-pocket costs and explanation of benefits (EOB) statements.

Estimate Costs

With our My Care Compare feature, you can view cost estimates before you go to the doctor or to the lab for certain tests.

Find a Provider

You can enter your ZIP Code to find the nearest doctor, hospital or urgent care facility covered by your plan and get step-by-step directions. You can also view quality and patient ratings for providers.

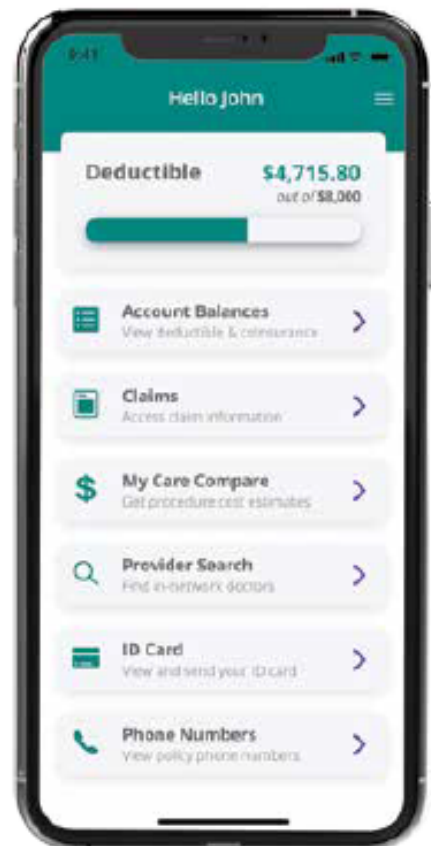
Access Your ID Card

You always have your ID card with you with our mobile app. View the front and back of your card and call any of the phone numbers listed with just a tap. You can also email or fax your card to your provider.

Securely Log In Without Your Password

You can even use your device's Facial Recognition or Touch ID feature for a simple, secure and convenient login. This means you don't have to type in your username and password if these features are enabled.

To download or update the app, visit your device's App Store (Apple) or Google Play (Android). Make sure your app is set to automatically update, so you don't miss out on future upgrades and new features.



© 2019 Apple Inc. All rights reserved. The App Store is a registered trademark of Apple Inc.

© 2019 Google Inc. All rights reserved. Google Play is a trademark of Google Inc.

Online Tools from Medical Mutual

Smart, Simple, Safe

Here are three ways online tools from Medical Mutual make your health insurance information accessible 24 hours a day, no matter where you are. Visit [MedMutual.com/Member](https://www.medmutual.com/Member) to register.



My Health Plan

- Understand your out-of-pocket spending with real-time deductible and coinsurance information
- Find doctors and hospitals in your network, and compare quality and satisfaction ratings
- Estimate costs—know before you go and save money



Go Paperless

- Receive your Explanation of Benefits (EOB), certificate books and other documents electronically
- There's no need to keep paper files—we'll store the records for you
- Keep your health information secure—it's safer and faster than mail



Download the Mobile App

- Use our most popular My Health Plan features when you're on the go
- Find providers, estimate costs, check claims, and fax or email your ID card
- Download the app today for free from the Apple App Store® or Google Play™ by searching for MedMutual

Get started now at [MedMutual.com/Member](https://www.medmutual.com/Member).

Where to Find Care

Understanding your options can help you save time and money



When it comes to taking care of yourself or your loved ones, you want to get the best care as quickly and affordably as possible. When you are ill, injured or feeling like you need immediate care, always call your primary care physician (PCP) first. If you can't reach your PCP or you don't have time for an office visit, you have options.

Nurse Line

A free call-in service offered by Medical Mutual, providing 24/7 access to registered nurses for answers to health-related questions. Call 1-888-912-0636.

Telehealth (Telemedicine)

A service that allows you to connect with your provider virtually using a smart phone, tablet or computer. Many providers offer scheduled telehealth appointments. You may also have access to an on-demand telehealth service that is available 24/7.

Convenience Clinic

A walk-in clinic located in some drug and grocery stores, staffed by a physician's assistant or nurse practitioner. Convenience clinics don't require an appointment and have shorter than average wait times.

Urgent Care

A walk-in clinic that saves time and money compared to an emergency room. Many are open evenings and weekends. Urgent care facilities don't require an appointment and have average wait times.

Emergency Room (ER)

A facility located in a hospital, providing 24/7 care in case of emergencies and acute care without an appointment. ER visits for non-emergency symptoms may result in extremely long wait times and significantly higher costs compared to visiting a non-emergency location.

Symptom Reference Chart



	ER/911	Urgent Care	Convenience Clinic	Primary Care Physician	Telehealth
Allergic reactions*	●	●		●	
Allergies		●	●	●	●
Annual preventive care visit				●	
Asthma		●		●	
Back pain (minor)		●	●	●	
Bleeding (heavy)	●				
Broken bone (major)	●				
Broken bone (minor)		●		●	
Bronchitis		●	●	●	●
Change in vision (sudden)	●				
Chest pain	●				
Cold and flu symptoms		●	●	●	●
Cut/burn (major)	●				
Cut/burn (minor)		●		●	●
Ear infection		●	●	●	●
Head injury (severe)	●				
Infection		●		●	
Insect bite		●		●	●
Pink eye		●	●	●	●
Rash		●		●	●
Respiratory infection		●	●	●	●
Shortness of breath	●				
Sinus problems		●	●	●	●
Spinal injury	●				
Sprain or strain		●		●	●
Trouble speaking (sudden)	●				
Urinary tract infection		●	●	●	●
Vaccinations (also flu shots)			●	●	
Wheezing		●		●	
X-ray		●		●	

*Severe allergic reactions, such as tongue/throat swelling, difficulty speaking, swallowing or breathing should be seen in an ER.

Please Note: This is a sample list of services and may not be all-inclusive. This does not take the place of professional medical advice, diagnosis or treatment. Although this information is intended to help make the best decision for care, if you feel that your situation is life-threatening, go to the nearest emergency room.

Cleveland Clinic Express Care[®] Online

Telemedicine

As a member of Medical Mutual's SuperMed PPO Network, you have access to Cleveland Clinic's Express Care Online. Express Care Online is a secure service that offers 24/7 care with no appointment needed for simple conditions such as sinus infections, cold symptoms, rashes, ear aches and stomach pain.

How do I learn more and access Express Care Online?

- From your smartphone or tablet: Visit clevelandclinic.org/eco or download the Express Care app from the Apple App Store or Google Play
- From your computer: Visit clevelandclinic.org/eco

How much does an Express Care Online visit cost?

An Express Care Online visit is considered the same as a normal visit to your primary care provider (PCP).

While Cleveland Clinic's website states a \$55 fee, depending on your plan type, you may be charged an office visit copay or a \$49 Express Care Online fee.

Who can I call if I have a billing issue with an Express Care Online visit?

Please call Cleveland Clinic directly at 1-866-621-6385 and reference Express Care Online.

Who can use Express Care Online?

Adults and children ages two and older may use Express Care Online. Patients ages 17 years and younger must be accompanied by a parent/guardian during the visit.

Can Express Care Online providers diagnose a condition and/or write prescriptions?

Yes, when medically appropriate and at the provider's discretion. The provider will decide based on what he or she learns during a consultation if a diagnosis is possible, or if you need further examination (e.g., tests, a physical exam, another specialty visit), and if a prescription is appropriate.

Do Express Care Online visits accumulate toward my maximum out-of-pocket (MOOP) annual expense?

Yes. When you reach your plan's annual MOOP expense, Express Care Online visits will be covered by your plan.

