2022

Prescription Drug Guide

Humana Medicare Employer Plan Abbreviated Formulary

Partial list of covered drugs

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

1

This abridged formulary was updated on 09/01/2021 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan with any questions at the number on the back of your membership card or for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com.**

Instructions for getting information about all covered drugs are inside.

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Welcome to The Humana Medicare Employer Plan!

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan," it means the Humana Medicare Employer Plan. This document includes a partial list of the drugs (formulary) for our plan which is current as of January 1, 2022. For a complete, updated formulary, please contact us on our website at **Humana.com/PlanDocuments** or you can call the number below to request a paper copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1 of each year, and from time to time during the year.

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

This document is a partial formulary, which means it includes only some of the drugs covered by the Humana Medicare Employer Plan. To search the complete list of all prescription drugs Humana covers, you can visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

If you are thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, please contact Group Medicare Customer Care number listed in your enrollment materials. If you are a current member, call the number or visit the website listed in your Annual Notice of Change (ANOC) or Evidence of Coverage (EOC), or call the number on the back of your Humana member identification card. Our live representatives are available from 8 a.m. to 9 p.m. (EST), Monday through Friday. Our automated phone system is available after hours, weekends, and holidays.

Can the formulary change?
Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

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

- **New generic drugs**. We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled "How do I request an exception to the Formulary?"
- **Drugs removed from the market**. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes**. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

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

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

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

The enclosed formulary is current as of January 1, 2022. We will update the printed formularies each month and they will be available on **Humana.com/medicaredruglist**.

To get updated information about the drugs that Humana covers, please visit **Humana.com/medicaredruglist.** The Drug List Search tool lets you search for your drug by name or drug type.

How do I use the formulary?
There are two ways to find your drug in the formulary:

Medical condition
The formulary starts on page 10. We have put the drugs into groups depending on the type of medical conditions that they are used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 10. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 5 for more information on Utilization Management Requirements).

Alphabetical listing
If you are not sure about your drug's group, you should look for your drug in the Index that begins on page 33. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

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

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

How much will I pay for covered drugs?
The Humana Medicare Employer Plan pays part of the costs for your covered drugs and you pay part of the costs, too.

The amount of money you pay depends on:

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

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

Are there any restrictions on my coverage?
Some covered drugs may have additional requirements or limits on coverage. These are called Utilization Management Requirements. These requirements and limits may include:

- **Prior Authorization (PA):** The Humana Medicare Employer Plan requires you to get prior authorization for certain drugs to be covered under your plan. This means that you will need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. If you do not get approval, the Humana Medicare Employer Plan may not cover the drug.
- **Quantity Limits (QL):** For some drugs, the Humana Medicare Employer Plan limits the amount of the drug that is covered. The Humana Medicare Employer Plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Some drugs are limited to a 30-day supply regardless of tier placement.
- **Step Therapy (ST):** In some cases, the Humana Medicare Employer Plan requires that you first try certain drugs to treat your medical condition before coverage is available for another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Medicare Employer Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Medicare Employer Plan will then cover Drug B.
- **Part B versus Part D (B vs D):** Some drugs may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted to the Humana Medicare Employer Plan that describes the use and the place where you receive and take the drug so a determination can be made.

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 10.

You can also visit **Humana.com/medicaredruglist** to get more information about the restrictions applied to specific covered drugs.

You can ask the Humana Medicare Employer Plan to make an exception to these restrictions or limits. See the section "**How do I request an exception to the formulary?**" on page 6 for information about how to request an exception.

What if my drug is not on the formulary?
If your drug is not included in this list of covered drugs, visit **Humana.com/medicaredruglist** to see if your plan covers your drug. You can also call Group Medicare Customer Care and ask if your drug is covered.

If the Humana Medicare Employer Plan does not cover your drug, you have two options:
- You can ask Group Medicare Customer Care for a list of similar drugs that the Humana Medicare Employer Plan covers. Show the list to your doctor and ask him or her to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

Talk to your health care provider to decide if you should switch to another drug that is covered or if you should request a formulary exception so that it can be considered for coverage.

How do I request an exception to the formulary?
You can ask the Humana Medicare Employer Plan to make an exception to the coverage rules. There are several types of exceptions that you can ask to be made.
- **Formulary exception:** You can request that your drug be covered if it is not on the formulary. If approved, this drug will be covered at a pre-determined cost sharing level, and you would not be able to ask us to provide the drug at a lower cost sharing level.
- **Utilization restriction exception:** You can request coverage restrictions or limits not be applied to your drug. For example, if your drug has a quantity limit, you can ask for the limit not to be applied and to cover more doses of the drug.
- **Tier exception:** You can request a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can request it to be covered as a preferred drug instead. This would lower how much money you must pay for your drug. Please remember a higher level of coverage cannot be requested for the drug if approval was granted to cover a drug that was not on the formulary. *You can ask us to cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier.*

Generally, the Humana Medicare Employer Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost sharing drug, or other restrictions would not be as effective in treating your health condition and/or would cause adverse medical effects.

You should contact us to ask for an initial coverage decision for a formulary, tier, or utilization restriction exception.

When you ask for an exception, you should submit a statement from your health care provider that supports your request. This is called a supporting statement.

Generally, we must make the decision within 72 hours of receiving your health care provider's supporting statement. You can request a fast, or expedited, exception if you or your health care provider thinks your health would seriously suffer if you wait as long as 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your health care provider's supporting statement.

Will my plan cover my drugs if they are not on the formulary?
You may take drugs that your plan does not cover. Or you may talk to your provider about taking a different drug that your plan covers, but that drug might have a Utilization Management Requirement, such as a Prior

Authorization or Step Therapy, that keeps you from getting the drug right away. In certain cases, we may cover as much as a 30-day supply of your drug during the first 90 days you are a member of the plan.

Here is what we will do for each of your current Part D drugs that are not on the formulary, or if you have limited ability to get your drugs:

- We will temporarily cover a 30-day supply of your drug unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 30 days of a drug) when you go to a pharmacy.
- There will be no coverage for the drugs after your first 30-day supply, even if you have been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you are a resident of a long-term care facility and you take Part D drugs that are not on the formulary, we will cover a 31-day supply unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 31 days of a drug) during the first 90 days you are a member of our plan. We will cover a 31-day emergency supply of your drug unless you have a prescription for fewer days (in which we will allow multiple fills to provide up to a total of 31 days of a drug) while you request a formulary exception if:

- You need a drug that is not on the formulary *or*
- You have limited ability to get your drugs *and*
- You are past the first 90 days of membership in the plan

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

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

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

Transition extension

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

A Transition Policy is available on Humana's Medicare website, **Humana.com**, in the same area where the Prescription Drug Guides are displayed.

Mail order pharmacies make it easy to manage your prescriptions

You may fill your medicines at any network pharmacy, Humana Pharmacy – Humana's mail-delivery pharmacy is one option. To get started or learn more, visit **humanapharmacy.com**. You can also call Humana Pharmacy at **1-800-379-0092** (**TTY: 711**) Monday – Friday, 8 a.m. to 11 p.m., and Saturday, 8 a.m. to 6:30 p.m.

Other pharmacies are available in our network.

For More Information

For more detailed information about your Humana Medicare Employer Plan prescription drug coverage, please read your Evidence of Coverage (EOC) and other plan materials.

If you have questions about Humana, please visit our website at **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

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

Humana Medicare Employer Plan Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by the Humana Medicare Employer Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 33.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug is not listed in this partial formulary, please visit our website at **Humana.com**. Our additional contact information is listed on the previous page.

How to read your formulary
The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand-name drugs are CAPITALIZED and generic drugs are listed in lower-case italics. Next to the drug name or Utilization Managemnet column, you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:
HI - Home Infusion drugs that are covered in the gap
DL - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
MO - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.
LA - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.

