L.A. Care Covered™

L.A. Care Health Plan

L.A. Care Covered™ Formulary

2022

Formulary is subject to change. All previous versions of the formulary are no longer in effect. You can view the most current drug list by going to our website at **http://www.lacare.org/members/getting-care/pharmacy-services**

For more details on how much you are required to pay for a covered service for your plan, visit our website:
http://www.lacare.org/members/welcome-la-care/member-documents/lacare-covered

LA1308C 02/15_EN
Last Updated: **01/03/2022**

lacare.org

L.A. Care Covered & L.A. Care Covered Direct Formulary

INTRODUCTION

Table of Contents

Forward……1
How to Use the Formulary……1
Generic and Brand Name Medications……2
How Drugs Are Listed……2
Non-Formulary Medications……2
Benefit Coverage and Limitations……3
How to Find a Pharmacy……3
Description of Coverage……4
How Much Will I Pay for My Drugs……4
Restrictions on Medication Coverage……5
Medication Request Process……6
General Benefit Exclusions (Not Covered)……6
Pharmacist and Physician Feedback……7
Definitions……7
Categorical List of Prescription Drugs……9
Index of Prescription Drugs……242

Foreword

The L.A. Care Covered & L.A. Care Covered Direct formulary is a preferred list of covered drugs, approved by the L.A. Care Health Plan Pharmacy Quality Oversight Committee. This formulary applies only to outpatient drugs and self-administered drugs. It does not apply to medications used in the inpatient setting or medical offices.

The formulary is a continually reviewed and revised list of preferred drugs based on safety, clinical efficacy, and cost-effectiveness. The formulary is updated on a monthly basis and is effective the first of every month. These updates may include, and are not limited to, the following: (i) Removal of drugs and/or dosage forms. (ii) changes in tier placement of a drug that results in an increase in cost sharing (iii) any changes of utilization management restrictions, including any additions of these restrictions. Updated documents are available online at: http://www.lacare.org.

If you have questions about your pharmacy coverage, call Member Services at 1-855-270-2327 (TTY 711), available 24 hours a day, 7 days a week.

How to Use the Formulary

The formulary drug listing begins on Page 9. A prescription drug may be located by looking up the therapeutic category and class of the drug or the brand or generic name of the drug in the alphabetical index. If a generic equivalent for a brand name drug is not available or is not covered, the drug will not be separately listed by its generic name. Drugs available in generic formulations are listed by their generic names and it's most common proprietary (branded) name is capitalized next to the generic name in parenthesis. Drugs that are only available in brand name formulations are listed in ALL CAPITAL letters.

The formulary can be searched by using the "Ctrl + F" function or the index. Drugs can be searched by the generic name, proprietary name, or therapeutic drug category.

The presence of a prescription drug on the formulary does not guarantee that a member will be prescribed that prescription drug by his or her prescribing provider for a particular medical condition.

Generic and Brand Name Medications

L.A. Care Covered & L.A. Care Covered Direct Plans cover generic and brand name drugs. However, when available, FDA approved generic drugs are to be used in all situations, regardless of the availability of a brand. Generic drugs generally cost less than brand name drugs. All drugs that are or become available generically are subject to review by L.A. Care's Pharmacy Quality Oversight Committee.

A prescriber may request a brand name product in lieu of an approved generic, if the prescriber determines that there is a documented medical need for the brand equivalent. This type of request for coverage may be made using the 'Medication Request Process' described on Page 6.

How Drugs Are Listed

Drugs are listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs. This formulary uses the Medispan classification system.

If a generic equivalent for a brand name drug is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all ***bold and italicized lowercase*** letters.

In the event a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed in all CAPITAL letters after the generic name in parentheses and regular typeface with first letter of each word capitalized.

A brand name drug is listed in all CAPITAL letters followed by the generic name in parenthesis in all ***bold and italicized lowercase*** letters.

Example: ANTICOAGULANTS
HEPARINS AND HEPARINOID-LIKE AGENTS

Drug Name	Drug Tier	Requirements/Limits
enoxaparin inj 100MG/ML, 120MG/0.8ML, 150MG/ML, 300MG/3ML, 30MG/0.3ML, 40MG/0.4ML, 60MG/0.6ML, 80MG/0.8ML	1	QL= 17 days supply
FRAGMIN INJ 10000UNIT/ML, 12500UNIT/0.5ML, 15000UNIT/0.6ML, 18000UNT/0.72ML, 2500UNIT/0.2ML, 5000UNIT/0.2ML, 7500UNIT/0.3ML, 9500UNIT/3.8ML (***dalteparin sodium***)	3	

From the above example:
Generic Drug:

- ***enoxaparin inj***

Brand Drug:

- FRAGMIN ING (***dalteparin sodium***)

Non-Formulary Medications

Any drug not found in this formulary listing published by L.A. Care Health Plan is considered a non-formulary drug.

Sometimes, doctors may prescribe a drug that is not on the formulary. This will require that the doctor get authorization from L.A. Care before the member can fill the prescription. To decide if the non-formulary drug will be covered, L.A. Care may ask the doctor and/or pharmacist for more information. This type of request for coverage may be made using the 'Medication Request Process' described on Page 6.

L.A. Care will reply to the doctor and/or pharmacist within 24 hours for urgent requests or 72 hours for standard requests after getting the requested medical information. Urgent circumstances exist when a health condition may seriously jeopardize life, health, or the ability to regain maximum function or when undergoing a current course of treatment using a non-formulary drug.

L.A. Care will provide coverage pursuant to a non-urgent request for the duration of the prescription, including refills.

L.A. Care will provide coverage, including refills, pursuant to a request based on exigent circumstances for the duration of the exigency.

The doctor or pharmacist will let you know if the drug is approved. After approval, you can get the drug at a Plan Pharmacy. If the non-formulary drug is denied, you have the right to appeal. You can file a grievance or complaint relating to denial of a coverage request. Coverage documents provide more information on appeal rights and procedures.

Benefit Coverage and Limitations

This printed formulary does not provide information regarding the specific coverage and limitations an individual may have. The individual may have specific benefit inclusions, exclusions, and/or cost share which are not reflected in the formulary.

This formulary only applies to outpatient drugs and self-administered drugs. These would be considered to be covered under a member's outpatient drug benefit. This formulary does NOT apply to medications used in an inpatient setting or drugs that are not self-administered. These would be considered to be covered under a member's medical benefit. Any specific questions regarding their coverage should be directed to L.A. Care Health Plan Member Services at 1-855-270-2327 (TTY 711)

How to Find a Pharmacy

To find a pharmacy near you, visit the L.A. Care website at lacare.org to find a L.A. Care network pharmacy in your neighborhood. Click on each of the following:
(1) For Members
(2) Pharmacy Services
(3) “Search Now” in the *Find a Pharmacy* tab

Be sure to show your L.A. Care Member ID card when you fill your prescriptions at the pharmacy.