Programs & Discounts

Disease Management Program

If you live with a chronic condition, having a coach to offer guidance and empowerment can be very helpful. Our Disease Management Program provides you with valuable information and a plan designed to meet your specific needs. The following conditions are eligible for the program:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease
- Diabetes
- Heart failure

WW® Program

Medical Mutual can save you almost 50 percent off the regular cost of a WW membership. You can choose from Digital (web-based) or Digital + Studio (formerly Meetings) programs to help achieve your health goals. We also offer a WW for Diabetes program if you've been diagnosed with Type 2 diabetes. For more information, call 1-800-251-2583 or visit MedMutual.com/WeightWatchers.

QuitLine Program

If you need help giving up your tobacco habit, our program can help. One-on-one coaching, a personalized plan and educational materials are available with no out-of-pocket costs. You may even qualify for nicotine patches or gum at no cost to you. Learn more by calling 1-866-845-7702.

24-Hour Nurse Line

If you have a health question, minor injury or medical question, you can get answers 24-hours-a-day from a clinical expert. Staffed by fully qualified registered nurses, our Nurse Line is available at no charge to members. Just call 1-888-912-0636 and have your member ID number ready.

Maternity Program

If a new baby is on the way, our Maternity Program can offer education and support. The program includes access to a specially trained maternity health coach who can provide valuable knowledge, advice and comfort during the pregnancy.

Both the Disease Management Program and the Maternity Program are available at no additional cost. To check eligibility or to enroll, call 1-800-861-4826. Select option 1 for Maternity or option 2 for Disease Management. You can also visit MedMutual.com/DiseaseManagement and MedMutual.com/Maternity for more information.

Fitness Discounts

Exercise can play a vital role in your health and happiness. That's why we've partnered with several health club chains to offer valuable discounts and benefits. Make fitness a new part of your routine with a membership discount at Curves®, or find a discounted gym membership at more than 10,000 fitness clubs throughout the U.S. through our national partner, GlobalFit®

Other Discounts

We've partnered with several vendors to offer discounts on a variety of unique health products and services including baby items, fitness club fees, hearing aids and other health products. You can find more details on My Health Plan.

AmericanFitness.net

A full selection of top brand exercise equipment to help you reach your fitness goals.

Beltone™ Hearing Aids

A full line of innovative hearing products that fit your lifestyle.

Safe Beginnings®

A large selection of items to help you keep your baby safe in your home.

YogaAccessories.com

High-quality yoga, meditation, spiritual, wellness and holistic living supplies.

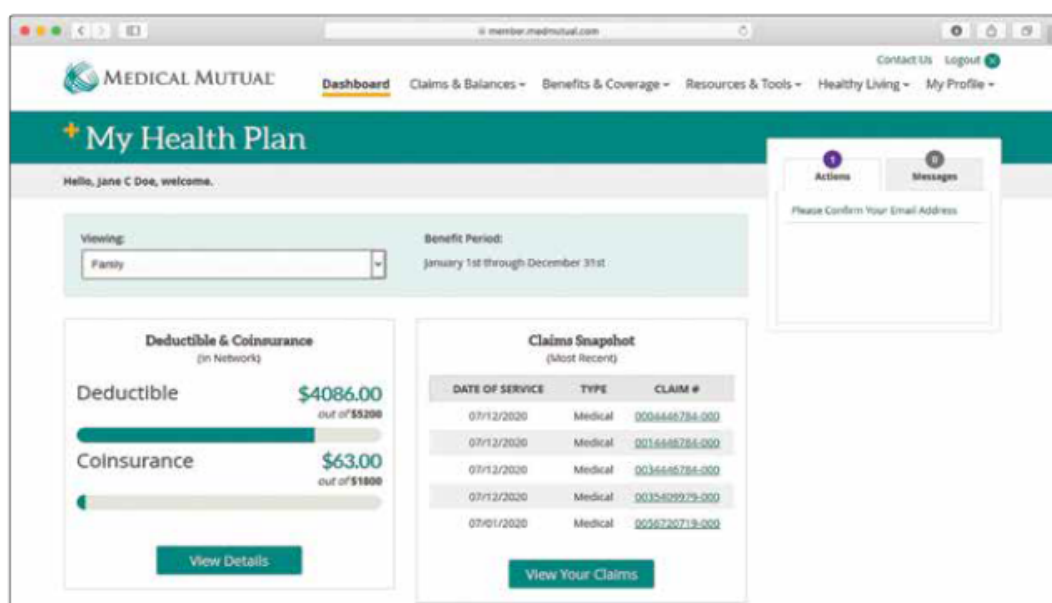
My Health Plan

Gain More Control of Your Health Benefits

My Health Plan is our secure website specifically for Medical Mutual members. It makes it easy and convenient to manage your plan and your health online. It allows you to compare your healthcare options so you can make better decisions and minimize costs.

You can do things like check your deductible, review your Explanation of Benefits (EOB) statements, find a doctor in your network and access a wealth of valuable information to help keep you healthy. Plus, you will find information on a variety of programs, discounts, money-saving tools and educational resources.

Creating your account is simple. Just visit [MedMutual.com/Member](https://www.MedMutual.com/Member). Click on the Register for an Account button. Then follow the instructions and you'll be ready to go!



My Health Plan Dashboard

Claims & Balances

Under this tab, you can view claims, check the balances of your health savings account (HSA), flexible spending account (FSA) or health reimbursement arrangement (HRA) and see detailed information about deductibles and coinsurance. If you have an individual plan, you can also pay your premium.

Benefits & Coverage

Discover the benefits of your health insurance and see what your plan covers by clicking on this tab. It allows you to view your plan details, including medical benefits, maximums and coinsurance, and print temporary ID cards.

Resource & Tools

- My Care Compare
View quality ratings of network doctors and compare cost estimates for lab tests and a variety of other procedures performed at different facilities.
- Find a Provider
Search for a network provider by name, specialty, gender, language spoken, hospital affiliation or specific practice.

Take My Health Plan with You

There's an easy way to make My Health Plan even more convenient when you're on the go. Download the Medical Mutual App from the App Store® or Google Play™ so you can access My Health Plan on your smartphone or tablet.

MEDICAL MUTUAL
FORMS

Enrollment/Change Form



MEDICAL MUTUAL®

Large Group Employee Application/Change Form

Section I: INSURANCE WAIVER

I understand that if I check any box in Part 1 of this waiver I am choosing not to have those persons covered under the health insurance designated.

Part 1: Waived Coverages: I do not want coverage for (Check all that apply)

Myself	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life/Disability
Spouse or Domestic Partner (if your group offers coverage to Domestic Partners)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life/Disability
Child(ren)	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life/Disability

Please list name(s) of spouse/domestic partner and/or child(ren) for whom coverage is being waived:

Part 2: Reason for waiving coverage: (Check appropriate waiver type)

Covered by spouse/domestic partner or parent's employer coverage

Name of Insurer: _____

Medicare TRICARE VA coverage Medicaid

Individual – My policy was obtained through an exchange and I was approved for a subsidy

Name of Insurer: _____

Enrolled in another carrier's group plan offered by this employer

Name of Insurer: _____

Enrolled in another employer's group plan as an employee or retiree

Name of Insurer: _____

Other: _____ No coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, you must request enrollment within 30 days after you or your dependent's other coverage ends (or after the employer stops contributing toward other coverage). If you or your dependent either becomes eligible for premium assistance or lose eligibility for coverage under the States Children's Health Insurance Program (SCHIP), you will be able to enroll in this plan. However you must request enrollment within 60 days after such event. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I have read and understood the above terms:

Current Employer _____ MMO Group Number _____

Print Employee Name _____

Employee Signature: _____ Date: _____

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTHCARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Employee Name
Social Security #

Group/Company Name
Group #/Section # (required)