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

The third column shows the Utilization Management Requirements for the drug. The Humana Medicare Employer Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 5 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Analgesics		
acetaminophen-cod #3 tablet **DL**	1	QL (360 per 30 days)
BELBUCA 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG, BUCCAL FILM **DL**	3	QL (60 per 30 days)
celecoxib 100 mg, 200 mg, 400 mg, 50 mg, capsule **MO**	1	QL (60 per 30 days)
diclofenac sod ec 25 mg, 50 mg, 75 mg, tab **MO**	1	
diclofenac sodium 1% gel **MO**	1	
fentanyl 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour, patch; fentanyl 37.5 mcg/hr patch; fentanyl 62.5 mcg/hr patch; fentanyl 87.5 mcg/hr patch **DL**	1	QL (20 per 30 days)
hydrocodone-acetamin 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg,; hydrocodone-acetamin 2.5-325; hydrocodone-acetamin 7.5-325 **DL**	1	QL (360 per 30 days)
ibuprofen 400 mg, 600 mg, 800 mg, tablet **MO**	1	
meloxicam 15 mg, tablet **MO**	1	QL (30 per 30 days)
meloxicam 7.5 mg, tablet **MO**	1	QL (60 per 30 days)
morphine sulf er 15 mg, 30 mg, 60 mg, tablet **DL**	1	QL (120 per 30 days)
naproxen 250 mg, 375 mg, 500 mg, tablet; naproxen dr 250 mg, 375 mg, 500 mg, tablet **MO**	1	
oxycodone hcl 10 mg, 15 mg, 20 mg, 30 mg, 5 mg, tablet **DL**	1	QL (360 per 30 days)
oxycodone-acetaminophen 10-325; oxycodone-acetaminophen 5-325; oxycodone-acetaminophn 2.5-325; oxycodone-acetaminophn 7.5-325 **DL**	1	QL (360 per 30 days)
tramadol hcl 50 mg, tablet **DL**	1	QL (240 per 30 days)
XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG, CAPSULE SPRINKLE **DL**	2	QL (60 per 30 days)
Anesthetics		
lidocaine 5% patch **MO**	1	PA,QL (90 per 30 days)
lidocaine-prilocaine cream **MO**	1	
Anti-Addiction/Substance Abuse Treatment Agents		
NARCAN 4 MG/ACTUATION, NASAL SPRAY **MO**	2	QL (2 per 30 days)
VIVITROL 380 MG, INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE **DL**	4	QL (1 per 28 days)
ZUBSOLV 0.7 MG-0.18 MG SUBLINGUAL TABLET; ZUBSOLV 1.4 MG-0.36 MG SUBLINGUAL TABLET; ZUBSOLV 2.9 MG-0.71 MG SUBLINGUAL TABLET; ZUBSOLV 5.7 MG-1.4 MG SUBLINGUAL TABLET **MO**	1	QL (90 per 30 days)
ZUBSOLV 11.4 MG-2.9 MG SUBLINGUAL TABLET **MO**	1	QL (30 per 30 days)
ZUBSOLV 8.6 MG-2.1 MG SUBLINGUAL TABLET **MO**	1	QL (60 per 30 days)
Antibacterials		
amoxicillin 250 mg, 500 mg, capsule **MO**	1	
amox-clav 250-125 mg, 500-125 mg, 875-125 mg, tablet **MO**	1	