You can fill prescriptions at any participating (network) pharmacy unless it is a prescription for a specialty drug. Some medications are subject to limited distribution by the U.S. Food and Drug Administration or require special handling, provider coordination, or special education that cannot be provided at your local pharmacy. Antineoplastic and biologic agents are examples of such specialty medications and are identified in the formulary with special code SP (Specialty Pharmacy Availability), MSP (Mandatory Specialty Pharmacy), LMSP (Mandatory Lumicera Specialty Pharmacy), or KMSP (Mandatory Kroger Specialty Pharmacy). You may refer to the formulary by visiting L.A. Care's website lacare.org for information on whether a medication must be filled at a specialty pharmacy.

Description of Coverage

We cover outpatient drugs, supplies, and supplements specified in this section when prescribed as follows and obtained at a Plan Pharmacy or through our mail-order service:

We cover a variety of Food and Drug Administration (FDA) approved prescription contraceptive methods including the following prescription contraceptive methods including the following contraceptive drugs and devices at no charge ($0 co-payment): (a) oral contraceptives (b) emergency contraception pills (c) contraceptive rings (d) contraceptive patches (e) cervical caps (f) diaphragms

Coverage also includes a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time.

If a covered contraceptive drug or device is unavailable or deemed medically inadvisable by your medical practitioner, you can request an authorization of a non-covered contraceptive drug or device as prescribed by your medical practitioner. If your authorization is approved by the plan, the contraceptive drug or device will be provided at no charge ($0 co-payment).

We cover the following preventive items at no charge ($0 co-payment) when prescribed by a Plan Provider: (a) aspirin (b) folic acid supplements for pregnant women (c) iron & fluoride supplements for children (d) tobacco cessation drugs and products

We cover the following outpatient drugs, supplies, and supplements: (a) drugs that require a prescription by law and certain drugs that do not require a prescription if they are listed on our drug formulary (b) needles & syringes needed to inject covered drugs and supplements (c) inhaler spacers needed to inhale covered drugs (d) diabetic testing supplies such as blood glucose test strips, urine test strips, lancets, insulin syringes/pens covered under the formulary drug list.

How Much I Will Pay for My Drugs

To see how much you will pay for a drug, check the abbreviations in the Drug Tier column on the formulary. The copayment or coinsurance for each tier is defined in your Summary of Benefits or other plan documents.

Below is a description for each tier:

Tier	***Description***
Tier 1	Most generic drugs and low cost preferred brands
Tier 2	Non-preferred generic drugs, preferred brand name drugs, any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy, and cost.
Tier 3	Non-preferred brand name drugs, drugs that are recommended by P&T committee based on drug safety, efficacy and cost, generally have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies, drugs that require the enrollee to have special training or clinical monitoring, drugs that cost the health plan (net of rebates) more than $600 of rebates of rebates for 1-month supply.

Cost-sharing of each tier is individualized by the type of plan. Please see the following link for the cost-sharing specific to your plan: http://www.lacare.org/members/welcome-la-care/member-documents/la-care-covered
Note: Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script of up to 30 days per state law

Restrictions on Medication Coverage

Certain covered drugs may have additional requirements or limits on coverage. These are denoted throughout the document using the following symbols:

Symbol	Restriction	Description
INF	Infertility	Infertility drugs
NC	Not Covered	Drug that is non-formulary and will not be paid for by the plan without prior approval/prior authorization
QL	Quantity Limit	Coverage may be limited to specific quantities per prescription and/or time period
VAC	Vaccine Program	Coverage is available through a vaccine program
LD	Limited Distribution	Coverage is available through a limited distributor or limited number of distributors
OTC	Over the Counter	Coverage of OTC medication
RS	Restricted to Specialist	Coverage may be dependent on the specialty of the prescribing physician
MSP	Mandatory Specialty Pharmacy Program	All fills, including the initial fill MUST be dispensed at the specialty pharmacy provider of the plans choice
KMSP	Mandatory Specialty Pharmacy Program	All fills, including the initial fill MUST be dispensed at the specialty pharmacy provider of the plans choice
LMSP	Mandatory Specialty Pharmacy Program	All fills, including the initial fill MUST be dispensed at the specialty pharmacy provider of the plans choice
PA	Prior Authorization	Requires specific physician request process
SMKG	Smoking Cessation	Coverage for the treatment of smoking cessation drugs, which may have specific restrictions
ST	Step Therapy	Coverage may require one or more “prerequisite” first step drugs to be tried before progressing to the second step drug
CO	Carve-Out	Drugs carved out by the Department of Health Care Services
EXC	Exclusion	Plan exclusion
SF	Split Fill	Limited to two 15 day fills per month for first 3 months

Please refer to the formulary listing beginning on Page 9 for details regarding specific agents.

Medication Request Process

Some drugs have coverage rules or have limits on the amount you can get.

Formulary Agents

A. Prior Authorization (PA): These drugs require approval prior to being dispensed at a network pharmacy. Requests are reviewed with specific Prior Authorization guidelines. Each request will be reviewed on individual patient need. If the request does not meet the guidelines established by the P&T Committee, the request will not be approved and alternative therapy may be recommended.
B. Quantity Limits (QL): These drugs have quantity limits. If quantities exceeding the limit are necessary, an exception to coverage may be requested by the prescriber. Each request will be reviewed on individual patient need. Approval will be given if a documented medical need exists without compromising safety.
C. Step Therapy (ST): These drugs require one or more first step drugs to be tried before progressing to the second step drug. If there is a medical need to use a second step drug without trying a first step drug, an exception to coverage may be requested by the prescriber. Each request will be reviewed on an individual patient need. If you have already tried and failed the preferred drug(s), or if you are already taking a drug that is subject to step therapy when you switch to an L.A. Care plan, you will not have to undergo step therapy and the drug will be approved for coverage when medically necessary

Non-Formulary Agents

A. Any drug not found on this list is considered non-formulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed on individual patient need. Approval will be given if a documented medical need exists.
B. The 'Medication Request Process' is generally not available for drugs that are specifically excluded by benefit design. For benefit exclusions refer to the 'General Exclusions' section below.

You can ask for a Prescription Drug Prior Authorization Or Step Therapy Exception Request Form be sent to the provider by calling Member Services at 1-855-270-2327 (TTY 711), available 24 hours a day, 7 days a week.

A decision for approval or denial of the exception request or prior authorization can be made within 24 hours if the request is urgent or within 72 hours if the request is not urgent. If we fail to respond within the appropriate time frames, the request is deemed granted.

Non-approved requests may be appealed. The prescriber must provide information to support the appeal on the basis of medical necessity.

General Benefit Exclusions (Not Covered)

Please note that this list is subject to change.