Section II: ACTION REQUIRED

New Application
 COBRA/Continuation
 Policy Change
 Change to Medicare Eligibility
 Qualifying event date: _____
 Action: (check type of change)
 Add dependent to the policy due to: (list dependents in section III)
 Birth
 Adoption
 Delete dependent from policy due to: (list dependents in section III)
 Divorce
 Death
 Other _____
 Add spouse due to marriage (list Spouse in section III)
 Date married: _____
 Name change (list new name in section III)
 Former name: _____
 Address change (enter new address in Section III)
 Cancel coverage
 Other (description) _____

Section III: APPLICANT INFORMATION

Last Name		First Name		MI
Permanent Residence		City	E-mail Address	
County	State	Zip Code	Best Contact # ()	Alternate # ()
Employment Status <input type="checkbox"/> Active, Full Time Date of (Re)Hire: _____ <input type="checkbox"/> Retired <input type="checkbox"/> COBRA, Expiration Date: _____			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	

Employee Clock Number:	Employee Dept. Number:	Payroll Location:
------------------------	------------------------	-------------------

Relationship	First Name, MI (and last name, if different)	Social Security Number ²	Birth Date	Gender	Tobacco User <small>Tobacco User definition –the legal use (other than religious or ceremonial) of any tobacco product on average four or more times per week within no longer than the last six months.</small>
Self				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Domestic Partner ¹				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

¹Refer to Section VII, Number 10, Terms and Conditions, for domestic partner eligibility requirements, if offered by your group.
²Providing Social Security Number is required by federal law.

PRIMARY CARE PHYSICIAN INFORMATION (HMO Plans Only)

Physician Name	Physician Phone Number () -	Physician's NPI Number
Physician Address		
City	State	ZIP Code

Employee Name
Social Security #

Group/Company Name
Group #/Section # (required)



Section IV: OTHER COVERAGE

Medicare Information Are you or any dependent covered by Medicare? Yes No If yes, please complete the section below:

Policyholder Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason for Medicare
				<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disability, Indicate Reason: _____
				<input type="checkbox"/> Age <input type="checkbox"/> End Stage Renal <input type="checkbox"/> Disability, Indicate Reason: _____

Important Notice for Medicare Eligible Individuals: If you are entitled to Medicare and Medicare is your primary coverage, you should enroll in and maintain that coverage, because when Medical Mutual is the secondary payer to Medicare Part B, Medical Mutual's plan will coordinate benefits as if you were covered under Part B, even if you are not. This can result in you being responsible for costs that would have been paid by Medicare. Your broker can assist you with any questions.
 (If you are entitled to Medicare because you are 65 and over and your employer employs fewer than 20 employees; or if you are entitled to Medicare due to disability and your employer employs fewer than 100 employees, Medicare will be the primary payer, that is, Medicare must pay benefits before the group health plan pays benefits.)

Continuing Coverage (other than Medicare) Are you or any dependent keeping other or dental health insurance coverage? Yes No If yes, please complete the section below:

Policyholder Name	Name and Address of Insurance Company	Policy Number	Effective Date	Coverage Type	Work Status	Policy Type
				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospital Only <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug	<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Single <input type="checkbox"/> Family

Section V: ABOUT YOUR NEEDS

If you have a special language or other cultural need that may affect the administration of your health plan or healthcare delivery, please indicate below so that Medical Mutual may better assist you:

- Y N**
- Hearing-impaired (Require use of TDD/TYY or other means of communication)
 - Vision-impaired (Require audio communication or large print document)
 - Speak a primary language other than English (Require interpretive services) please list language: _____
 - Other cultural need/preference: _____

Employee Name
Social Security #

Group/Company Name
Group #/Section # (required)



Section VI: MEDICAL, DENTAL AND VISION PRODUCTS

Plan selected (if more than one offered): _____

Section VII: LIFE AND DISABILITY PRODUCTS

A. COVERAGE SELECTION

Your group insurance provided by MedMutual Life Insurance Company may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, (if any), and whether you will be required to submit evidence of insurability.

Employer Paid Plans*			Class and Salary Information			
Elect	Waive	Coverage Type	Life Class:			
<input type="checkbox"/>	<input type="checkbox"/>	Basic Life and AD&D	Occupation/Job Title:			
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	Current Earnings: \$			
<input type="checkbox"/>	<input type="checkbox"/>	Short-Term Disability	<input type="checkbox"/> Hour	<input type="checkbox"/> Month	<input type="checkbox"/> Week	<input type="checkbox"/> Year
<input type="checkbox"/>	<input type="checkbox"/>	Long-Term Disability				

*If employer pays 100% of premium, employee may not waive coverage

Employee Paid Plans**

Elect	Waive	Coverage Type	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Life	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental AD&D	\$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life	\$ _____

B. VOLUNTARY SHORT-TERM DISABILITY PRE-EXISTING CONDITION NOTICE

MedMutual Life will not cover a disability which begins in the first 12-months after your effective date of coverage that is caused by, contributed to by, or results from a Pre-existing condition.
 A Pre-existing condition is a sickness or injury for which you, within 12 months of your effective date of coverage:
 1. Received medical treatment, consultation, care of service, including diagnostic measures, or
 2. had taken prescribed drugs or medicines.

C. BENEFICIARY DESIGNATION (For Employee Only: Must be completed if you have applied for Life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage).

Last Name	First Name	Date of Birth	Relationship	Benefit %
Primary:				
Primary:				
Contingent:				
Contingent:				

Continued on page 5

Employee Name
Social Security #

Group/Company Name
Group #/Section # (required)



Section VII: LIFE AND DISABILITY PRODUCTS (continued)
D. VOLUNTARY FIXED INDEMNITY AND ACCIDENT-ONLY PLANS (MEDMUTUAL EXTEND) (51-99 Only)
<input type="checkbox"/> Premium <input type="checkbox"/> Preferred <input type="checkbox"/> Select <input type="checkbox"/> Critical Illness <input type="checkbox"/> Accident

Employee Name
Social Security #

Group/Company Name
Group #/Section # (required)



Section VIII: TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this Application. Your insurance is being offered through Medical Mutual of Ohio and/or one of its wholly owned subsidiaries, Medical Health Insuring Corporation of Ohio, or MedMutual Life Insurance Company, collectively referred to as "Medical Mutual."

1. I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to Medical Mutual and/or any affiliates or divisions of Medical Mutual; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, pharmacy benefit manager, government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize Medical Mutual to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application. I authorize Medical Mutual or its reinsurers to make a brief report of my personal health information to MIB.
2. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Health and Life Application and the questions asked herein; (b) I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application; (c) I have answered each and every question set forth in this Application; (d) all of my answers to each of the questions are accurate, complete and true and (e) I did not sign a blank or partially completed Application. I agree that Medical Mutual, in its sole discretion, may rescind my policy on the basis of any material misrepresentation or fraudulent response to any question in this Application. I further agree that if a policy is issued, it will be issued by Medical Mutual in full reliance and in consideration of the information, answers and statements contained herein.
3. I agree that: (a) to be eligible for coverage, I must be an active full-time employee as defined by the policy(ies); (b) to be eligible for life, disability income, fixed indemnity and/or accident-only insurance, I must be actively at work as defined in the group policy. If I am not actively at work on the date my life, disability, fixed indemnity and/or accident-only coverage would become effective, such coverage will begin on the day I return to work; and (c) if coverage is issued, it will be based on full reliance on the information contained in this Application.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. The applicable certificate or evidence of coverage will determine the rights and responsibilities of covered persons and will govern in the event they conflict with any benefit comparison summary or other description of the plan.
5. No issuance, waiver, modification or change of policy or any of Medical Mutual rules or amendments shall be binding upon Medical Mutual unless it is in writing and signed by an authorized officer of Medical Mutual, as applicable.
6. Other than for fixed indemnity and accident-only plans, a permanent ID card will be issued following the final review and acceptance of this Application.
7. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information Medical Mutual requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning benefits that are inconsistent with, or different from, any written information provided by Medical Mutual; or (d) to bind Medical Mutual in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage.