Need more information about the indicators displayed by the drug names? Please go to page 9.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
DL – Dispensing Limit • HI – Home Infusion • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
azithromycin 250 mg, 500 mg, 600 mg, tablet **MO**	1	
BETHKIS 300 MG/4 ML, SOLUTION FOR NEBULIZATION **DL**	4	PA
cefdinir 300 mg, capsule **MO**	1	
cephalexin 250 mg, 500 mg, 750 mg, capsule **MO**	1	
ciprofloxacin hcl 100 mg, 250 mg, 500 mg, 750 mg, tab **MO**	1	
clindamycin hcl 150 mg, 300 mg, 75 mg, capsule **MO**	1	
daptomycin 500 mg, vial **DL, HI**	4	
DIFICID 200 MG, TABLET **DL**	4	
DIFICID 40 MG/ML, ORAL SUSPENSION **DL**	4	
doxycycline hyclate 100 mg, 50 mg, cap **MO**	1	
imipenem-cilastatin 250 mg, 500 mg, vl **HI,MO**	1	
levofloxacin 250 mg, 500 mg, 750 mg, tablet **MO**	1	
meropenem iv 1 gm vial; meropenem iv 1 gram, 500 mg, vial **HI,MO**	1	
meropenem-0.9% nacl 1 gram/50; meropenem-0.9% nacl 500 mg/50 **MO**	1	
metronidazole 250 mg, 500 mg, tablet **MO**	1	
nafcillin 1 gm add-van vial; nafcillin 2 gm add-vant vial **MO**	1	
nafcillin 1 gm vial; nafcillin 10 gm bulk vial; nafcillin 2 gm vial **HI,MO**	1	
nafcillin 1 gm/ 50 ml inj; nafcillin 2 gm/ 100 ml inj **DL, HI**	4	
nitrofurantoin mono-mcr 100 mg, **MO**	1	
NUZYRA 100 MG, INTRAVENOUS SOLUTION **DL**	4	
NUZYRA 150 MG, TABLET **DL**	4	QL (30 per 14 days)
piperacil-tazobact 13.5 gm vl; piperacil-tazobact 13.5 gram, 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram,; piperacil-tazobact 2.25 gm vl; piperacil-tazobact 3.375 gm vl; piperacil-tazobact 4.5 gm vial **HI,MO**	1	
polymyxin b sulfate vial **HI,MO**	1	
sulfamethoxazole-tmp ds tablet; sulfamethoxazole-tmp ss tablet **MO**	1	
TOBI 300 MG/5 ML, SOLUTION FOR NEBULIZATION **DL**	4	PA
vanco 1 gram/200 ml, 500 mg/100 ml, 750 mg/150 ml,-0.9% nacl; vancomycin 1 g/200ml-0.9% nacl **MO**	3	
ANTICONVULSANTS		
divalproex sod dr 125 mg, 250 mg, 500 mg, tab **MO**	1	
divalproex sod er 250 mg, 500 mg, tab **MO**	1	
EPIDIOLEX 100 MG/ML, ORAL SOLUTION **DL**	4	PA
gabapentin 100 mg, 300 mg, 400 mg, capsule **MO**	1	QL (270 per 30 days)
gabapentin 600 mg, 800 mg, tablet **MO**	1	QL (180 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
DL – Dispensing Limit • HI – Home Infusion • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
lamotrigine 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14), tablet; lamotrigine odt 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14), tablet; lamotrigine odt kit (blue); lamotrigine odt kit (green); lamotrigine odt kit (orange); lamotrigine tab start kit-blue; lamotrigine tab start kt-green; lamotrigine tab start kt-orang **MO**	1	
levetiracetam 1,000 mg, 500 mg, 750 mg, tablet **MO**	1	
topiramate 100 mg, 200 mg, 50 mg, tablet **MO**	1	QL (120 per 30 days)
VIMPAT 10 MG/ML, ORAL SOLUTION **MO**	3	QL (1395 per 30 days)
VIMPAT 100 MG, 150 MG, 200 MG, 50 MG, TABLET **MO**	3	QL (60 per 30 days)
VIMPAT 200 MG/20 ML, INTRAVENOUS SOLUTION **MO**	3	
Antidementia Agents		
donepezil hcl 10 mg, 23 mg, 5 mg, tablet; donepezil hcl odt 10 mg, 23 mg, 5 mg, tablet **MO**	1	QL (30 per 30 days)
donepezil hcl 10 mg, tablet **MO**	1	QL (60 per 30 days)
memantine hcl 10 mg, 5 mg, tablet **MO**	1	PA,QL (60 per 30 days)
NAMZARIC 14 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 21 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 28 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 7 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG, CAPSULE,SPRINKLE,EXTEND RELEASE,DOSE PACK **MO**	2	QL (28 per 28 days)
Antidepressants		
amitriptyline hcl 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg, tab **MO**	1	
bupropion hcl sr 150 mg, tablet **MO**	1	QL (90 per 30 days)
bupropion hcl xl 300 mg, tablet **MO**	1	QL (60 per 30 days)
citalopram hbr 10 mg, 40 mg, tablet **MO**	1	QL (30 per 30 days)
citalopram hbr 20 mg, tablet **MO**	1	QL (60 per 30 days)
duloxetine hcl dr 20 mg, 30 mg, 40 mg, 60 mg, cap **MO**	1	QL (60 per 30 days)
escitalopram 10 mg, tablet **MO**	1	QL (45 per 30 days)
fluoxetine hcl 10 mg, 40 mg, capsule **MO**	1	QL (60 per 30 days)
fluoxetine hcl 20 mg, capsule **MO**	1	QL (120 per 30 days)
mirtazapine 15 mg, 30 mg, 45 mg, 7.5 mg, tablet **MO**	1	
paroxetine hcl 10 mg, 20 mg, tablet **MO**	1	QL (30 per 30 days)
paroxetine hcl 30 mg, 40 mg, tablet **MO**	1	QL (60 per 30 days)
sertraline hcl 100 mg, tablet **MO**	1	QL (60 per 30 days)
sertraline hcl 25 mg, 50 mg, tablet **MO**	1	QL (90 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
trazodone 100 mg, 150 mg, 300 mg, 50 mg, tablet **MO**	1	
TRINTELLIX 10 MG, 20 MG, 5 MG, TABLET **MO**	3	ST,QL (30 per 30 days)
venlafaxine hcl er 150 mg, cap **MO**	1	QL (60 per 30 days)
venlafaxine hcl er 75 mg, cap **MO**	1	QL (90 per 30 days)
Antiemetics		
meclizine 12.5 mg, 25 mg, tablet **MO**	1	
ondansetron odt 4 mg, 8 mg, tablet **MO**	1	B vs D,QL (90 per 30 days)
ondansetron hcl 4 mg, 8 mg, tablet **MO**	1	B vs D,QL (90 per 30 days)
promethazine 12.5 mg, 25 mg, 50 mg, tablet **MO**	1	
SANCUSO 3.1 MG/24 HOUR, TRANSDERMAL PATCH **MO**	3	QL (4 per 30 days)
Antifungals		
clotrimazole-betamethasone crm **MO**	1	QL (180 per 30 days)
fluconazole 100 mg, 150 mg, 200 mg, 50 mg, tablet **MO**	1	
ketoconazole 2% shampoo **MO**	1	QL (120 per 30 days)
nystatin 100,000 unit/gm cream **MO**	1	
Antigout Agents		
allopurinol 100 mg, 300 mg, tablet **MO**	1	
MITIGARE 0.6 MG, CAPSULE **MO**	2	
ANTIMIGRAINE AGENTS		
AIMOVIG AUTOINJECTOR 140 MG/ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	3	PA,QL (1 per 30 days)
AIMOVIG AUTOINJECTOR 70 MG/ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	3	PA,QL (2 per 30 days)
EMGALITY PEN 120 MG/ML, SUBCUTANEOUS PEN INJECTOR **MO**	3	PA,QL (2 per 30 days)
EMGALITY 120 MG/ML, SUBCUTANEOUS SYRINGE **MO**	3	PA,QL (2 per 30 days)
EMGALITY 300 MG/3 ML (100 MG/ML X 3), SUBCUTANEOUS SYRINGE **MO**	3	PA,QL (3 per 30 days)
sumatriptan succ 100 mg, 25 mg, 50 mg, tablet **MO**	1	QL (9 per 30 days)
Antimyasthenic Agents		
MESTINON TIMESPAN 180 MG, TABLET,EXTENDED RELEASE **DL**	4	PA
pyridostigmine 60 mg/5 ml, soln **MO**	1	
pyridostigmine br 30 mg, 60 mg, tablet **MO**	1	
pyridostigmine er 180 mg, tab **MO**	1	
Antimycobacterials		
rifabutin 150 mg, capsule **MO**	1	
RIFADIN 600 MG, INTRAVENOUS SOLUTION **MO**	3	
rifampin 150 mg, 300 mg, capsule **MO**	1	
ANTINEOPLASTICS		
AFINITOR 10 MG, 2.5 MG, 5 MG, 7.5 MG, TABLET **DL**	4	PA,QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
AFINITOR DISPERZ 2 MG, 3 MG, 5 MG, TABLET FOR ORAL SUSPENSION DL	4	PA
ALUNBRIG 180 MG, 90 MG, 90 MG (7)- 180 MG (23), TABLET; ALUNBRIG 90 MG (7)-180 MG (23) TABLETS IN A DOSE PACK DL	4	PA,QL (30 per 30 days)
ALUNBRIG 30 MG, TABLET DL	4	PA,QL (180 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG, TABLET DL	4	PA,QL (30 per 30 days)
ERIVEDGE 150 MG, CAPSULE DL	4	PA,QL (28 per 28 days)
ERLEADA 60 MG, TABLET DL	4	PA,QL (120 per 30 days)
HERCEPTIN 150 MG, INTRAVENOUS SOLUTION DL	4	PA
HERCEPTIN HYLECTA 600 MG-10,000 UNIT/5 ML, SUBCUTANEOUS SOLUTION DL	4	PA,QL (5 per 21 days)
IBRANCE 100 MG, 125 MG, 75 MG, CAPSULE DL	4	PA,QL (21 per 28 days)
IBRANCE 100 MG, 125 MG, 75 MG, TABLET DL	4	PA,QL (21 per 28 days)
IMBRUVICA 140 MG, CAPSULE DL	4	PA,QL (90 per 30 days)
IMBRUVICA 420 MG, 560 MG, TABLET DL	4	PA,QL (28 per 28 days)
IMBRUVICA 70 MG, CAPSULE DL	4	PA,QL (28 per 28 days)
NUBEQA 300 MG, TABLET DL	4	PA,QL (120 per 30 days)
RITUXAN 10 MG/ML, CONCENTRATE,INTRAVENOUS DL	4	PA
SPRYCEL 100 MG, 50 MG, 70 MG, 80 MG, TABLET DL	4	PA,QL (60 per 30 days)
SPRYCEL 140 MG, TABLET DL	4	PA,QL (30 per 30 days)
SPRYCEL 20 MG, TABLET DL	4	PA,QL (90 per 30 days)
TYKERB 250 MG, TABLET DL	4	PA,QL (180 per 30 days)
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG, TABLET DL	4	PA,QL (60 per 30 days)
XTANDI 40 MG, CAPSULE DL	4	PA,QL (120 per 30 days)
Antiparasitics		
hydroxychloroquine 200 mg, tab MO	1	
ivermectin 3 mg, tablet MO	1	
ANTIPARKINSON AGENTS		
benztropine mes 0.5 mg, 1 mg, 2 mg, tab; benztropine mes 0.5 mg, 1 mg, 2 mg, tablet MO	1	
carbidopa-levo 10-100 mg, 25-100 mg, 25-250 mg, odt; carbidopa-levodopa 10-100 tab; carbidopa-levodopa 25-100 tab; carbidopa-levodopa 25-250 tab MO	1	
KYNMOBI 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG, SUBLINGUAL FILM; KYNMOBI 10 MG-15 MG-20 MG-25 MG-30 MG SUBLINGUAL FILM DL	4	PA,QL (150 per 30 days)
NEUPRO 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR, TRANSDERMAL 24 HOUR PATCH MO	3	QL (30 per 30 days)
pramipexole 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, tablet MO	1	