A. Drugs specifically listed as not covered
B. Any drug products used for cosmetic purposes
C. Infertility agents, when used to treat infertility
D. Experimental drug products, or any drug product used in an experimental manner, unless accepted for use by professionally recognized standards of practice

If L.A. Care's coverage is amended to exclude a drug that we have been covering and providing to you, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Food and Drug Administration.

For additional information regarding prescription drug coverage, please refer to the L.A. Care Covered Evidence of Coverage (Member Handbook).

Pharmacist and Physician Feedback

The formulary is a tool to promote cost-effective prescription drug use. L.A. Care has made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. L.A. Care welcomes the participation of physicians, pharmacists, and ancillary medical providers, in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions or comments to L.A. Care via the Provider's Solution Center at 1-866-522-2736.

Definitions

"**Brand name drug"** is a drug that is marketed under a proprietary, trademark protected name. The brand name drug is listed in all CAPITAL letters.

"Coinsurance" is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

"Copayment" is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

"Deductible" is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

"Drug Tier" is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

"Enrollee" is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

"Exception request" is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing healthcare provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

"Exigent circumstances" are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

"Formulary" is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list,

"Generic drug" is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in ***bold and italicized lowercase letters.***

"Nonformulary drug" is a prescription drug that is not listed on the health plan's formulary.

"Out-of-pocket cost" are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

"Prescribing provider" is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

"Prescription" is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

“Prescription drug” is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

“Prior Authorization” is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

“Step therapy” is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

“Subscriber” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated 1/3/2022

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - Drugs to treat ADHD, sleep disorders, and weight loss		
AMPHETAMINES - Drugs to treat ADHD, sleep disorders, and weight loss		
ADDERALL TAB 10MG, 12.5MG, 15MG, 20MG, 30MG, 5MG, 7.5MG ***(amphetamine-dextroamphetamine)***	3	-
amphetamine/dextroamphetamine ER cap 10MG, 15MG, 20MG, 25MG, 30MG, 5MG (ADDERALL XR Equiv)	1	-
amphetamine/dextroamphetamine tab 10MG, 12.5MG, 15MG, 20MG, 30MG, 5MG, 7.5MG (ADDERALL Equiv)	1	-
DEXEDRINE CAP 10MG, 15MG, 5MG ***(dextroamphetamine sulfate)***	3	-
dextroamphetamine ER cap 10MG, 15MG, 5MG (DEXEDRINE Equiv)	1	-
dextroamphetamine soln 5MG/5ML (PROCENTRA Equiv)	1	-
dextroamphetamine tab 10MG, 15MG, 20MG, 30MG, 5MG (DEXEDRINE Equiv)	1	-
VYVANSE CAP 10MG, 20MG, 30MG, 40MG, 50MG, 60MG, 70MG ***(lisdexamfetamine dimesylate)***	2	-
VYVANSE CHEW TAB 10MG, 20MG, 30MG, 40MG, 50MG, 60MG ***(lisdexamfetamine dimesylate)***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ANOREXIANTS NON-AMPHETAMINE - Drugs to help weight loss		
ADIPEX-P CAP 37.5MG ***(phentermine hcl)***	3	PA-QL
ADIPEX-P TAB 37.5MG ***(phentermine hcl)***	3	PA-QL
phentermine cap 15MG, 30MG, 37.5MG (ADIPEX Equiv)	1	PA-QL QL= 1 cap/day
phentermine tab 37.5MG (ADIPEX Equiv)	1	PA-QL QL= 1 tab/day
QSYMIA CAP 11.25MG-69MG, 15MG-92MG, 3.75MG-23MG, 7.5MG-46MG ***(phentermine hcl-topiramate)***	3	PA-QL QL= 1 cap/day
ANTI-OBESITY AGENTS - Drugs to help weight loss		
CONTRAVE TAB 8MG-90MG ***(naltrexone hcl-bupropion hcl)***	2	PA-QL QL= 4 tabs/day
IMCIVREE INJ 10MG/ML ***(setmelanotide acetate)***	4	LD-PA-QL QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - Drugs to treat ADHD and sleep disorders		