Continued on page 8

Employee Name
Social Security #

Group/Company Name
Group #/Section # (required)



Section VIII: TERMS AND CONDITIONS (continued)

8. My dependents and I understand and agree that any information obtained will not be released by Medical Mutual to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations, payment related, or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to Medical Mutual's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my application, a claim or a pending insurance action. The revocation will become effective after it is received by Medical Mutual Privacy Office. Your refusal to authorize the release of this information may impact your ability to enroll in Medical Mutual's plan if Medical Mutual needs this information to determine your eligibility for coverage.
9. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.
10. If I am applying for coverage for my domestic partner (if offered by your group), I represent and warrant that I and my domestic partner: 1) cohabit and reside together in the same residence and have done so for at least six months and intend to do so indefinitely; 2) are engaged in an exclusive and committed relationship and are financially interdependent; 3) are both at least 18 years of age and are each other's sole domestic partner; 4) are not married or separated from anyone else; 5) have not had another domestic partner within six months of establishing the current domestic partnership; 6) are not related by blood; and 7) are not in this relationship solely for the purpose of obtaining insurance benefits.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original.

Applicant's or Guardian's Signature

Date

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21).

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities.

Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201-0004
- By phone at:
1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

MEDICAL MUTUAL FORMS

Prescription Drug Claim Form

INSTRUCTIONS

Please read this carefully before completing the claim form. Claim forms without the required information will be returned.

PATIENT INSTRUCTIONS

1. Bring the claim form to the pharmacy when you obtain a prescription.
2. Each prescription **must have an original prescription receipt** returned with the claim form. A cash register tape is **not** satisfactory evidence of purchase.
3. A separate claim form must be used for each prescription.
4. If a pharmacy printout is used as the prescription receipt, each prescription line requires a separate claim form.
5. You must complete Sections A, C and E. Your pharmacist must complete Sections B and D.
3. **If you have prescription drug benefits through another insurance carrier (and you are submitting co-payments) the pharmacist does not need to sign the form. Just complete sections A & C and attach your receipt in Section E.**
7. Submit this claim form to Medical Mutual of Ohio®.

PHARMACIST INSTRUCTIONS

1. Please complete all information under Section B and D for each prescription filled.
2. Compound medications will be paid only if **at least one component is a Federal Legend Drug**. The NDC number and name of ingredient must be provided for all Federal Legend Drugs contained in the compound.
3. Each claim form must include the pharmacy name, address and NCPDP Provider I.D. Number.

Mail your completed claim form (including the original receipt) to:

**MEDICAL MUTUAL®
MZ 01-2B-4550, PRESCRIPTION PROCESSING
2060 EAST 9TH STREET
CLEVELAND OH 44115-1355**

LIFE INSURANCE FORMS

Enrollment and Beneficiary Designation Form

GROUP LIFE INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

 Policy Number 01-020258-00

 Employer/Policyholder Name City of Macedonia

9691 Valley View Rd	Macedonia	OH	44056
Street Address	City	State	Zip Code

Employee Occupation/Job Title	Employee Date of Employment
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 Full Time Employee Part Time Employee

Effective Date of Coverage

 \$ _____ / HR WK MO YR
 Basic Earnings

Life Class 1
 Class Number (if applicable)

I. EMPLOYEE/ENROLLEE INFORMATION

 Name _____ Sex M F

Street Address	City	State	Zip Code
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Home Telephone Number	Date of Birth	Marital Status
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II. BENEFITS (Please check if you wish to enroll)

	Yes	N	Indicate the benefit amount
Employee Life	X		\$50,000 Flat Amount
Employee AD&D	X		\$50,000 Flat Amount
Employee Supplemental Life			Supplemental Life: \$ _____
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Spouse Supplemental Life and AD&D			Supplemental Sp Life: \$ _____
Dependent Child Supplemental Life			\$ _____

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

- I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution).**
- I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature

Date Signed

LIFE INSURANCE FORMS

Evidence of Insurability (EOI) Form

Evidence of Insurability for Group Coverage

Instructions

Employer/Policyholder

Please complete Page 2 and provide to the employee/applicant to complete.

Employee/Applicant

Please complete page 3, sign and date page 4 and an "Authorization for Release of Medical Information" form. If applying for spouse coverage, have your spouse complete page 6, sign and date page 7 and an "Authorization for Release of Medical Information" form. Return to Symetra for processing.

Two copies of the 'Authorization for Release of Medical Information' form are included in the back of this packet. One for you and one for your spouse, if applicable.

Completed forms can be mailed or faxed to:
Symetra Life Insurance Company
PO Box 34690
Seattle, WA 98124-1690

Fax: 1-866-348-0058

Comments

EVIDENCE OF INSURABILITY FOR GROUP COVERAGE

Policyholders: Completely fill out Sections 1 – 3 and forward to the applicant to complete, sign and return to Symetra.

Section 1: Group Plan Details *(to be completed by Policyholder)*

Company name (policyholder)	Policy number
Division or associated company (if applicable)	
Company mailing address (street, city, state, zip code)	
Benefits contact name (first, last)	
Benefits contact email address	Benefits contact phone (include area code)

Section 2: Applicant Details *(to be completed by Policyholder)*

Name of applicant	Date of hire (mm/dd/yyyy)
Class	Basic Annual Earnings*

*As described in the group policy

Section 3: Coverages Requested *(to be completed by Policyholder)* **Check all that apply**

Coverage (Check all that apply)	Current amount of coverage (including GI** amount)	Additional coverage requested	Total coverage amount
(Example for Life Policies)	\$50,000	\$300,000	\$350,000
<input type="checkbox"/> Applicant: Basic Life			
<input type="checkbox"/> Applicant: Supplemental or Voluntary Life			
<input type="checkbox"/> Spouse: Basic Life			
<input type="checkbox"/> Spouse: Supplemental or Voluntary Life			
<input type="checkbox"/> Applicant: Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Applicant: Voluntary Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Applicant: Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Applicant: Voluntary Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Guarantee Issue (GI) is the maximum amount of coverage defined by the group policy that does not require evidence of insurability.

Section 4: Applicant Information (to be completed by applicant)

Applicant name (first, last)					Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Applicant address (street, city, state, zip code)						
Date of birth	Height	Weight	Driver License number		Email address	
State of birth		Day phone (include area code)		Evening phone (include area code)		
How may we best contact you? Symetra offers secure e-mail for the quickest turnaround time <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Day phone <input type="checkbox"/> Evening phone						
Full name, address and phone of your personal physician						

Section 5: Applicant Health Information (to be completed by applicant)

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant? Yes No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**

a) <input type="checkbox"/> Heart Disease or Disorder b) <input type="checkbox"/> Bipolar Disorder, Major Depressive Disorder, or Schizophrenia c) <input type="checkbox"/> Alcoholism and/or Drug Use d) <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)	e) <input type="checkbox"/> Stroke, Paralysis f) <input type="checkbox"/> Multiple Sclerosis, ALS (Lou Gehrig's Disease) g) <input type="checkbox"/> Type I/Insulin-Dependent Diabetes h) <input type="checkbox"/> Grand Mal Epilepsy or Generalized Seizures i) <input type="checkbox"/> Hepatitis B or C j) <input type="checkbox"/> Cirrhosis of the liver
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3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**

k) <input type="checkbox"/> Non-Insulin Dependent/ Type II Diabetes l) <input type="checkbox"/> Mental & Nervous Disorder; Depression/Anxiety m) <input type="checkbox"/> Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy n) <input type="checkbox"/> Liver Disorder o) <input type="checkbox"/> Kidney Disorder	p) <input type="checkbox"/> Blood Disorder q) <input type="checkbox"/> Stomach, Abdominal, Intestinal Disorder r) <input type="checkbox"/> Bone, Joint, Connective Tissue Disorder s) <input type="checkbox"/> Cancer, Tumors t) <input type="checkbox"/> Gland Disorder u) <input type="checkbox"/> Lungs, Respiratory Disorder
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4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? Yes No
If yes, please indicate condition and provide details in the Health Information Section.