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ropinirole hcl 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg, tablet **MO**	1	
RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE; RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE **MO**	3	ST,QL (360 per 30 days)
RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE **MO**	3	ST,QL (270 per 30 days)
RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE **MO**	3	ST,QL (300 per 30 days)
ANTIPSYCHOTICS		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG, TABLET **DL**	4	PA
ABILIFY MAINTENA 300 MG, 400 MG, INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE **DL**	4	QL (1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG, SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE **DL**	4	QL (1 per 28 days)
ABILIFY MYCITE 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG, TABLET WITH SENSOR AND PATCH **DL**	4	PA,QL (30 per 30 days)
aripiprazole 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg, tablet **MO**	1	
ARISTADA 1,064 MG/3.9 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **MO**	4	QL (3.9 per 56 days)
ARISTADA 441 MG/1.6 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (1.6 per 28 days)
ARISTADA 662 MG/2.4 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (2.4 per 28 days)
ARISTADA 882 MG/3.2 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (2.4 per 42 days)
INVEGA 1.5 MG, 3 MG, 9 MG, TABLET,EXTENDED RELEASE **DL**	4	PA,QL (30 per 30 days)
INVEGA 6 MG, TABLET,EXTENDED RELEASE **DL**	4	PA,QL (60 per 30 days)
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML, INTRAMUSCULAR SYRINGE **DL**	4	QL (1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML, INTRAMUSCULAR SYRINGE **DL**	4	QL (1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML, INTRAMUSCULAR SYRINGE **MO**	3	QL (1.5 per 28 days)
INVEGA TRINZA 273 MG/0.875 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (0.875 per 90 days)
INVEGA TRINZA 410 MG/1.315 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (1.315 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (1.75 per 90 days)
INVEGA TRINZA 819 MG/2.625 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (2.625 per 90 days)
olanzapine 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg, tablet **MO**	1	
PERSERIS 120 MG, 90 MG, ABDOMINAL SUBCUTANEOUS EXT. RELEASE SUSPENSION SYRINGE **DL**	4	QL (1 per 28 days)
quetiapine fumarate 200 mg, 25 mg, 50 mg, tab **MO**	1	QL (120 per 30 days)
REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG, TABLET **MO**	3	PA,QL (30 per 30 days)
RISPERDAL 0.25 MG, 1 MG, 2 MG, 3 MG, 4 MG, TABLET **DL**	4	QL (60 per 30 days)
RISPERDAL 0.5 MG, TABLET **MO**	3	QL (120 per 30 days)
RISPERDAL 1 MG/ML, ORAL SOLUTION **DL**	4	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML, INTRAMUSCULAR SUSP,EXTENDED RELEASE **MO**	3	QL (2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML, INTRAMUSCULAR SUSP,EXTENDED RELEASE **DL**	4	QL (2 per 28 days)
risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg, odt; risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg, tablet **MO**	1	QL (60 per 30 days)
Antispasticity Agents		
baclofen 10 mg, 20 mg, tablet **MO**	1	
dantrolene sodium 100 mg, 25 mg, 50 mg, cap **MO**	1	
tizanidine hcl 2 mg, 4 mg, tablet **MO**	1	
ANTIVIRALS		
acyclovir 400 mg, 800 mg, tablet **MO**	1	
BIKTARVY 50 MG-200 MG-25 MG TABLET **DL**	4	QL (30 per 30 days)
DESCOVY 200 MG-25 MG TABLET **DL**	4	QL (30 per 30 days)
EPCLUSA 200 MG-50 MG TABLET; EPCLUSA 400 MG-100 MG TABLET **DL**	4	PA,QL (28 per 28 days)
GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET **DL**	4	QL (30 per 30 days)
HARVONI 33.75 MG-150 MG ORAL PELLETS IN PACKET **DL**	4	PA,QL (28 per 28 days)
HARVONI 45 MG-200 MG ORAL PELLETS IN PACKET **DL**	4	PA,QL (56 per 28 days)
HARVONI 45 MG-200 MG TABLET; HARVONI 90 MG-400 MG TABLET **DL**	4	PA,QL (28 per 28 days)
ledipasvir-sofosbuvir 90-400mg **DL**	4	PA,QL (28 per 28 days)
ODEFSEY 200 MG-25 MG-25 MG TABLET **DL**	4	QL (30 per 30 days)
oseltamivir phos 45 mg, 75 mg, capsule **MO**	1	QL (112 per 365 days)
VOSEVI 400 MG-100 MG-100 MG TABLET **DL**	4	PA,QL (28 per 28 days)
XOFLUZA 20 MG, 40 MG, TABLET **MO**	3	QL (10 per 365 days)
Anxiolytics		
alprazolam 0.25 mg, 0.5 mg, 1 mg, tablet **DL**	1	QL (120 per 30 days)
buspirone hcl 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg, tablet **MO**	1	
clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg odt; clonazepam 0.5 mg, 1 mg, 2 mg tablet **DL**	1	
diazepam 2 mg, 5 mg, tablet **DL**	1	QL (90 per 30 days)
hydroxyzine hcl 10 mg, 25 mg, 50 mg, tablet **MO**	1	
lorazepam 0.5 mg, 1 mg, tablet **DL**	1	QL (90 per 30 days)
Bipolar Agents		
lithium carbonate 150 mg, 300 mg, 600 mg, cap **MO**	1	
lithium carbonate 300 mg, tab **MO**	1	
lithium carbonate er 300 mg, 450 mg, tb **MO**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
lithium 8 meq/5 ml, solution **MO**	1	
LITHOBID 300 MG, TABLET,EXTENDED RELEASE **DL**	4	
Blood Glucose Regulators		
BAQSIMI 3 MG/ACTUATION, NASAL SPRAY **MO**	2	
BYDUREON 2 MG PEN INJECT **MO**	3	QL (4 per 28 days)
BYDUREON BCISE 2 MG/0.85 ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	3	QL (3.4 per 28 days)
FARXIGA 10 MG, 5 MG, TABLET **MO**	3	QL (30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS CARTRIDGE **MO**	2	
FIASP U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
glimepiride 1 mg, 2 mg, 4 mg, tablet **MO**	1	
glipizide 10 mg, 5 mg, tablet **MO**	1	
glipizide er 10 mg, 2.5 mg, 5 mg, tablet **MO**	1	
GLUCAGEN HYPOKIT 1 MG, INJECTION **MO**	2	
GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET **MO**	2	QL (30 per 30 days)
GVOKE HYPOPEN 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	2	
GVOKE PFS 1-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS SYRINGE **MO**	2	
GVOKE PFS 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS SYRINGE **MO**	2	
HUMALOG JUNIOR KWIKPEN (U-100) 100 UNIT/ML, SUBCUTANEOUS HALF-UNIT PEN **MO**	3	ST
HUMALOG KWIKPEN (U-100) INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML), SUBCUTANEOUS; HUMALOG KWIKPEN U-200 INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML), SUBCUTANEOUS **MO**	3	ST
HUMALOG MIX 50-50 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO**	3	ST
HUMALOG MIX 50-50 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN **MO**	3	ST
HUMALOG MIX 75-25 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN **MO**	3	ST
HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO**	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS CARTRIDGE **MO**	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	3	ST
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO**	3	ST

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMULIN 70/30 U-100 INSULIN KWIKPEN 100 UNIT/ML SUBCUTANEOUS **MO**	3	ST
HUMULIN N NPH U-100 INSULIN KWIKPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS **MO**	3	ST
HUMULIN N NPH U-100 INSULIN (ISOPHANE SUSP) 100 UNIT/ML, SUBCUTANEOUS **MO**	3	ST
HUMULIN R REGULAR U-100 INSULIN 100 UNIT/ML, INJECTION SOLUTION **MO**	3	ST
HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML, SUBCUTANEOUS SOLN **DL**	4	
HUMULIN R U-500 (CONC) INSULIN KWIKPEN 500 UNIT/ML (3 ML), SUBCUTANEOUS **DL**	4	
INSULIN ASPART PRO MIX70-30 PN **MO**	2	
INSULIN ASPART PRO MIX70-30 VL **MO**	2	
INSULIN ASPART 100 UNIT/ML PEN **MO**	2	
INSULIN ASPART 100 UNIT/ML, CRT **MO**	2	
INSULIN ASPART 100 UNIT/ML, VL **MO**	2	
INSULIN LISPRO 100 UNIT/ML, PEN; INSULIN LISPRO JR 100 UNIT/ML, **MO**	3	ST
INSULIN LISPRO 100 UNIT/ML, VL **MO**	3	ST
INSULIN LISPRO MIX 75-25 KWKPN **MO**	3	ST
INVOKAMET 150 MG-1,000 MG TABLET; INVOKAMET 150 MG-500 MG TABLET; INVOKAMET 50 MG-1,000 MG TABLET; INVOKAMET 50 MG-500 MG TABLET **MO**	2	QL (60 per 30 days)
INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
INVOKANA 100 MG, 300 MG, TABLET **MO**	2	QL (30 per 30 days)
JANUMET 50 MG-1,000 MG TABLET; JANUMET 50 MG-500 MG TABLET **MO**	2	QL (60 per 30 days)
JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE; JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG, TABLET **MO**	2	QL (30 per 30 days)
JARDIANCE 10 MG, 25 MG, TABLET **MO**	2	QL (30 per 30 days)
JENTADUETO 2.5 MG-1,000 MG TABLET; JENTADUETO 2.5 MG-500 MG TABLET; JENTADUETO 2.5 MG-850 MG TABLET **MO**	2	QL (60 per 30 days)
JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE **MO**	3	QL (60 per 30 days)