atomoxetine cap 100MG, 10MG, 18MG, 25MG, 40MG, 60MG, 80MG (STRATTERA Equiv)	1	-
clonidine ER tab .1MG (KAPVAY Equiv)	1	-
guanfacine ER tab 1MG, 2MG, 3MG, 4MG (INTUNIV Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
INTUNIV TAB 1MG, 2MG, 3MG, 4MG ***(guanfacine hcl (adhd))***	3	-
KAPVAY TAB .1MG ***(clonidine hcl (adhd))***	3	-
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS) - drugs to treat sleep disorders		
SUNOSI TAB 150MG, 75MG ***(solriamfetol hcl)***	2	PA-QL QL= 1 tab/day
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS - drugs to treat sleep disorders		
WAKIX TAB 17.8MG, 4.45MG ***(pitolisant hcl)***	4	LD-PA-QL QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479
STIMULANTS - MISC. - Miscellaneous stimulant drugs		
armodafinil tab 150MG, 200MG, 250MG, 50MG (NUVIGIL Equiv)	1	PA-QL QL= 1 tab/day
CONCERTA TAB, RITALIN SR TAB 18MG, 27MG, 36MG, 54MG ***(methylphenidate hcl)***	3	-
DAYTRANA PATCH 10MG/9HR, 15MG/9HR, 20MG/9HR, 30MG/9HR ***(methylphenidate)***	3	-
dexmethylphenidate ER cap 10MG, 15MG, 20MG, 25MG, 30MG, 35MG, 40MG, 5MG (FOCALIN XR Equiv)	1	-
dexmethylphenidate tab 10MG, 2.5MG, 5MG (FOCALIN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FOCALIN TAB 10MG, 2.5MG, 5MG ***(dexmethylphenidate hcl)***	3	-
FOCALIN XR CAP 10MG, 15MG, 20MG, 25MG, 30MG, 35MG, 40MG, 5MG ***(dexmethylphenidate hcl)***	3	-
METADATE CD CAP ***(methylphenidate hcl)***	3	-
METHYLIN CHEW TAB ***(methylphenidate hcl)***	3	-
METHYLIN SOLN 10MG/5ML, 5MG/5ML ***(methylphenidate hcl)***	2	-
methylphenidate CD cap 10MG, 20MG, 30MG, 40MG, 50MG, 60MG (METADATE CD Equiv)	1	-
methylphenidate chew tab 10MG, 2.5MG, 5MG (METHYLIN Equiv)	1	-
methylphenidate ER cap 10MG, 20MG, 30MG, 40MG, 60MG (RITALIN LA Equiv)	1	-
METHYLPHENIDATE ER TAB 18MG ***(methylphenidate hcl)***	2	-
methylphenidate ER tab 10MG, 18MG, 20MG, 27MG, 36MG, 54MG	1	-
methylphenidate soln 10MG/5ML, 5MG/5ML (METHYLIN Equiv)	1	-
methylphenidate tab 10MG, 20MG, 5MG (RITALIN Equiv)	1	-
modafinil tab 100MG, 200MG (PROVIGIL Equiv)	1	PA-QL QL= 2 tabs/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NUVIGIL TAB 150MG, 200MG, 250MG, 50MG ***(armodafinil)***	3	PA-QL QL= 1 tab/day
PROVIGIL TAB 100MG, 200MG ***(modafinil)***	3	PA-QL QL= 2 tabs/day
RITALIN LA CAP 10MG, 20MG, 30MG, 40MG ***(methylphenidate hcl)***	3	-
RITALIN TAB 10MG, 20MG, 5MG ***(methylphenidate hcl)***	3	-
AMEBICIDES - drugs to treat infections		
AMEBICIDES - drugs to treat infections		
YODOXIN TAB ***(iodoquinol)***	3	-
AMINOGLYCOSIDES - Drugs to treat bacterial infections		
AMINOGLYCOSIDES - Drugs to treat infections		
amikacin inj 1GM/4ML, 500MG/2ML (KANAMYCIN Equiv)	M	M
KANAMYCIN INJ ***(amikacin sulfate)***	M	M
neomycin tab 500MG	1	-
paromomycin cap 250MG (HUMATIN Equiv)	1	-
TOBI PODHALER 28MG ***(tobramycin)***	4	KMSP-PA
tobramycin neb soln 300MG/4ML, 300MG/5ML (TOBI Equiv)	4	LMSP-RS Restricted to Infectious Disease or Pulmonology Specialist
ANALGESICS - ANTI-INFLAMMATORY - Drugs to treat pain and inflammation		
ANTIRHEUMATIC - ENZYME INHIBITORS - Drugs to treat disorders of the immune system		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
OLUMIANT TAB 1MG, 2MG ***(baricitinib)***	4	LMSP-PA-QL QL= 1 tab/day
RINVOQ ER TAB 15MG ***(upadacitinib)***	4	LMSP-PA-QL QL= 1 tab/day
XELJANZ SOLN 1MG/ML ***(tofacitinib citrate)***	4	LMSP-PA-QL QL= 10ml/day
XELJANZ TAB 10MG, 5MG ***(tofacitinib citrate)***	4	LMSP-PA-QL QL= 2 tabs/day
XELJANZ XR TAB 11MG, 22MG ***(tofacitinib citrate)***	4	LMSP-PA-QL QL= 1 tab/day
ANTIRHEUMATIC ANTIMETABOLITES - Drugs to treat disorders of the immune system		
RHEUMATREX TAB ***(methotrexate sodium (antirheumatic))***	3	-
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES - Drugs to treat disorders of the immune system		
HUMIRA INJ 10MG 10MG/0.1ML, 10MG/0.2ML ***(adalimumab)***	4	LMSP-PA-QL QL= 2 syringes/28 days
HUMIRA INJ 20MG 20MG/0.2ML, 20MG/0.4ML ***(adalimumab)***	4	LMSP-PA-QL QL= 2 syringes/28 days
HUMIRA INJ 40MG 40MG/0.4ML, 40MG/0.8ML ***(adalimumab)***	4	LMSP-PA-QL QL= 2 syringes/28 days
HUMIRA INJ 80MG 80MG/0.8ML ***(adalimumab)***	4	PA-QL-SP QL= 2 syringes/28 days
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK 80MG/0.8ML ***(adalimumab)***	4	LMSP-PA-QL QL= 1 pack/fill, 1 fill/plan year