Section 6: Applicant Health Information (to be completed by the applicable person)

Question # or Letter	Details of Yes answers	Onset		Duration	Degree of recovery	Name/address/phone of attending physician
		Mo.	Yr.			

Please list all your medications

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset	
			Mo.	Yr.

By signing below, I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of applicant	Date
Print name	

Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.

Applicant's copy

Disclosure Notice to Applicants for Insurance

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

Sources of Information:

Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, pharmacy benefit manager or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

Disclosure to Others:

Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

Disclosure to You:

If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.*

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

**For residents of Louisiana and Massachusetts only:*

Medical record information will be given to a medical professional designated by you and licensed to provide the kind of medical care in question or, if you prefer, to you directly. Mental health record information will be given directly to you only with the approval or the professional who has treatment responsibility for the condition in question.

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: The following applies to health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Section 7: Spouse/Domestic Partner/Civil Union Partner Information (to be completed by the Spouse or Domestic Partner/Civil Union Partner (if applicable))

Spouse/Domestic Partner name (first, last)					Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (street, city, state, zip code)						
Date of birth	Height	Weight	Drivers license number		Email address	
State of birth		Day phone (include area code)		Evening phone (include area code)		
How may we best contact you? Symetra offers secure e-mail for the quickest turnaround time <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Day phone <input type="checkbox"/> Evening phone						
Full name, address and phone of your personal physician						

Section 8: Spouse/Domestic Partner/Civil Union Partner Health Information (to be completed by the applicable person)

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant? Yes No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**

a) <input type="checkbox"/> Heart Disease or Disorder	e) <input type="checkbox"/> Stroke, Paralysis
b) <input type="checkbox"/> Bipolar Disorder, Major Depressive Disorder, or Schizophrenia	f) <input type="checkbox"/> Multiple Sclerosis, ALS (Lou Gehrig's Disease)
c) <input type="checkbox"/> Alcoholism and/or Drug Use	g) <input type="checkbox"/> Type I/Insulin-Dependent Diabetes
d) <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)	h) <input type="checkbox"/> Grand Mal Epilepsy or Generalized Seizures
	i) <input type="checkbox"/> Hepatitis B or C
	j) <input type="checkbox"/> Cirrhosis of the liver
3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**

k) <input type="checkbox"/> Non-Insulin Dependent/ Type II Diabetes	p) <input type="checkbox"/> Blood Disorder
l) <input type="checkbox"/> Mental & Nervous Disorder; Depression/Anxiety	q) <input type="checkbox"/> Stomach, Abdominal, Intestinal Disorder
m) <input type="checkbox"/> Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy	r) <input type="checkbox"/> Bone, Joint, Connective Tissue Disorder
n) <input type="checkbox"/> Liver Disorder	s) <input type="checkbox"/> Cancer, Tumors
o) <input type="checkbox"/> Kidney Disorder	t) <input type="checkbox"/> Gland Disorder
	u) <input type="checkbox"/> Lungs, Respiratory Disorder
4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? Yes No
If yes, please indicate condition and provide details in the Health Information Section.

Section 9: Spouse/Domestic Partner/Civil Union Partner Health Information (to be completed by the applicable person)

Question # or Letter	Details of Yes answers	Onset		Duration	Degree of recovery	Name/address/phone of attending physician
		Mo.	Yr.			

Please list all your medications

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset	
			Mo.	Yr.

By signing below, I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of Spouse/Domestic Partner (if applicable)	Date
Print name	

Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.

Applicant's copy

Disclosure Notice to Applicants for Insurance

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

Sources of Information:

Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, pharmacy benefit manager or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

Disclosure to Others:

Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

Disclosure to You:

If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.*

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

**For residents of Louisiana and Massachusetts only:*

Medical record information will be given to a medical professional designated by you and licensed to provide the kind of medical care in question or, if you prefer, to you directly. Mental health record information will be given directly to you only with the approval of the professional who has treatment responsibility for the condition in question.

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: The following applies to health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may:

- 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage;
- 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may:

- 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage;
- 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

LIFE INSURANCE FORMS

Portability & Conversion Forms

Extending life insurance protection after group coverage ends

Symetra Life Insurance Company

Your group life insurance policy includes conversion and portability provisions. Exercising one of these options can help you avoid a future gap in your life insurance coverage.

Portability: Continuing group term life benefits for a period of time

Portability allows you to continue your existing group coverage for a limited period of time or until you're eligible under a new group plan. Coverage offers a lower-cost option than converting to a permanent policy. Portability may be available for your spouse and dependents if they're covered under your current group plan.

Portability coverage is subject to certain conditions and restrictions, including:

- You must not elect more than the amount that is ending and length of coverage that may be continued.
- Your benefit amount may be subject to age-based reductions.
- Your original company's group life insurance policy and the portability provision must be in-force at the time of application.
- You must not have reached Social Security Normal Retirement Age.
- You must not be entering active military service.

Portability can be a good option if you're likely to become employed at a company offering its own group life plan. The ported policy can effectively serve as a 'bridge' until your new group life insurance goes into effect.

Conversion: Offering a lifetime of coverage

Conversion allows you to transition your employer-sponsored coverage to a permanent, individual life insurance policy. This type of coverage may make sense if you need a more consistent level of coverage, perhaps following the purchase of a new home, the birth of a child or other life events.

When deciding if conversion is the right choice for you, keep in mind the following:

- Coverage for you, your covered spouse and/or eligible dependents will generally remain the same as your group term policy and does not require a new medical exam.
- Compared to group coverage, individual life insurance tends to be more expensive due to determining factors such as age, gender and the amount of coverage requested.
- Permanent life insurance coverage can accumulate cash value.

Though a life insurance policy is a bigger financial commitment than group term policy, conversion may be a good option if you're looking for a more permanent solution.

Understanding the difference between portability and conversion will help you decide which option is right for you. The chart on the next page provides an easy-to-follow overview of these two provisions.

continued >

At-a-Glance: Portability vs. Conversion

	Policy Type	Length of Coverage	Cost	Cash Value	Maximum Benefit
Portability	Group term life insurance	Provides protection until the age maximum is reached, provided that required premiums are paid.	Pricing is set by Symetra and is determined by age and tobacco usage. Ported rates tend to be lower than conversion rates.	No	Determined by the insurance carrier; the lesser of your current amount or the port maximum. Generally \$250,000.
Conversion	Individual permanent life insurance	Provides lifetime protection when sufficient premiums are paid.	Pricing is based on individual rates which tend to be more expensive than a "ported" policy.	Yes	Employees can usually convert their full group policy face amount.

Frequently Asked Questions

Will I be required to take a medical exam?

No. A medical exam is not required. You also do not have to answer any medical questions.

Can my Accidental Death and Dismemberment (AD&D) coverage be ported or converted?

No. Your AD&D benefits are not eligible for portability or conversion.

How much does it cost?