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KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE; KOMBIGLYZE XR 5 MG-500 MG TABLET,EXTENDED RELEASE **MO**	3	QL (30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
LANTUS U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
LEVEMIR FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
LEVEMIR U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS **MO**	3	ST
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML), SUBCUTANEOUS **MO**	3	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	3	ST
metformin hcl 1,000 mg, 500 mg, 850 mg, tablet **MO**	1	
metformin hcl er 500 mg, tablet **MO**	1	QL (120 per 30 days)
NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30), SUBCUTANEOUS **MO**	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO**	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN **MO**	2	
NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML, SUBCUTANEOUS SUSP **MO**	2	
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN **MO**	2	
NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML, INJECTION SOLUTION **MO**	2	
NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML), SUBCUTANEOUS **MO**	2	
NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION **MO**	2	
NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN **MO**	2	
NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML, SUBCUTANEOUS CARTRIDG **MO**	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
ONGLYZA 2.5 MG, 5 MG, TABLET **MO**	3	QL (30 per 30 days)
OZEMPIC 0.25 MG OR 0.5 MG (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (1.5 per 28 days)
OZEMPIC 1 MG/DOSE (2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (3 per 28 days)
pioglitazone hcl 15 mg, 30 mg, 45 mg, tablet **MO**	1	QL (30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG, TABLET **MO**	2	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SOLIQUA 100/33 100 UNIT-33 MCG/ML, SUBCUTANEOUS INSULIN PEN **MO**	2	QL (15 per 24 days)
SYNJARDY 12.5 MG-1,000 MG TABLET; SYNJARDY 12.5 MG-500 MG TABLET; SYNJARDY 5 MG-1,000 MG TABLET; SYNJARDY 5 MG-500 MG TABLET **MO**	2	QL (60 per 30 days)
SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN **MO**	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML), SUBCUTANEOUS PEN **MO**	2	
TRADJENTA 5 MG, TABLET **MO**	2	QL (30 per 30 days)
TRESIBA FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
TRESIBA FLEXTOUCH U-200 INSULIN 200 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
TRESIBA U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
TRIJARDY XR 10 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE; TRIJARDY XR 25 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
TRIJARDY XR 12.5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE; TRIJARDY XR 5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML, SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (2 per 28 days)
VICTOZA 2-PAK 0.6 MG/0.1 ML (18 MG/3 ML), SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (9 per 30 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML), SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (9 per 30 days)
XIGDUO XR 10 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 10 MG-500 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-500 MG TABLET,EXTENDED RELEASE **MO**	3	QL (30 per 30 days)
XIGDUO XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE **MO**	3	QL (60 per 30 days)
XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN **MO**	2	QL (15 per 30 days)
BLOOD PRODUCTS AND MODIFIERS		
BRILINTA 60 MG, 90 MG, TABLET **MO**	2	QL (60 per 30 days)
clopidogrel 75 mg, tablet **MO**	1	QL (30 per 30 days)
ELIQUIS 2.5 MG, TABLET **MO**	2	QL (60 per 30 days)
ELIQUIS 5 MG, TABLET **MO**	2	QL (74 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ELIQUIS DVT-PE TREATMENT 30-DAY STARTER 5 MG (74 TABLETS) IN DOSE PACK **MO**	2	QL (74 per 30 days)
enoxaparin 100 mg/ml, 150 mg/ml, syringe **HI,MO**	1	QL (28 per 28 days)
enoxaparin 120 mg/0.8 ml, 80 mg/0.8 ml, syr **HI,MO**	1	QL (22.4 per 28 days)
enoxaparin 30 mg/0.3 ml, 60 mg/0.6 ml, syr **HI,MO**	1	QL (16.8 per 28 days)
enoxaparin 300 mg/3 ml, vial **MO**	1	QL (84 per 28 days)
enoxaparin 40 mg/0.4 ml, syr **HI,MO**	1	QL (11.2 per 28 days)
NEULASTA 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.2 per 28 days)
NEULASTA ONPRO 6 MG/0.6 ML, WITH WEARABLE SUBCUTANEOUS INJECTOR **DL**	4	PA,QL (1.2 per 28 days)
NEUPOGEN 300 MCG/0.5 ML, INJECTION SYRINGE **DL**	4	PA,QL (7 per 30 days)
NEUPOGEN 300 MCG/ML, INJECTION SOLUTION **DL**	4	PA,QL (14 per 30 days)
NEUPOGEN 480 MCG/0.8 ML, INJECTION SYRINGE **DL**	4	PA,QL (11.2 per 30 days)
NEUPOGEN 480 MCG/1.6 ML, INJECTION SOLUTION **DL**	4	PA,QL (22.4 per 30 days)
NIVESTYM 300 MCG/0.5 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (7 per 30 days)
NIVESTYM 300 MCG/ML, INJECTION SOLUTION **DL**	4	PA,QL (14 per 30 days)
NIVESTYM 480 MCG/0.8 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (11.2 per 30 days)
NIVESTYM 480 MCG/1.6 ML, INJECTION SOLUTION **DL**	4	PA,QL (22.4 per 30 days)
PRADAXA 110 MG, 150 MG, 75 MG, CAPSULE **MO**	3	QL (60 per 30 days)
PROMACTA 12.5 MG, 75 MG, TABLET **DL, LA**	4	PA,QL (60 per 30 days)
PROMACTA 12.5 MG, ORAL POWDER PACKET **DL, LA**	4	PA,QL (360 per 30 days)
PROMACTA 25 MG, ORAL POWDER PACKET **DL, LA**	4	PA,QL (180 per 30 days)
PROMACTA 25 MG, TABLET **DL, LA**	4	PA,QL (30 per 30 days)
PROMACTA 50 MG, TABLET **DL, LA**	4	PA,QL (90 per 30 days)
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML, INJECTION SOLUTION **MO**	3	PA,QL (14 per 30 days)
UDENYCA 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.2 per 28 days)
warfarin sodium 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg, tablet **MO**	1	
XARELTO 10 MG, 20 MG, TABLET **MO**	2	QL (30 per 30 days)
XARELTO 15 MG, 2.5 MG, TABLET **MO**	2	QL (60 per 30 days)
XARELTO DVT-PE TREATMENT 30-DAY STARTER 15 MG(42)-20 MG(9) TABLET PACK **MO**	2	QL (51 per 30 days)
ZARXIO 300 MCG/0.5 ML, INJECTION SYRINGE **DL**	4	PA,QL (7 per 30 days)
ZARXIO 480 MCG/0.8 ML, INJECTION SYRINGE **DL**	4	PA,QL (11.2 per 30 days)
ZIEXTENZO 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.2 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cardiovascular Agents		
amiodarone hcl 100 mg, 200 mg, tablet **MO**	1	
amlodipine besylate 10 mg, 2.5 mg, 5 mg, tab **MO**	1	
amlodipine-benazepril 10-20 mg, 2.5-10 mg, 5-10 mg, 5-20 mg,; amlodipine-benazepril 2.5-10 **MO**	1	QL (60 per 30 days)
atenolol 100 mg, 25 mg, 50 mg, tablet **MO**	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg, tablet **MO**	1	
benazepril hcl 10 mg, 20 mg, 40 mg, 5 mg, tablet **MO**	1	
bumetanide 0.5 mg, 1 mg, 2 mg, tablet **MO**	1	
BYSTOLIC 10 MG, TABLET **MO**	2	QL (120 per 30 days)
BYSTOLIC 2.5 MG, 5 MG, TABLET **MO**	2	QL (30 per 30 days)
BYSTOLIC 20 MG, TABLET **MO**	2	QL (60 per 30 days)
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg, tablet **MO**	1	
chlorthalidone 25 mg, 50 mg, tablet **MO**	1	
clonidine hcl 0.1 mg, 0.2 mg, 0.3 mg, tablet **MO**	1	
CORLANOR 5 MG, 7.5 MG, TABLET **MO**	3	PA,QL (60 per 30 days)
CORLANOR 5 MG/5 ML, ORAL SOLUTION **MO**	3	PA,QL (560 per 28 days)
digoxin 125 mcg tablet; digoxin 250 mcg tablet **MO**	1	QL (30 per 30 days)
diltiazem 24h er(cd) 120 mg, 180 mg, 240 mg, cp; diltiazem 24hr er 120 mg, 180 mg, 240 mg, cap **MO**	1	QL (60 per 30 days)
doxazosin mesylate 1 mg, 2 mg, 4 mg, 8 mg, tab **MO**	1	
enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg, tab; enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg, tablet **MO**	1	
ENTRESTO 24 MG-26 MG TABLET; ENTRESTO 49 MG-51 MG TABLET; ENTRESTO 97 MG-103 MG TABLET **MO**	2	QL (60 per 30 days)
ezetimibe 10 mg, tablet **MO**	1	QL (30 per 30 days)
fenofibrate 120 mg, 160 mg, tablet **MO**	1	QL (30 per 30 days)
furosemide 20 mg, 40 mg, 80 mg, tablet **MO**	1	
hydralazine 10 mg, 100 mg, 25 mg, 50 mg, tablet **MO**	1	
hydrochlorothiazide 12.5 mg, 25 mg, 50 mg, tab; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg, tb **MO**	1	
irbesartan 150 mg, 300 mg, 75 mg, tablet **MO**	1	QL (30 per 30 days)