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK 40MG/0.8ML ***(adalimumab)***	4	LMSP-PA-QL QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PEDIATRIC UC STARTER PACK 80MG/0.8ML ***(adalimumab)***	4	LMSP-PA-QL QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK ***(adalimumab)***	4	LMSP-PA-QL QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG 40MG/0.4ML, 40MG/0.8ML ***(adalimumab)***	4	LMSP-PA-QL QL= 2 pens/28 days
SIMPONI AUTO-INJECTOR 100MG 100MG/ML ***(golimumab)***	4	LMSP-PA-QL QL=1 inj/28 days
SIMPONI INJ 100MG 100MG/ML ***(golimumab)***	4	LMSP-PA-QL QL=1 inj/28 days
GOLD COMPOUNDS - Drugs to treat disorders of the immune system		
RIDAURA CAP 3MG ***(auranofin)***	2	-
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA) - Drugs to treat rheumatoid arthritis		
KINERET INJ 100MG/0.67ML ***(anakinra)***	4	LD-PA-QL QL= 1 inj/day; Only available through Biologics 800-850-4306
INTERLEUKIN-6 RECEPTOR INHIBITORS - Drugs to treat rheumatoid arthritis		
ACTEMRA ACTPEN INJ 162MG/0.9ML ***(tocilizumab)***	4	LMSP-PA-QL QL= 2 inj/28 days
ACTEMRA SC INJ 162MG/0.9ML ***(tocilizumab)***	4	LMSP-PA-QL QL= 2 inj/28 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
KEVZARA INJ 150MG/1.14ML, 200MG/1.14ML ***(sarilumab)***	4	LMSP-PA-QL QL= 2 inj/28 days
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS) - Drugs to treat pain and inflammation		
ARTHROTEC TAB 50MG-200MCG, 75MG-200MCG ***(diclofenac w/ misoprostol)***	3	-
CATAFLAM TAB ***(diclofenac potassium)***	3	-
CELEBREX CAP 100MG, 200MG, 400MG, 50MG ***(celecoxib)***	3	QL QL= 2 caps/day
celecoxib cap 100MG, 200MG, 400MG, 50MG (CELEBREX Equiv)	1	QL QL= 2 caps/day
CLINORIL TAB ***(sulindac)***	3	-
diclofenac potassium tab 50MG (CATAFLAM Equiv)	1	-
diclofenac sodium EC tab 25MG, 50MG, 75MG (VOLTAREN Equiv)	1	-
diclofenac sodium XR tab 100MG (VOLTAREN XR Equiv)	1	-
diclofenac/misoprostol DR tab .2MG-50MG, 50MG-200MCG, 75MG-200MCG (ARTHROTEC Equiv)	1	-
etodolac cap 200MG, 300MG (LODINE Equiv)	1	-
etodolac ER tab 400MG, 500MG, 600MG (LODINE XL Equiv)	1	-
etodolac tab 400MG, 500MG	1	-
FELDENE CAP 10MG, 20MG ***(piroxicam)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FLURBIPROFEN TAB 50MG (ANSAID Equiv) ***(flurbiprofen)***	1	-
flurbiprofen tab 100MG, 50MG (ANSAID Equiv)	1	-
ibuprofen susp (Rx ONLY) 100MG/5ML, 40MG/ML, 50MG/1.25ML (ADVIL, MOTRIN Equiv)	1	-
ibuprofen tab 400MG, 600MG	1	-
indomethacin cap 25MG, 50MG (INDOCIN Equiv)	1	-
indomethacin CR cap 75MG (INDOCIN SR Equiv)	1	-
ketorolac tab 10MG (TORADOL Equiv)	1	QL QL= 20 tabs/5 days
MELOXICAM SUSP ***(meloxicam)***	3	-
meloxicam tab 15MG, 7.5MG (MOBIC Equiv)	1	-
MOBIC TAB 15MG, 7.5MG ***(meloxicam)***	3	-
MOTRIN SUSP 100MG/5ML, 50MG/1.25ML ***(ibuprofen)***	3	-
nabumetone tab 500MG, 750MG (RELAFEN Equiv)	1	-
NAPROSYN EC TAB 375MG, 500MG ***(naproxen)***	3	-
NAPROSYN TAB 250MG, 500MG ***(naproxen)***	3	-
naproxen EC tab 375MG, 500MG (NAPROSYN EC Equiv)	1	-
naproxen tab 250MG, 375MG, 500MG (NAPROSYN Equiv)	1	-
piroxicam cap 10MG, 20MG (FELDENE Equiv)	1	-
sulindac tab 150MG, 200MG (CLINORIL Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TOLMETIN TAB 200MG, 600MG ***(tolmetin sodium)***	3	-
VOLTAREN TAB ***(diclofenac sodium)***	3	-
VOLTAREN XR TAB ***(diclofenac sodium)***	3	-
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - Drugs to treat disorders of the immune system		
OTEZLA STARTER PACK ***(apremilast)***	4	LMSP-PA-QL QL= 1 pack/28 days
OTEZLA TAB 30MG ***(apremilast)***	4	LMSP-PA-QL QL= 2 tabs/day
PYRIMIDINE SYNTHESIS INHIBITORS - Drugs to treat disorders of the immune system		
ARAVA TAB 10MG, 20MG ***(leflunomide)***	3	-
leflunomide tab 10MG, 20MG (ARAVA Equiv)	1	-
SELECTIVE COSTIMULATION MODULATORS - Drugs to treat disorders of the immune system		
ORENCIA CLICK INJ 125MG/ML ***(abatacept)***	4	LMSP-PA-QL QL= 4 inj/28 days
ORENCIA SC INJ 125MG/ML 125MG/ML ***(abatacept)***	4	LMSP-PA-QL QL= 4 inj/28 days
ORENCIA SC INJ 50MG/0.4ML 50MG/0.4ML ***(abatacept)***	4	LMSP-PA-QL QL= 4 inj/28 days
ORENCIA SC INJ 87.5MG/0.7ML 87.5MG/0.7ML ***(abatacept)***	4	LMSP-PA-QL QL= 4 inj/28 days
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS - Drugs to treat disorders of the immune system		
ENBREL INJ 25MG 25MG/0.5ML ***(etanercept)***	4	LMSP-PA-QL QL= 8 inj/28 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ENBREL INJ 50MG 50MG/ML ***(etanercept)***	4	LMSP-PA-QL QL= 4 inj/28 days
ENBREL MINI INJ 50MG/ML ***(etanercept)***	4	LMSP-PA-QL QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG 50MG/ML ***(etanercept)***	4	LMSP-PA-QL QL= 4 inj/28 days
ANALGESICS - NONNARCOTIC - Drugs to treat pain		
SALICYLATES - Drugs to treat pain		
aspirin chew tab 81mg 81MG	$0	OTC Covered for males age 45-79; Covered for females (no age restriction)
aspirin ec tab 325mg 324MG, 325MG	$0	OTC Covered for males age 45-79 and females age 55-79
aspirin ec tab 81mg 81MG	$0	OTC Covered for males age 45-79; Covered for females (no age restriction)
aspirin tab 325mg 325MG	$0	OTC Covered for males age 45-79 and females age 55-79