- **Portability** – Symetra has set portability rates based on tobacco usage within the last 12 months and age; the actual cost (rate) will differ from your current group rate and tends to be lower than conversion. Rates are reviewed annually and may change.
- **Conversion** – You can estimate your new life insurance rates by using our online calculator located at www.symetralifeconv.com. Enter your information as directed and then if interested in applying for conversion, fill out the Request for Information Form. The actual cost is determined by your age, gender, the amount of life insurance coverage you elect and other factors. Call HRMP at 1-800-426-7784 for a quote.

How much time do I have to port or convert my coverage?

Your completed application must be received within 31 days from the date your group coverage ends. In some states, your employer is required to notify you of your right to convert at least 15 days prior to this date.

Once I'm covered, will my benefit amount stay the same?

- **Portability** – Your benefit amount remains the same as of the time you port coverage. However, the benefit amount will reduce beginning at age 65. Contact your HR representative for more information.
- **Conversion** – Your benefit amount will stay the same provided that required premiums are paid. Call HRMP at 1-800-426-7784 for more information.

Will I have life insurance coverage during the port/conversion period?

Yes. Your group insurance benefits remain in effect during the 31-day transition to the ported/converted policy.



For more information about portability and conversion, talk with your Human Resources representative.

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com

Symetra® is a registered service mark of Symetra Life Insurance Company.

Group life insurance policies are insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004. Base policy form number is LGC 13500-CERT 08/06 and is not available in any U.S. territory. Our New York subsidiary insures products for New York policyholders. Policies contain exclusions, limitations, reduction of benefits and terms for keeping them in force. Please contact your group life representative for complete details.

Individual life insurance coverage after your group coverage ends



Your group life insurance coverage—provided by Symetra Life Insurance Company—allows you to keep your life insurance coverage on an individual basis after your group life insurance coverage ends.

This feature, called “conversion,” allows you to easily convert your Symetra Group Life Insurance policy to an individual life insurance policy offered through HRMP and insured by Gerber Life Insurance Company. You can also convert any spouse and dependent coverage.

Converting your Symetra Group Life Insurance policy lets you maintain your current level of life insurance coverage without having to answer additional health questions or go through any type of medical exam.

Getting Started

To apply for conversion to an individual life insurance policy, fill out the enclosed Request for Information Form. This must be completed for any coverage you wish to convert for you, your spouse and/or your dependents.

It's important to get started as soon as possible. HRMP must receive your Request for Information Form **within 31 days** after the date your group life insurance ends.

Contact Information

HRMP

Toll-free: 1-888-999-4767

Local: (978) 762-0661

Fax: (978) 762-4767

Monday-Friday

7:30 a.m. to 5:00 p.m. ET

Frequently Asked Questions

Do I need a medical exam?

No. A medical exam is not required and you will not have to answer any medical questions.

How much does it cost?

The actual cost (rate) is determined by your age, gender, the amount of life insurance coverage you elect and other factors. You can estimate your new life insurance rates using our online calculator located at www.symetralifeconv.com. Enter your information as directed, then fill out the enclosed Request for Information Form. Rates are also included in the mailing that HRMP sends once they receive the Request for Information Form.

Can I choose what kind of individual life insurance policy I want?

You can only convert your existing Symetra Group Life Insurance policy to an individual whole life insurance policy.¹

How long will it take to get coverage?

Your HRMP representative will respond to you by U.S. Mail (or by email if your email address is provided) within two days of submitting your completed request for conversion. If you elect to convert, you must return your completed application and initial premium within the 31-day conversion period.

Your conversion policy will be effective on the day after your 31-day conversion period ends.

Will I have life insurance coverage during the conversion process period?

Yes. Your group insurance benefits remain in effect during your 31-day conversion period.

Does my employer need to submit anything?

Yes. The Request for Information Form has two parts—A and B. Your employer needs to complete Part A and you will complete Part B. Your HRMP representative will go over what exactly is required when you call to apply.

To learn more about conversion, call HRMP at 1-888-999-4767 or visit www.symetralifeconv.com.

Getting Started

Don't miss the deadline to convert your group life insurance coverage. Complete your Request for Information Form today.

Call HRMP at **1-888-999-4767** if you have any questions.

Group life insurance policies are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004 and are not available in any U.S. territory. Policies may be subject to exclusions, limitations, reductions and termination of benefit provisions. Our New York Company insures products for New York Policyholders. Please contact your representative for complete details.

Individual life insurance offered through the Symetra Group Life Insurance Conversion provision is offered through HRMP and insured by Gerber Life Insurance Company; not affiliated with any of the subsidiaries under Symetra Financial Corporation.

¹ May vary by state. In West Virginia, you may purchase preliminary term for one year which will automatically convert to whole life thereafter.

INDIVIDUAL LIFE CONVERSION
Request for Information Form



This form enables you and your insured dependents to obtain information on any right you may have to purchase an individual life insurance policy within **31 days** after your Symetra Group Life coverage ends or is reduced because of termination of employment or change in your classification or status in the eligible member group. Please complete the information below, if you are interested, and an application and premium costs will be sent. Your Request for Information Form needs to be submitted to this office within **31 days** after the date of your Symetra Group Life Insurance ending. **Please review the Conversion Right provision in your existing Certificate (or if unavailable contact the Policyholder/Plan Administrator) to ensure an understanding of your conversion rights, responsibilities and any extension to convert that may be available in your state.**

PART A - POLICYHOLDER OR ADMINISTRATOR TO CERTIFY

Name of Employee/Member		Symetra Life Insurance Company	
Name of Policyholder (use name shown in group policy or booklet)		Policy#	
Policyholder's address		Contact name	
DATE OF GROUP LIFE INSURANCE TERMINATION / /	LAST DATE WORKED / /	TOTAL AMOUNT OF GROUP LIFE INSURANCE ON TERMINATION DATE Basic \$ _____ Supplemental \$ _____	
Employee/Member's Occupation _____		Class _____ Annual Salary _____	
Employee/Member's Hire Date ____/____/____		Employee/Member's effective date of Symetra Group Life Insurance Coverage under the Group Policy ____/____/____	
Did Employee/Member have Dependent Life Insurance on Group Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Amount of Spouse Life Insurance \$ _____		Amount of Child Life Insurance \$ _____	

REASON FOR TERMINATION:

EMPLOYEE/MEMBER

- Termination of Policy
- Termination of Employment
- Disability
- Other (please explain) _____

DEPENDENT

- Termination of Policy
- Divorce
- Marriage of a child
- A surviving spouse or child of deceased employee/member
- Other (please explain) _____

Is Employee/Member Disabled? Yes No

Is Employee/Member on Disability? Yes No If Yes, did he/she become disabled prior to age 60? Yes No

Has the insured Employee/Member made an Absolute Assignment of the group life insurance to be converted? Yes No
If yes, please attach a copy of the Absolute Assignment form.

Date on which this Notice was given to Employee/Member ____/____/____

Date Notice completed / /	Signature of Policyholder/Plan Administrator	Title	Phone number ()
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PART B - TO BE COMPLETED BY EMPLOYEE/MEMBER REQUESTING CONVERSION INFORMATION

Name	Soc Sec #	Date of birth / /	Age	Sex
Home address Street	City	State	Zip code	
Phone # ()	Email			

If Spouse or Children are checked above, provide information below:

Name of dependent(s)	Age	Date of birth / /	Soc Sec #	Sex	Relationship to you
		/ /			
		/ /			
		/ /			

Employee/Member's signature _____ Date completed and mailed ____/____/____

Mail to: HRMP Life Conversion Facility, 300 Rosewood Drive, Suite 250, Danvers, MA 01923
Toll Free: 1-888-999-4767 Phone: (978) 762-0661 Fax: (978) 762-4767 Email: Conversions@HRMP.com

Group Life Insurance Portability Kit

Life insurance protection after
group coverage ends



Your group life insurance coverage—provided by Symetra Life Insurance Company—includes a provision called portability. This allows you to continue your coverage when you leave your job. And, you don't have to answer any medical questions.