isosorbide mononit er 120 mg, 30 mg, 60 mg,; isosorbide mononit er 120 mg, 30 mg, 60 mg, tb **MO**	1	
lisinopril 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg, tablet **MO**	1	
lisinopril-hctz 10-12.5 mg, 20-12.5 mg, 20-25 mg, tab **MO**	1	
losartan potassium 100 mg, 25 mg, 50 mg, tab **MO**	1	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
losartan-hctz 100-12.5 mg, 100-25 mg, 50-12.5 mg, tab **MO**	1	QL (60 per 30 days)
lovastatin 10 mg, 20 mg, 40 mg, tablet **MO**	1	
metoprolol succ er 100 mg, 200 mg, 25 mg, 50 mg, tab **MO**	1	QL (60 per 30 days)
metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg, tab; metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg, tb **MO**	1	
MULTAQ 400 MG, TABLET **MO**	2	QL (60 per 30 days)
NEXLETOL 180 MG, TABLET **MO**	2	PA,QL (30 per 30 days)
NEXLIZET 180 MG-10 MG TABLET **MO**	2	PA,QL (30 per 30 days)
nifedipine er 30 mg, 60 mg, 90 mg, tablet **MO**	1	QL (60 per 30 days)
nitroglycerin 0.3 mg, 0.4 mg, 0.6 mg, tablet sl **MO**	1	
olmesartan medoxomil 20 mg, 40 mg, 5 mg, tab **MO**	1	QL (30 per 30 days)
pravastatin sodium 10 mg, 20 mg, 40 mg, 80 mg, tab **MO**	1	
propranolol 10 mg, 20 mg, 40 mg, 60 mg, 80 mg, tablet **MO**	1	
ramipril 1.25 mg, 10 mg, 2.5 mg, 5 mg, capsule **MO**	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML, SUBCUTANEOUS WEARABLE INJECTOR **MO**	2	PA,QL (3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML, SUBCUTANEOUS PEN INJECTOR **MO**	2	PA,QL (3 per 28 days)
REPATHA SYRINGE 140 MG/ML, SUBCUTANEOUS SYRINGE **MO**	2	PA,QL (3 per 28 days)
rosuvastatin calcium 10 mg, 20 mg, 40 mg, 5 mg, tab **MO**	1	
simvastatin 10 mg, 20 mg, 40 mg, 5 mg, 80 mg, tablet **MO**	1	
spironolactone 100 mg, 25 mg, 50 mg, tablet **MO**	1	
TEKTURNA 150 MG, 300 MG, TABLET **MO**	3	PA,QL (30 per 30 days)
TEKTURNA HCT 150 MG-12.5 MG TABLET; TEKTURNA HCT 150 MG-25 MG TABLET; TEKTURNA HCT 300 MG-12.5 MG TABLET; TEKTURNA HCT 300 MG-25 MG TABLET **MO**	3	ST,QL (30 per 30 days)
torsemide 10 mg, 100 mg, 20 mg, 5 mg, tablet **MO**	1	
triamterene-hctz 37.5-25 mg, 75-50 mg, tab; triamterene-hctz 37.5-25 mg, 75-50 mg, tb **MO**	1	
valsartan 160 mg, 320 mg, 40 mg, 80 mg, tablet **MO**	1	QL (60 per 30 days)
VASCEPA 0.5 GRAM, CAPSULE **MO**	2	QL (240 per 30 days)
VASCEPA 1 GRAM, CAPSULE **MO**	2	QL (120 per 30 days)
WELCHOL 3.75 GRAM, ORAL POWDER PACKET **MO**	3	QL (30 per 30 days)
WELCHOL 625 MG, TABLET **MO**	3	QL (180 per 30 days)
ZYPITAMAG 1 MG, 2 MG, 4 MG, TABLET **MO**	2	ST,QL (30 per 30 days)
Central Nervous System Agents		
AUSTEDO 12 MG, 9 MG, TABLET **DL**	4	PA,QL (120 per 30 days)
AUSTEDO 6 MG, TABLET **DL**	4	PA,QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
BETASERON 0.3 MG, SUBCUTANEOUS KIT DL	4	PA,QL (15 per 30 days)
COPAXONE 20 MG/ML, SUBCUTANEOUS SYRINGE DL	4	PA,QL (30 per 30 days)
COPAXONE 40 MG/ML, SUBCUTANEOUS SYRINGE DL	4	PA,QL (12 per 28 days)
dextroamp-amphetam 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg, tab; dextroamp-amphetamin 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg, tab; dextroamp-amphetamine 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg, tab MO	1	QL (90 per 30 days)
GILENYA 0.25 MG, 0.5 MG, CAPSULE DL	4	PA,QL (30 per 30 days)
pregabalin 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg, capsule MO	1	QL (90 per 30 days)
SAVELLA 100 MG, 12.5 MG, 12.5 MG (5)-25 MG(8)-50 MG(42), 25 MG, 50 MG, TABLET; SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK MO	2	QL (60 per 30 days)
TECFIDERA 120 MG (14)- 240 MG (46), 240 MG, CAPSULE,DELAYED RELEASE; TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE DL	4	PA,QL (60 per 30 days)
TECFIDERA 120 MG, CAPSULE,DELAYED RELEASE DL	4	PA,QL (14 per 30 days)
Dental & Oral Agents		
chlorhexidine 0.12% rinse MO	1	
triamcinolone 0.1% paste MO	1	
DERMATOLOGICAL AGENTS		
ENSTILAR 0.005 %-0.064 % TOPICAL FOAM MO	3	QL (120 per 30 days)
hydrocortisone 1% cream; hydrocortisone 2.5% cream MO	1	QL (240 per 30 days)
mupirocin 2% ointment MO	1	
PICATO 0.015 %, TOPICAL GEL MO	4	QL (3 per 30 days)
PICATO 0.05 %, TOPICAL GEL MO	4	QL (2 per 30 days)
REGRANEX 0.01 %, TOPICAL GEL DL	4	PA
SANTYL 250 UNIT/GRAM, TOPICAL OINTMENT MO	2	QL (180 per 30 days)
TACLONEX 0.005 %-0.064 % TOPICAL OINTMENT DL	4	PA,QL (60 per 30 days)
TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION MO	4	PA,QL (420 per 30 days)
Electrolytes/Minerals/Metals/Vitamins		
AURYXIA 210 MG IRON, TABLET MO	3	PA,QL (360 per 30 days)
EXJADE 125 MG, 250 MG, 500 MG, DISPERSIBLE TABLET DL	4	PA
JADENU 180 MG, 360 MG, 90 MG, TABLET DL	4	PA
JADENU SPRINKLE 180 MG, 360 MG, 90 MG, ORAL GRANULES IN PACKET DL	4	PA
LOKELMA 10 GRAM, 5 GRAM, ORAL POWDER PACKET MO	2	QL (30 per 30 days)
potassium cl er 10 meq, 15 meq, 20 meq, tablet MO	1	
GASTROINTESTINAL AGENTS		
DEXILANT 30 MG, 60 MG, CAPSULE, DELAYED RELEASE MO	3	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
dicyclomine 10 mg, capsule **MO**	1	
esomeprazole mag dr 20 mg, 40 mg, cap **MO**	1	QL (60 per 30 days)
famotidine 20 mg, 40 mg, tablet **MO**	1	
LINZESS 145 MCG, 290 MCG, 72 MCG, CAPSULE **MO**	2	QL (30 per 30 days)
MOVANTIK 12.5 MG, 25 MG, TABLET **MO**	2	QL (30 per 30 days)
omeprazole dr 10 mg, 20 mg, 40 mg, capsule **MO**	1	QL (60 per 30 days)
pantoprazole sod dr 20 mg, 40 mg, tab **MO**	1	QL (60 per 30 days)
PYLERA 140 MG-125 MG-125 MG CAPSULE **MO**	3	QL (120 per 30 days)
RELISTOR 12 MG/0.6 ML, SUBCUTANEOUS SOLUTION **MO**	3	QL (36 per 30 days)
RELISTOR 12 MG/0.6 ML, SUBCUTANEOUS SYRINGE **MO**	3	QL (36 per 28 days)
RELISTOR 150 MG, TABLET **MO**	3	QL (90 per 30 days)
RELISTOR 8 MG/0.4 ML, SUBCUTANEOUS SYRINGE **MO**	3	QL (12 per 30 days)
sucralfate 1 gm tablet **MO**	1	
SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION **MO**	2	
SUTAB 1.479-0.188-0.225 GRAM TABLET **MO**	3	
XIFAXAN 200 MG, TABLET **DL**	4	PA,QL (9 per 30 days)
XIFAXAN 550 MG, TABLET **DL**	4	PA,QL (84 per 28 days)
GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
CERDELGA 84 MG, CAPSULE **DL**	4	PA
CEREZYME 400 UNIT, INTRAVENOUS SOLUTION **DL**	4	PA
CREON 12,000-38,000-60,000 UNIT CAPSULE,DELAYED RELEASE; CREON 24,000-76,000-120,000 UNIT CAPSULE,DELAYED RELEASE; CREON 3,000 UNIT-9,500 UNIT-15,000 UNIT CAPSULE,DELAYED RELEASE; CREON 36,000 UNIT-114,000 UNIT-180,000 UNIT CAPSULE,DELAYED RELEASE; CREON 6,000-19,000-30,000 UNIT CAPSULE,DELAYED RELEASE **MO**	2	
ELELYSO 200 UNIT, INTRAVENOUS SOLUTION **DL**	4	PA
ONPATTRO 2 MG/ML, INTRAVENOUS SOLUTION **MO**	4	PA
PROLASTIN-C 1,000 MG (+/-)/20 ML INTRAVENOUS SOLUTION; PROLASTIN-C 1,000 MG, 1,000 MG (+/-)/20 ML, INTRAVENOUS POWDER FOR SOLUTION **DL, LA**	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML, SUBCUTANEOUS SOLUTION **DL**	4	PA
ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE **MO**	3	
GENITOURINARY AGENTS		
finasteride 5 mg, tablet **MO**	1	QL (30 per 30 days)
GEMTESA 75 MG, TABLET **MO**	3	QL (30 per 30 days)
MYRBETRIQ 25 MG, 50 MG, TABLET,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
oxybutynin 5 mg, tablet **MO**	1	
oxybutynin cl er 10 mg, 15 mg, 5 mg, tablet **MO**	1	QL (60 per 30 days)
tamsulosin hcl 0.4 mg, capsule **MO**	1	
TOVIAZ 4 MG, 8 MG, TABLET,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
methylprednisolone 4 mg, dosepk **MO**	1	
prednisone 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg, tablet **MO**	1	B vs D
triamcinolone 0.025% cream; triamcinolone 0.1% cream; triamcinolone 0.5% cream **MO**	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
desmopressin acetate 0.1 mg, tb **MO**	1	QL (180 per 30 days)
desmopressin acetate 0.2 mg, tb **MO**	1	
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML), SUBCUTANEOUS CARTRIDGE **DL**	4	PA
OMNITROPE 5.8 MG, SUBCUTANEOUS SOLUTION **DL**	4	PA
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg, tablet; estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg, vaginal insrt **MO**	1	
OSPHENA 60 MG, TABLET **MO**	2	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG, TABLET **MO**	3	
PREMARIN 0.625 MG/GRAM, VAGINAL CREAM **MO**	2	
PREMARIN 25 MG, SOLUTION FOR INJECTION **MO**	3	