ASPIRIN TAB 81MG ***(aspirin)***	$0	OTC Covered for males age 45-79; Covered for females (no age restriction)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
aspirin tab 81mg	$0	OTC Covered for males age 45-79; Covered for females (no age restriction)
CHOLINE MAGNESIUM TRISALICYLATE TAB (TRILISATE Equiv) ***(choline & mag salicylate)***	1	-
choline magnesium trisalicylate tab (TRILISATE Equiv)	1	-
salsalate tab 500MG, 750MG (DISALCID Equiv)	1	-
ZORPRIN TAB ***(aspirin)***	3	-
ANALGESICS - OPIOID - Drugs to treat pain		
OPIOID AGONISTS - Drugs to treat pain		
ABSTRAL SL TAB 100MCG, 200MCG, 300MCG, 400MCG, 600MCG, 800MCG ***(fentanyl citrate)***	3	PA-QL QL= 120 tabs/30 days
ACTIQ LOZENGE 1200MCG, 1600MCG, 200MCG, 400MCG, 600MCG, 800MCG ***(fentanyl citrate)***	3	PA-QL QL= 120 units/30 days
AVINZA CAP ***(morphine sulfate beads)***	3	QL QL= 2 caps/day
CODEINE SULFATE TAB 15MG 15MG ***(codeine sulfate)***	1	QL QL= 240 tabs/30 days
CODEINE SULFATE TAB 60MG 60MG ***(codeine sulfate)***	1	QL QL= 180 tabs/30 days
codeine sulfate tab 60mg 60MG	1	QL QL= 180 tabs/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
codeine sulfate tablet 15mg, 30mg 30MG	1	QL QL= 240 tabs/30 days
DAZIDOX TAB ***(oxycodone hcl)***	3	QL QL=120 tabs/30 days
DILAUDID TAB 2MG 2MG ***(hydromorphone hcl)***	3	QL QL= 240 tabs/30 days
DILAUDID TAB 4MG 4MG ***(hydromorphone hcl)***	3	QL QL=180 tabs/30 days
DILAUDID TAB 8MG 8MG ***(hydromorphone hcl)***	3	QL QL=120 tabs/30 days
DOLOPHINE TAB 10MG, 5MG ***(methadone hcl)***	3	QL QL=120 tabs/30 days
DURAGESIC PATCH 100MCG/HR, 12MCG/HR, 25MCG/HR, 50MCG/HR, 75MCG/HR ***(fentanyl)***	3	QL QL=10 patches/30 days
fentanyl citrate lollipop 1200MCG, 1600MCG, 200MCG, 400MCG, 600MCG, 800MCG (ACTIQ Equiv)	1	PA-QL QL= 120 lozenges/30 days
fentanyl patch 100MCG/HR, 12MCG/HR, 25MCG/HR, 50MCG/HR, 75MCG/HR (DURAGESIC Equiv)	1	QL QL=10 patches/30 days
FENTORA TAB, FENTANYL BUCCAL TAB 100MCG, 200MCG, 400MCG, 600MCG, 800MCG ***(fentanyl citrate)***	3	PA-QL QL= 120 tabs/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
hydromorphone tab 2mg 2MG (DILAUDID Equiv)	1	QL QL= 240 tabs/30 days
hydromorphone tab 4mg 4MG (DILAUDID Equiv)	1	QL QL=180 tabs/30 days
hydromorphone tab 8mg 8MG (DILAUDID Equiv)	1	QL QL=120 tabs/30 days
LAZANDA NASAL SPRAY 100MCG/ACT, 300MCG/ACT, 400MCG/ACT ***(fentanyl citrate)***	3	PA-QL QL= 15 bottles/30 days
methadone conc 10MG/ML	1	QL QL=600ml/30 days
METHADONE SOLN 10MG/5ML 10MG/5ML ***(methadone hcl)***	1	QL QL=600ml/30 days
methadone soln 10mg/5ml 10MG/5ML	1	QL QL=600ml/30 days
METHADONE SOLN 5MG/5ML 5MG/5ML ***(methadone hcl)***	1	QL QL= 1200ml/30 days
methadone soln 5mg/5ml 5MG/5ML	1	QL QL= 1200ml/30 days
methadone tab 5MG (DOLOPHINE Equiv)	1	QL QL=120 tabs/30 days
methadone tab 10mg 10MG (DOLOPHINE Equiv)	1	QL QL= 240 tabs/30 days
METHADOSE CONC 10MG/ML, 5MG/0.5ML ***(methadone hcl)***	3	QL QL=600ml/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
MORPHINE SULFATE ER BEAD CAP 120MG, 30MG, 45MG, 60MG, 75MG, 90MG ***(morphine sulfate beads)***	3	QL QL= 2 caps/day
morphine sulfate ER tab 100MG, 15MG, 200MG, 30MG, 60MG (MS CONTIN Equiv)	1	QL QL= 90 tabs/ 30 days
morphine sulfate soln 100MG/5ML, 10MG/0.5ML, 10MG/5ML, 20MG/5ML, 20MG/ML, 5MG/0.25ML	1	QL QL=120ml/30 days
MORPHINE SULFATE TAB ***(morphine sulfate)***	1	QL QL=180 tabs/30 days
MORPHINE SULFATE TAB 15MG, 30MG ***(morphine sulfate)***	1	QL QL=180 tabs/30 days
morphine sulfate tab 15MG, 30MG	1	QL QL=180 tabs/30 days
NUCYNTA TAB 100MG, 50MG, 75MG ***(tapentadol hcl)***	3	QL QL= 180 tabs/30 days
oxycodone soln 5MG/5ML (ROXICODONE Equiv)	1	QL QL=240ml/30 days
oxycodone tab 10MG, 15MG, 20MG, 30MG, 5MG (ROXICODONE Equiv)	1	QL QL=120 tabs/30 days
ROXICODONE TAB 15MG, 30MG, 5MG ***(oxycodone hcl)***	3	QL QL=120 tabs/30 days
tramadol ER tab 100MG, 200MG, 300MG (ULTRAM ER Equiv)	1	QL QL= 30 tabs/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
tramadol tab 50MG (ULTRAM Equiv)	1	QL QL= 240 tabs/30 days
ULTRAM TAB 50MG ***(tramadol hcl)***	3	QL QL= 240 tabs/30 days
XTAMPZA ER CAP 13.5MG, 18MG, 27MG, 36MG, 9MG ***(oxycodone)***	2	PA-QL QL= 120 caps/30 days
OPIOID COMBINATIONS - Drugs to treat pain		
acetaminophen/codeine soln 12MG/5ML-120MG/5ML	1	QL QL=240ml/30 days
acetaminophen/codeine tab 15MG-300MG, 30MG-300MG, 60MG-300MG (TYLENOL/CODEINE Equiv)	1	QL QL=180 tabs/30 days
CAPITAL/CODEINE SUSP ***(acetaminophen w/ codeine)***	3	QL QL=240ml/30 days
HYCET SOLN ***(hydrocodone-acetaminophen)***	3	QL QL=1800ml/30 days
hydrocodone/acetaminophen soln 2.5MG/5ML-108MG/5ML, 5MG/10ML-217MG/10ML, 7.5MG/15ML-325MG/15ML (HYCET, LORTAB Equiv)	1	QL QL=1800ml/30 days
hydrocodone/acetaminophen soln 10-325 mg/15ml 10MG/15ML-325MG/15ML (HYCET Equiv)	1	QL QL=1800ml/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
hydrocodone/acetaminophen tab (LORTAB Equiv)	1	QL QL=120 tabs/30 days
hydrocodone/acetaminophen tab 2.5-325mg 2.5MG-325MG (NORCO Equiv)	1	QL QL=120 tabs/30 days