Eligibility

You are eligible for portability coverage as long as:

- ✓ Your company's group life insurance policy, and the portability provision, is in-force at the time of application.
- ✓ You haven't reached Social Security Normal Retirement Age (SSNRA).
- ✓ You're not entering active military service.

How portability works

You can choose to continue 50%, 75% or 100% of your current life insurance benefit amount. Be sure to carefully consider all of your life insurance needs—if you decide to port a reduced percentage of your current life insurance benefit amount, you won't be able to continue any portion of the remaining amount at a later date.

Portability may also be available for your spouse and dependents. If this provision is included in your company's policy, you can select portability coverage as long as they are insured under the current group life policy at the time your group coverage terminates. Child coverage may only be ported if you or your spouse elects portability.¹

Whatever you choose, the benefit amount will be rounded to the next higher multiple of \$1,000 (example: \$125,100 rounds to \$126,000).

	Maximum Amount	Minimum Amount
You	\$250,000	\$5,000
Your spouse	\$50,000	\$5,000
Your dependent child	\$10,000	\$5,000

This chart represents standard benefit maximums. For more information on your company's policy, talk with your HR representative.

Frequently Asked Questions

Do I need a medical exam?

No. A medical exam is not required and you will not have to answer any medical questions.

How much does it cost?

The actual cost (rate) is based on your age at the time you are approved for portability and whether or not you have used tobacco products within the last 12 months. Rates are reviewed annually and may change.

Provision	Policy Type
Portability	Group Term Life Insurance. This type of policy provides protection until the age maximum is reached, provided that required premiums are paid. Pricing is determined by age, and tends to be lower than conversion. Coverage does not remain associated with the group life insurance policy that provided the right to port. There is no cash value.
Conversion	Individual Permanent Life Insurance. This type of policy provides lifetime protection provided that sufficient premiums are paid. Pricing is based on individual rates which tend to be more expensive than a ported policy. This is an individual policy so the employee is the policyowner rather than the group. The policy also accumulates a cash value that can be borrowed against, if needed.

My group life plan includes portability and conversion provisions. What's the difference?

The primary difference is the type of insurance policy you receive (see chart to the left).

Once I'm covered, will my benefit amount stay the same?

Your benefit amount remains the same when you port coverage. However, the benefit amount will reduce beginning at age 65. Contact your HR representative for more information.

Will I have life insurance coverage during the port period?

Yes. Your group insurance benefits remain in effect during the 31-day transition to the ported policy.

Can I convert to an individual policy if my coverage is reduced?

Yes, if your benefit amount is reduced due to the age reduction schedule, you can convert your ported coverage to individual coverage. The cost is based on your age at the time you apply for conversion so choosing to port first and convert at a later date may impact the amount of premium you pay.

Getting started

To apply for portability, fill out Part A of the enclosed application. Your employer is responsible for completing Part B.

Please don't delay. We need to receive your application and initial premium within 31 days from the date your group coverage ends.

Send your completed application and initial premium to:

Symetra Life Insurance Company
P.O. Box 1491
Minneapolis, MN 55480-1491



Getting Started

Don't miss the deadline. Complete your portability application today.

For more information on how to port your coverage, talk with your HR representative.



Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com

Symetra® is a registered service mark of Symetra Life Insurance Company.

Group life insurance policies are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. Policy form number is LGC-13000 8/06 in most states and is not available in any U.S. territory. Our New York subsidiary insures products for New York policyholders. Policies contain exclusions, limitations, reduction of benefits and terms for keeping them in-force. Please contact your group life representative for complete details.

¹ Dependent children that have reached maximum issue age are not eligible to port their coverage. **Page 270**

APPLICATION FOR PORTABILITY CONTINUATION OF GROUP TERM LIFE INSURANCE

Part A: TO BE COMPLETED BY THE APPLICANT “Applicant” means the employee or member of the Group Policy from which coverage is being ported or the employee/member’s eligible Spouse as defined in the Group Policy.

IMPORTANT INFORMATION—The enrollment period ends 31 days after the date the Group coverage ends. The application, enrollment form(s) and premium sent to Symetra must be postmarked within this 31 day period. *Submit your first premium with this application to Symetra Life Insurance Company at the above mailing address. Please make your check payable to Symetra Life Insurance Company.*

1. Applicant’s Name _____ Employee/Member Spouse

2. Address _____

Telephone No. Home (_____) _____ Cell (_____) _____

Premium billing address for Life Insurance, if different than above:

Address: _____

3. Birth Date _____ Sex: Male Female
mo-day-year

4. Policyholder Name _____ Group Policy No. _____

5. Important: The minimum and maximum amounts of insurance for which You are eligible are shown in your Group Insurance Certificate. Refer to the “Benefits” section, “Limitations” provision, for specific information.

Yes, I would like to continue my Portability Continuation Basic Life Insurance amount of \$ _____

Yes, I would like to continue my Portability Continuation Supplemental Life Insurance amount of \$ _____

Yes, I would like to continue my Spouse Life Insurance amount of \$ _____ Date of Birth _____
mo-day-year

Spouse’s Name (If the Spouse is not the Applicant) _____

Yes, I would like to continue my Child Life Insurance amount of \$ _____

Child Name _____ Date of Birth _____
mo-day-year

Child Name _____ Date of Birth _____
(Add additional pages if necessary) mo-day-year

6. Premium Mode: Quarterly \$ _____ Semi-Annual \$ _____ Annual \$ _____

In order to be eligible for Portability Continuation Insurance, you must submit your first premium with this application to Symetra Life Insurance Company at the mailing address above. Important: Premium modes other than annual are subject to a minimum premium payment of \$50.

7. Please provide your last day of active work. _____
mo-day-year

8. Are you disabled? No Yes If yes, date of disability: from _____ to _____
If yes, have you applied for Waiver of Premium? No Yes
mo-day-year mo-day-year

Please note: If you have applied for Waiver of Premium, you may not be eligible for Portability.

Diagnosis _____

9. Have you used any form of tobacco product within the last 12 months? No Yes Spouse? No Yes
(Tobacco product includes cigarettes, cigars, pipes, chewing tobacco, snuff, etc.)

By signing below, I attest that the above information is correct to the best of my knowledge. I also attest that I have read and understand the fraud warning on the following page which applies to me.

Signature of Applicant _____ Date _____
mo-day-year

PLEASE HAVE THE GROUP POLICYHOLDER COMPLETE PART B THIS APPLICATION.

FRAUD WARNINGS All Other States: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA: For your protection California law requires the following to appear on this form: any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ID: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IN: Any person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Instructions:
Please fully complete this form and submit with ALL original enrollment cards and any requests for change of beneficiary.

Part B: TO BE COMPLETED BY THE GROUP POLICYHOLDER

“Applicant” means the employee or member of the Group Policy from which coverage is being ported or the employee/member’s eligible Spouse as defined in the Group Policy.