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Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg, tablet **MO**	1	
liothyronine sod 10 mcg/ml, vl **MO**	1	
liothyronine sod 25 mcg, 5 mcg, 50 mcg, tab **MO**	1	
SYNTHROID 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG, TABLET **MO**	2	
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN 500 MG, TABLET **DL**	4	
Hormonal Agents, Suppressant (Pituitary)		
ORGOVYX 120 MG, TABLET **DL**	4	PA,QL (32 per 30 days)
SOMATULINE DEPOT 120 MG/0.5 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (0.5 per 28 days)
SOMATULINE DEPOT 60 MG/0.2 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (0.2 per 28 days)
SOMATULINE DEPOT 90 MG/0.3 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (0.3 per 28 days)
Hormonal Agents, Suppressant (Thyroid)		
methimazole 10 mg, 5 mg, tablet **MO**	1	
TAPAZOLE 10 MG, 5 MG, TABLET **MO**	1	
IMMUNOLOGICAL AGENTS		
COSENTYX 150 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (8 per 28 days)
COSENTYX 300 MG/2 SYRINGES (150 MG/ML,) SUBCUTANEOUS **DL**	4	PA,QL (8 per 28 days)
COSENTYX PEN 150 MG/ML, SUBCUTANEOUS **DL**	4	PA,QL (8 per 28 days)
COSENTYX PEN 300 MG/2 PENS (150 MG/ML,) SUBCUTANEOUS **DL**	4	PA,QL (8 per 28 days)
DUPIXENT 300 MG/2 ML, SUBCUTANEOUS PEN INJECTOR **DL**	4	PA,QL (6 per 28 days)
DUPIXENT 200 MG/1.14 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (3.42 per 28 days)
DUPIXENT 300 MG/2 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (6 per 28 days)
ENBREL 25 MG (1 ML), 25 MG/0.5 ML, SUBCUTANEOUS POWDER FOR SOLUTION; ENBREL 25 MG (1 ML), 25 MG/0.5 ML, SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (8 per 28 days)
ENBREL 25 MG/0.5 ML (0.5 ML) SUBCUTANEOUS SYRINGE; ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML), SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (8 per 28 days)
ENBREL MINI 50 MG/ML (1 ML), SUBCUTANEOUS CARTRIDGE **DL**	4	PA,QL (8 per 28 days)
ENBREL SURECLICK 50 MG/ML (1 ML), SUBCUTANEOUS PEN INJECTOR **DL**	4	PA,QL (8 per 28 days)
ENVARSUS XR 0.75 MG, 1 MG, 4 MG, TABLET,EXTENDED RELEASE **MO**	3	PA
GAMUNEX-C 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %), INJECTION SOLUTION **DL**	4	PA
HIZENTRA 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %), SUBCUTANEOUS SOLUTION **DL**	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMIRA 10 MG/0.2 ML, SYRINGE **DL**	4	PA,QL (2 per 28 days)
HUMIRA 20 MG/0.4 ML, 40 MG/0.8 ML, SUBCUTANEOUS SYRINGE KIT; HUMIRA 20 MG/0.4 ML, 40 MG/0.8 ML, SYRINGE **DL**	4	PA,QL (6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML, SUBCUTANEOUS KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML, SUBCUT KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS-ADOL HID SUP START 40 MG/0.8 ML, SUBCUT KT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML, SUBCUTANEOUS SYRINGE KIT **DL**	4	PA,QL (2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML, SUBCUTANEOUS SYRINGE KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEDI CROHN'S START 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML, SUBCUT SYR KIT; HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML, SUBCUT SYRINGE KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML, SUBCUTANEOUS KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEN CROHN'S-ULC COLITIS-HID SUP STRT 80 MG/0.8 ML, SUBCUT KT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEN PS-UV-ADOL HS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT **DL**	4	PA,QL (6 per 28 days)
INFLECTRA 100 MG, INTRAVENOUS SOLUTION **DL**	4	PA
KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML, SUBCUTANEOUS PEN INJECTOR **DL**	4	PA,QL (2.28 per 28 days)
KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (2.28 per 28 days)
methotrexate 2.5 mg, tablet **MO**	1	B vs D
REMICADE 100 MG, INTRAVENOUS SOLUTION **DL**	4	PA
RINVOQ 15 MG, TABLET,EXTENDED RELEASE **DL**	4	PA,QL (30 per 30 days)
RUCONEST 2,100 UNIT, INTRAVENOUS SOLUTION **DL**	4	PA,QL (8 per 28 days)
SHINGRIX (PF) 50 MCG/0.5 ML, INTRAMUSCULAR SUSPENSION, KIT **DL**	2	QL (2 per 999 days)
SIMPONI ARIA 12.5 MG/ML, INTRAVENOUS SOLUTION **DL**	4	PA,QL (20 per 28 days)
SKYRIZI 150 MG/1.66 ML(75 MG/0.83 ML X 2) SUBCUTANEOUS SYRINGE KIT; SKYRIZI 150 MG/ML, 150MG/1.66ML(75 MG/0.83 ML X2), SUBCUTANEOUS SYRINGE **MO**	4	PA,QL (6 per 365 days)
STELARA 130 MG/26 ML, INTRAVENOUS SOLUTION **DL**	4	PA,QL (104 per 30 days)
STELARA 45 MG/0.5 ML, SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (1.5 per 84 days)
STELARA 45 MG/0.5 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.5 per 84 days)
STELARA 90 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (3 per 84 days)
Inflammatory Bowel Disease Agents		
ASACOL HD 800 MG, TABLET,DELAYED RELEASE **DL**	4	ST,QL (180 per 30 days)
mesalamine 800 mg, dr tablet **MO**	1	ST,QL (180 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
mesalamine er 0.375 gram, cap MO	1	QL (120 per 30 days)
PENTASA 500 MG, CAPSULE,CONTROLLED RELEASE DL	4	ST,QL (300 per 30 days)
Metabolic Bone Disease Agents		
alendronate sodium 35 mg, 70 mg, tab MO	1	QL (4 per 28 days)
FORTEO 20 MCG/DOSE (620 MCG/2.48 ML) SUBCUTANEOUS PEN INJECTOR MO	4	PA,QL (2.48 per 28 days)
PROLIA 60 MG/ML, SUBCUTANEOUS SYRINGE MO	3	QL (1 per 180 days)
RAYALDEE 30 MCG, CAPSULE,EXTENDED RELEASE DL	4	PA,QL (60 per 30 days)
TYMLOS 80 MCG/DOSE (3,120 MCG/1.56 ML) SUBCUTANEOUS PEN INJECTOR MO	4	PA,QL (1.56 per 30 days)
XGEVA 120 MG/1.7 ML (70 MG/ML), SUBCUTANEOUS SOLUTION DL	4	PA,QL (1.7 per 28 days)
Miscellaneous Therapeutic Agents		
BD ALCOHOL SWABS MO	1	
OMNIPOD DASH 5 PACK INSULIN POD SUBCUTANEOUS CARTRIDGE MO	2	
OMNIPOD INSULIN MANAGEMENT MO	2	
OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE MO	2	
RECTIV 0.4 % (W/W), OINTMENT MO	3	QL (30 per 30 days)
V-GO 20 DEVICE MO	2	
V-GO 30 DEVICE MO	2	
V-GO 40 DEVICE MO	2	
Ophthalmic Agents		
ALPHAGAN P 0.1 %, EYE DROPS MO	2	
ALPHAGAN P 0.15 %, EYE DROPS MO	3	PA