LORTAB 10MG-325MG, 5MG-325MG, 7.5MG-325MG ***(hydrocodone-acetaminophen)***	3	QL QL=120 tabs/30 days
LORTAB ELIXIR 10MG/15ML-300MG/15ML, 10MG/15ML-325MG/15ML ***(hydrocodone-acetaminophen)***	3	QL QL=1800ml/30 days
oxycodone/acetaminophen tab 10MG-325MG, 2.5MG-325MG, 5MG-325MG, 7.5MG-325MG (PERCOCET Equiv)	1	QL QL=120 tabs/30 days
OXYCODONE/ASPIRIN TAB 4.835MG-325MG (PERCODAN Equiv) ***(oxycodone-aspirin)***	1	QL QL=120 tabs/30 days
oxycodone/aspirin tab 4.835MG-325MG (PERCODAN Equiv)	1	QL QL=120 tabs/30 days
PERCOCET TAB 10MG-325MG, 2.5MG-325MG, 5MG-325MG, 7.5MG-325MG ***(oxycodone w/ acetaminophen)***	3	QL QL=120 tabs/30 days
PERCODAN TAB ***(oxycodone-aspirin)***	3	QL QL=120 tabs/30 days
tramadol/acetaminophen tab 37.5MG-325MG (ULTRACET Equiv)	1	QL QL= 240 tabs/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TYLENOL/CODEINE TAB 30MG-300MG, 60MG-300MG ***(acetaminophen w/ codeine)***	3	QL QL=180 tabs/30 days
OPIOID PARTIAL AGONISTS - Drugs to treat pain		
buprenorphine patch 10MCG/HR, 15MCG/HR, 20MCG/HR, 5MCG/HR, 7.5MCG/HR (BUTRANS Equiv)	1	QL QL= 4 patches/28 days
buprenorphine SL tab 2MG, 8MG (SUBUTEX Equiv)	1	-
buprenorphine/naloxone sl film .5MG-2MG, 1MG-4MG, 2MG-8MG, 3MG-12MG (SUBOXONE Equiv)	1	-
buprenorphine/naloxone SL tab .5MG-2MG, 2MG-8MG (SUBOXONE Equiv)	1	-
butorphanol nasal spray 10MG/ML (STADOL Equiv)	1	QL QL= 1 bottle/fill, 2 fills/30 days
BUTRANS PATCH 10MCG/HR, 15MCG/HR, 20MCG/HR, 5MCG/HR, 7.5MCG/HR ***(buprenorphine)***	3	QL QL= 4 patches/28 days
SUBOXONE SL FILM .5MG-2MG, 1MG-4MG, 2MG-8MG, 3MG-12MG ***(buprenorphine hcl-naloxone hcl dihydrate)***	3	-
ANDROGENS-ANABOLIC - Drugs to regulate male hormones		
ANABOLIC STEROIDS - Drugs used to gain weight		
ANADROL TAB 50MG ***(oxymetholone)***	3	-
OXANDRIN TAB 10MG, 2.5MG ***(oxandrolone)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
oxandrolone tab 10MG, 2.5MG (OXANDRIN Equiv)	1	-
ANDROGENS - Drugs to treat low testosterone level		
ANDRODERM PATCH 2MG/24HR, 4MG/24HR ***(testosterone)***	2	PA-QL QL= 1 patch/day
ANDROGEL 1% 25MG 25MG/2.5GM ***(testosterone)***	3	PA-QL QL= 1 packet/day
ANDROGEL 1% 50MG, TESTIM GEL 1% 1%, 50MG/5GM ***(testosterone)***	3	PA-QL QL= 2 packets/day
ANDROGEL 1.62% 1.25GM 20.25MG/1.25GM ***(testosterone)***	3	PA-QL QL= 1 packet/day
ANDROGEL 1.62% 2.5GM 40.5MG/2.5GM ***(testosterone)***	3	PA-QL QL= 2 packets/day
ANDROGEL PUMP 1% ***(testosterone)***	3	PA-QL QL= 4 bottles/30 days
ANDROGEL PUMP 1.62% 1.62% ***(testosterone)***	3	PA-QL QL= 2 bottles/30 days
ANDROID CAP, TESTRED CAP 10MG ***(methyltestosterone)***	3	PA
AXIRON SOLN ***(testosterone)***	3	PA-QL QL= 2 bottles/30 days
danazol cap 100MG, 200MG, 50MG (DANOCRINE Equiv)	1	-
DEPO-TESTOSTERONE INJ 100MG/ML, 200MG/ML ***(testosterone cypionate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
METHITEST TAB 10MG ***(methyltestosterone)***	3	PA
METHYLTESTOSTERONE CAP 10MG ***(methyltestosterone)***	3	PA
testosterone cypionate inj 100MG/ML, 200MG/ML (DEPO-TESTOSTERONE Equiv)	1	-
TESTOSTERONE GEL 1% 25MG 25MG/2.5GM ***(testosterone)***	2	PA-QL QL= 1 packet/day
testosterone gel 1% 25mg 25MG/2.5GM (ANDROGEL Equiv)	1	PA-QL QL= 1 packet/day
testosterone gel 1% 50mg 1%, 50MG/5GM (ANDROGEL Equiv)	1	PA-QL QL= 2 packets/day
testosterone gel 1% pump 1% (ANDROGEL Equiv)	1	PA-QL QL= 4 bottles/30 days
testosterone gel 1.62% 1.25gm 20.25MG/1.25GM (ANDROGEL Equiv)	1	PA-QL QL= 1 packet/day
testosterone gel 1.62% 2.5gm 40.5MG/2.5GM (ANDROGEL Equiv)	1	PA-QL QL= 2 packets/day
TESTOSTERONE GEL PUMP 1% ***(testosterone)***	2	PA-QL QL= 4 bottles/30 days
testosterone gel pump 1.62% 1.62% (ANDROGEL Equiv)	1	PA-QL QL= 2 bottles/30 days
testosterone soln 30MG/ACT (AXIRON Equiv)	1	PA-QL QL= 2 bottles/30 days
ANORECTAL AGENTS - Drugs to treat problems related to the rectum		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
INTRARECTAL STEROIDS - Drugs to treat systemic swelling conditions		
CORTENEMA 100MG/60ML ***(hydrocortisone (intrarectal))***	3	-
hydrocortisone enema 100MG/60ML (CORTENEMA Equiv)	1	-
UCERIS RECTAL FOAM 2MG/ACT ***(budesonide (intrarectal))***	3	PA
RECTAL COMBINATIONS - Drugs to treat systemic swelling conditions		
lidocaine/hydrocortisone cream .5%-3% (ANAMANTLE Equiv)	1	-
pramoxine/hydrocortisone cream 1%, 1%-2.5% (ANALPRAM-HC Equiv)	1	-
RECTAL STEROIDS - Drugs to treat systemic swelling conditions		
ANUSOL-HC CREAM 1%, 2.5% ***(hydrocortisone (rectal))***	3	-
proctosol HC cream 1%, 2.5% (ANUSOL HC Equiv)	1	-
ANTHELMINTICS - Drugs to treat worm infections		
ANTHELMINTICS - Drugs to treat parasites		
albendazole tab 200MG (ALBENZA Equiv)	1	-
ALBENZA TAB 200MG ***(albendazole)***	3	-
BENZNIDAZOLE TAB 100MG, 12.5MG ***(benznidazole)***	2	PA
BILTRICIDE TAB 600MG ***(praziquantel)***	3	-
EMVERM TAB 100MG ***(mebendazole)***	2	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ivermectin tab 3MG (STROMECTOL Equiv)	1	PA
mebendazole chew tab (VERMOX Equiv)	1	-
praziquantel tab 600MG (BILTRICIDE Equiv)	1	-
STROMECTOL TAB 3MG ***(ivermectin)***	3	PA
ANTIANGINAL AGENTS - Drugs to treat chest pain		