1. Symetra Group Policy Number _____ Policyholder Name _____
Division of _____
Address _____
2. Applicant’s Name _____ Employee/Member Spouse
3. Date of hire or membership of employee/member _____ Effective date of Applicant’s life insurance _____
mo-day-year mo-day-year
4. Insurance class _____ Occupation _____
5. Current salary of employee/member (if applicable) \$ _____ per hour week month year
6. Number of hours worked each week (if applicable) _____
7. Date employment or membership terminated _____ Last day of active work (if applicable) _____
mo-day-year mo-day-year
8. Date through which premiums were paid for this Applicant _____
mo-day-year
9. Is the Applicant disabled? No Yes If yes, date of disability: from _____ to _____
mo-day-year mo-day-year
10. Reason for stopping work (if applicable) _____
11. At time coverage terminated under this policy, the following amounts of Life Insurance were in force for each of the following:
 - a. Applicant Basic \$ _____
 - b. Applicant Supp \$ _____
 - c. Applicant’s Spouse \$ _____
 - d. Applicant’s Child(ren) \$ _____
12. Enrollment verification submitted? No Yes
If no, please explain _____

Important: Applicants who choose to convert their Group Term Life Insurance coverage to an individual policy upon termination of employment are not eligible for Portability Continuation Insurance. Applicants who have applied for Waiver of Premium may not be eligible for Portability.

I hereby certify that: 1) the Applicant was a full-time, permanent, active employee or other eligible member with coverage under the Group Policy; 2) I am not a beneficiary, nor am I related to the beneficiary or the above individual; 3) I am an authorized policyholder representative; and 4) the above statements are true.

Name of person signing _____ Phone No. (____) _____
Email _____ FAX No. (____) _____
By _____ Title _____ Date _____
Signature mo-day-year

How to Compute Portability Continuation Insurance Premium

Important: Premium modes other than annual are subject to a minimum premium payment of \$50.

Employee Life Insurance

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-67
Non Tobacco	\$0.090	\$0.100	\$0.140	\$0.210	\$0.350	\$0.530	\$0.880	\$1.400	\$2.180
Tobacco	\$0.170	\$0.190	\$0.230	\$0.350	\$0.570	\$0.910	\$1.430	\$2.050	\$3.620

To determine your cost for coverage, please determine your rate based on your age above, and then use the following formula(s) to calculate your cost:

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{Rate} = \$ \text{Monthly Premium} \times 3 = \$ \text{Quarterly Premium}$$

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{Rate} = \$ \text{Monthly Premium} \times 6 = \$ \text{Semi Annual Premium}$$

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{Rate} = \$ \text{Monthly Premium} \times 12 = \$ \text{Annual Premium}$$

Spouse Life Insurance

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-67
Non Tobacco	\$0.090	\$0.100	\$0.140	\$0.210	\$0.350	\$0.530	\$0.880	\$1.400	\$2.180
Tobacco	\$0.170	\$0.190	\$0.230	\$0.350	\$0.570	\$0.910	\$1.430	\$2.050	\$3.620

To determine your cost for coverage, please determine your rate based on your age above, and then use the following formula(s) to calculate your cost:

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{Rate} = \$ \text{Monthly Premium} \times 3 = \$ \text{Quarterly Premium}$$

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{Rate} = \$ \text{Monthly Premium} \times 6 = \$ \text{Semi Annual Premium}$$

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{Rate} = \$ \text{Monthly Premium} \times 12 = \$ \text{Annual Premium}$$

Dependent Child Life Insurance

Rate	\$0.220
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$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{0.220} = \$ \text{Monthly Premium} \times 3 = \$ \text{Quarterly Premium}$$

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{0.220} = \$ \text{Monthly Premium} \times 6 = \$ \text{Semi Annual Premium}$$

$$\frac{\$ \text{Life Benefit Amount}}{1,000} = \$ \text{Rate} \times \$ \text{0.220} = \$ \text{Monthly Premium} \times 12 = \$ \text{Annual Premium}$$

Total Portability Premium

\$ _____
Quarterly Total

\$ _____
Semi Annual Total

\$ _____
Annual Total

Beneficiary Information

Primary Insured _____ Effective Date _____

Symetra Life Insurance Company and the Insured agree as follows:

Symetra Life Insurance Company will make payment to the most recently named beneficiary as shown below.

Primary *(Print each name in full)*

Name _____

Address _____

Relationship to Insured _____ Birth Date _____ Percentage(%) _____
mo-day-year

Name _____

Address _____

Relationship to Insured _____ Birth Date _____ Percentage(%) _____
mo-day-year

Contingent *(Print each name in full)*

Name _____

Address _____

Relationship to Insured _____ Birth Date _____ Percentage(%) _____
mo-day-year

Name _____

Address _____

Relationship to Insured _____ Birth Date _____ Percentage(%) _____
mo-day-year

Primary Insured's signature _____ Date _____

Annual Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Uniformed Services Employment and Reemployment Rights Act

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- * All stages of reconstruction of the breast on which the mastectomy was performed;
- * Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- * Prosthesis and treatment of physical complications of the mastectomy, including lymphedema.
- * These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan and coinsurance applicable to other medical and surgical benefits provided under this plan.

Annual Notices

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact the Human Resources Department.

Medicaid and the Children's Health Insurance Program (CHIP)

If you or your dependent(s) are not currently enrolled in Medicaid or CHIP and you think your dependents might be eligible, you can contact the Ohio Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit your dependent(s) to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. You have 60 days to request coverage after it is determined you are eligible for premium assistance.

The State Based Exchanges

Under the PPACA a federally-operated Exchange, or Marketplace, was established for individuals to purchase health insurance. Your company provides employee healthcare benefits that meet the minimum value and affordability standards of the PPACA. Therefore, if you are eligible for healthcare benefits, you will not qualify for federal subsidies or tax credits through Marketplace enrollment.

Medicare and Medicaid

Medicare


As employees approach age 65, questions often arise over Medicare eligibility, benefits, and supplemental coverage. Advanced planning will ensure that you are on the best medical plan, whether you continue under your employer plan or enroll in Medicare.

If you are still working after age 65 and have insurance through Cuyahoga County Public Library you do not need to sign up for Medicare. Once you reach Normal Social Security Retirement Age (ranging from age 66 to 67, depending on your birthday) and elect to receive social security benefits, you will be automatically enrolled in Medicare Part A. You can also actively enroll in Medicare Part A at age 65 prior to enrolling for social security benefits.

HSA plan members might consider not enrolling in Part A as contributions into an HSA account are not allowed for those covered under Medicare.

Medicare Part A usually has no cost to the member. Part A covers hospital, skilled nursing care, and hospice. If you have medical claims, Medicare will coordinate with your employer plan. When you are ready to leave your employer plan, you will need to sign up for Medicare Part B coverage. For Part B a medical premium will apply. Most eligible Medicare members elect supplemental coverage through a Medicare Advantage plan administered by private insurance companies.

The rules pertaining to Medicare are complex and your eligibility can vary depending on your individual circumstances.



If you have any questions on Medicare, contact Kathy Hirko from the KAZ Company at: **216-901-9300** or **khirko@medicareplansneo.com**, and she can help you determine the best option for you.

Medicaid

Medicaid is a joint federal and state program that helps low income adults, their children and people with certain disabilities obtain affordable health coverage. Program requirements vary by state.

In general, those with incomes at or below 133% of the federal poverty level may qualify for benefits. Each state has dedicated resources to help families that may qualify. Contact your state Medicaid bureau for more information.

Contacts

<p>MEDICAL: Medical Mutual of Ohio</p> 	<p>www.medmutual.com (800) 382-5729 Policy Number: 160069</p>
<p>DENTAL & VISION Ameritas</p>	<p>www.ameritas.com (800) 659-2223 Policy Number: 50705</p>
<p>LIFE, AD&D, and Voluntary Life, AD&D Symetra</p> 	<p>www.symetra.com (877) 377-6773 Policy Number: 01-020268-00</p>
<p>Employee Assistance Program Life Services EAP</p>	<p>www.lifeserviceseap.com</p>
<p>Wellness Program Be Well Solutions</p> 	<p>(888) WEL-SERV (888-935-7378 info@bewellsolutions.com</p>
<p>Office Contacts: Annette Smith (330) 468-8353 asmith@macedonia.oh.us</p>	

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