brimonidine 0.2% eye drop; brimonidine tartrate 0.15% drp MO	1	
COMBIGAN 0.2 %-0.5 % EYE DROPS MO	2	QL (5 per 25 days)
dorzolamide-timolol eye drops MO	1	
DUREZOL 0.05 %, EYE DROPS MO	2	
ILEVRO 0.3 %, EYE DROPS,SUSPENSION MO	2	QL (3 per 30 days)
latanoprost 0.005% eye drops MO	1	QL (5 per 25 days)
LOTEMAX 0.5 %, EYE DROPS,SUSPENSION; LOTEMAX 0.5 %, EYE GEL DROPS MO	3	ST
LOTEMAX 0.5 %, EYE OINTMENT MO	3	ST
LOTEMAX SM 0.38 %, EYE GEL DROPS MO	3	
LUMIGAN 0.01 %, EYE DROPS MO	2	QL (2.5 per 25 days)
PAZEO 0.7% EYE DROPS MO	3	QL (2.5 per 25 days)
prednisolone ac 1% eye drop MO	1	
RESTASIS 0.05 %, EYE DROPS IN A DROPPERETTE MO	2	QL (60 per 30 days)
RESTASIS MULTIDOSE 0.05 %, EYE DROPS MO	2	QL (5.5 per 25 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RHOPRESSA 0.02 %, EYE DROPS **MO**	2	ST,QL (2.5 per 25 days)
ROCKLATAN 0.02 %-0.005 % EYE DROPS **MO**	2	ST,QL (2.5 per 25 days)
VYZULTA 0.024 %, EYE DROPS **MO**	3	QL (5 per 30 days)
Otic Agents		
ciproflox-dexameth otic susp **MO**	1	
neomycin-polymyxin-hc ear soln **MO**	1	
neomycin-polymyxin-hc ear susp **MO**	1	
ofloxacin 0.3% ear drops **MO**	1	
Respiratory Tract/Pulmonary Agents		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG, TABLET **DL**	4	PA,QL (90 per 30 days)
ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)
ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER **MO**	2	QL (12 per 30 days)
albuterol hfa 90 mcg inhaler **MO**	1	QL (36 per 30 days)
ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION **MO**	3	PA,QL (60 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION, POWDER FOR INHALATION **MO**	2	QL (30 per 30 days)
BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER **MO**	3	QL (10.7 per 30 days)
BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION; BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)
BREZTRI AEROSPHERE 160 MCG-9MCG-4.8MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL (10.7 per 30 days)
COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION **MO**	3	QL (4 per 20 days)
DALIRESP 250 MCG, TABLET **MO**	2	QL (28 per 365 days)
DALIRESP 500 MCG, TABLET **MO**	2	QL (30 per 30 days)
ESBRIET 267 MG, CAPSULE **DL, LA**	4	PA,QL (270 per 30 days)
ESBRIET 267 MG, TABLET **DL, LA**	4	PA,QL (270 per 30 days)
ESBRIET 801 MG, TABLET **DL, LA**	4	PA,QL (90 per 30 days)
FASENRA 30 MG/ML, SUBCUTANEOUS SYRINGE **MO**	4	PA,QL (1 per 28 days)
FASENRA PEN 30 MG/ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	4	PA,QL (1 per 28 days)
FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION, POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
FLOVENT HFA 110 MCG/ACTUATION, 220 MCG/ACTUATION, AEROSOL INHALER **MO**	2	QL (24 per 30 days)
FLOVENT HFA 44 MCG/ACTUATION, AEROSOL INHALER **MO**	2	QL (10.6 per 30 days)
fluticasone prop 50 mcg spray **MO**	1	QL (16 per 30 days)
hydroxyzine pam 100 mg, 25 mg, 50 mg, cap **MO**	1	
INCRUSE ELLIPTA 62.5 MCG/ACTUATION, POWDER FOR INHALATION **MO**	3	PA,QL (30 per 30 days)
levocetirizine 5 mg, tablet **MO**	1	QL (30 per 30 days)
montelukast sod 10 mg, tablet **MO**	1	QL (30 per 30 days)
NUCALA 100 MG, 100 MG/ML, SUBCUTANEOUS AUTO-INJECTOR; NUCALA 100 MG, 100 MG/ML, SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (3 per 28 days)
NUCALA 100 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (3 per 28 days)
OFEV 100 MG, 150 MG, CAPSULE **DL, LA**	4	PA,QL (60 per 30 days)
PERFOROMIST 20 MCG/2 ML, SOLUTION FOR NEBULIZATION **MO**	3	PA,QL (120 per 30 days)
SEREVENT DISKUS 50 MCG/DOSE, POWDER FOR INHALATION **MO**	3	PA,QL (60 per 30 days)
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION, SOLUTION FOR INHALATION **MO**	2	QL (4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG, AND INHALATION CAPSULES **MO**	2	QL (30 per 30 days)
STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO**	2	QL (4 per 28 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION, SOLUTION FOR INHALATION **MO**	2	QL (4 per 30 days)
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL (10.2 per 30 days)
TOBI PODHALER 28 MG, CAPSULE WITH INHALATION DEVICE; TOBI PODHALER 28 MG, INHALE CAP **DL**	4	PA,QL (224 per 28 days)
TRELEGY ELLIPTA 100 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION; TRELEGY ELLIPTA 200 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION, AEROSOL INHALER **MO**	2	QL (36 per 30 days)
wixela inhub 100 mcg-50 mcg/dose powder for inhalation; wixela inhub 250 mcg-50 mcg/dose powder for inhalation; wixela inhub 500 mcg-50 mcg/dose powder for inhalation **MO**	1	QL (60 per 30 days)
Skeletal Muscle Relaxants		
cyclobenzaprine 10 mg, 5 mg, tablet **MO**	1	
methocarbamol 500 mg, 750 mg, tablet **MO**	1	
SLEEP DISORDER AGENTS		
BELSOMRA 10 MG, TABLET **MO**	2	QL (60 per 30 days)
BELSOMRA 15 MG, 20 MG, TABLET **MO**	2	QL (30 per 30 days)
BELSOMRA 5 MG, TABLET **MO**	2	QL (120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
temazepam 15 mg, 22.5 mg, 30 mg, 7.5 mg, capsule **DL**	1	QL (30 per 30 days)
zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tab sl; *zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tablet sl;* *zolpidem tart er 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tab;* *zolpidem tartrate 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tablet* **MO**	1	QL (30 per 30 days)

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B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
DL – Dispensing Limit • HI – Home Infusion • LA – Limited Access

Index

E

F

G

H

N

O

P

Important!

At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD).**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ę́ niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Notes

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Notes

This abridged formulary was updated on 09/01/2021 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan with any questions at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com**.