ANTIANGINALS-OTHER - Drugs to treat chest pain		
RANEXA TAB 1000MG, 500MG ***(ranolazine)***	3	-
ranolazine tab 1000MG, 500MG (RANEXA Equiv)	1	-
NITRATES - Drugs to treat chest pain		
DILATRATE SR CAP 40MG ***(isosorbide dinitrate)***	3	-
IMDUR TAB ***(isosorbide mononitrate)***	3	-
ISORDIL TITRADOSE TAB 40MG, 5MG ***(isosorbide dinitrate)***	3	-
isosorbide dinitrate ER tab (ISOCHRON Equiv)	1	-
isosorbide dinitrate SL tab	1	-
isosorbide dinitrate tab 10MG, 20MG, 30MG, 5MG (ISORDIL Equiv)	1	-
isosorbide dinitrate tab 40mg 40MG (ISORDIL Equiv)	1	-
isosorbide mononitrate ER tab 120MG, 30MG, 60MG (IMDUR Equiv)	1	-
isosorbide mononitrate tab 10MG, 20MG (MONOKET Equiv)	1	-
NITRO-BID OINT 2% ***(nitroglycerin)***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NITRO-DUR PATCH .1MG/HR, .2MG/HR, .4MG/HR, .6MG/HR ***(nitroglycerin)***	3	-
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR .3MG/HR, .8MG/HR ***(nitroglycerin)***	3	-
nitroglycerin lingual spray .4MG/SPRAY (NITROLINGUAL Equiv)	1	-
nitroglycerin patch .1MG/HR, .2MG/HR, .4MG/HR, .6MG/HR (NITRO-DUR Equiv)	1	-
nitroglycerin SL tab .3MG, .4MG, .6MG (NITROSTAT Equiv)	1	-
NITROLINGUAL PUMP SPRAY .4MG/SPRAY ***(nitroglycerin)***	3	-
NITROSTAT SL TAB .3MG, .4MG, .6MG ***(nitroglycerin)***	3	-
ANTIANXIETY AGENTS - Drugs to treat anxiety		
ANTIANXIETY AGENTS - MISC. - Miscellaneous anti-anxiety drugs		
BUSPAR TAB ***(buspirone hcl)***	3	-
buspirone tab 10MG, 15MG, 5MG, 7.5MG (BUSPAR Equiv)	1	-
hydroxyzine pamoate cap 25MG, 50MG (VISTARIL Equiv)	1	-
HYDROXYZINE PAMOATE CAP 100MG 100MG ***(hydroxyzine pamoate)***	1	-
hydroxyzine syrup 10MG/5ML (ATARAX Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
hydroxyzine tab 10MG, 25MG, 50MG (ATARAX Equiv)	1	-
VISTARIL CAP 25MG, 50MG ***(hydroxyzine pamoate)***	3	-
BENZODIAZEPINES - Drugs to treat anxiety		
alprazolam tab .25MG, .5MG, 1MG, 2MG (XANAX Equiv)	1	QL QL= 5 tabs/day
chlordiazepoxide cap 10MG, 25MG, 5MG (LIBRIUM Equiv)	1	-
diazepam conc 5MG/ML (VALIUM Equiv)	1	QL QL= 180ml/30 days
diazepam oral soln 5mg/5ml 5MG/5ML (DIAZEPAM Equiv)	1	QL QL= 180ml/30 days
diazepam tab 2mg, 10mg 10MG, 2MG (VALIUM Equiv)	1	QL QL= 4 tabs/day
diazepam tab 5mg 5MG (VALILUM Equiv)	1	QL QL= 3 tabs/day
LIBRIUM CAP ***(chlordiazepoxide hcl)***	3	-
lorazepam conc 1MG/0.5ML, 2MG/ML (ATIVAN Equiv)	1	-
lorazepam tab .5MG, 1MG, 2MG (ATIVAN Equiv)	1	-
VALIUM TAB 2MG, 10MG 10MG, 2MG ***(diazepam)***	3	QL QL= 4 tabs/day
VALIUM TAB 5MG 5MG ***(diazepam)***	3	QL QL= 3 tabs/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ANTIARRHYTHMICS - Drugs to control heart rhythm		
ANTIARRHYTHMICS TYPE I-A - Drugs to control heart rhythm		
disopyramide cap 100MG, 150MG (NORPACE Equiv)	1	-
NORPACE CAP 100MG, 150MG ***(disopyramide phosphate)***	3	-
quinidine gluconate CR tab 324MG	1	-
QUINIDINE SULFATE ER TAB ***(quinidine sulfate)***	3	-
quinidine sulfate tab 200MG, 300MG	1	-
ANTIARRHYTHMICS TYPE I-B - Drugs to control heart rhythm		
mexiletine hcl cap 150MG, 200MG, 250MG	1	-
ANTIARRHYTHMICS TYPE I-C - Drugs to control heart rhythm		
flecainide tab 100MG, 150MG, 50MG (TAMBOCOR Equiv)	1	-
propafenone ER cap 225MG, 325MG, 425MG (RYTHMOL SR Equiv)	1	-
propafenone tab 150MG, 225MG, 300MG (RYTHMOL Equiv)	1	-
RYTHMOL SR CAP 225MG, 325MG, 425MG ***(propafenone hcl)***	3	-
RYTHMOL TAB ***(propafenone hcl)***	3	-
TAMBOCOR TAB ***(flecainide acetate)***	3	-
ANTIARRHYTHMICS TYPE III - Drugs to control heart rhythm		
amiodarone tab 100MG, 200MG, 400MG (CORDARONE Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CORDARONE TAB ***(amiodarone hcl)***	3	-
dofetilide cap 125MCG, 250MCG, 500MCG (TIKOSYN Equiv)	1	-
MULTAQ TAB 400MG ***(dronedarone hcl)***	2	-
TIKOSYN CAP 125MCG, 250MCG, 500MCG ***(dofetilide)***	3	-
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - Drugs to treat asthma and COPD		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES - Drugs to treat asthma		
FASENRA PEN INJ 30MG/ML ***(benralizumab)***	4	MSP-PA-QL QL= 1 inj/56 days
NUCALA INJ 100MG/ML ***(mepolizumab)***	4	LMSP-PA-QL QL= 1 inj/28 days
ANTI-INFLAMMATORY AGENTS - Drugs to treat asthma and COPD		
cromolyn neb soln 20MG/2ML (INTAL Equiv)	1	-
BRONCHODILATORS - ANTICHOLINERGICS - Drugs to treat breathing disorders		
ATROVENT HFA INHALER 17MCG/ACT ***(ipratropium bromide hfa)***	2	-
INCRUSE ELLIPTA INHALER 62.5MCG/INH ***(umeclidinium bromide)***	2	-
ipratropium neb soln .02% (ATROVENT Equiv)	1	-
SPIRIVA HANDIHALER 18MCG ***(tiotropium bromide monohydrate)***	3	PA For use with Handihaler device

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT 1.25MCG/ACT ***(tiotropium bromide monohydrate)***	2	QL-ST QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT 2.5MCG/ACT ***(tiotropium bromide monohydrate)***	3	PA
LEUKOTRIENE MODULATORS - Drugs to treat asthma and COPD		
ACCOLATE TAB 10MG, 20MG ***(zafirlukast)***	3	-
montelukast chew tab 4MG, 5MG (SINGULAIR Equiv)	1	-
montelukast granule pack 4MG (SINGULAIR Equiv)	1	-
montelukast tab 10MG (SINGULAIR Equiv)	1	-
SINGULAIR CHEW TAB 4MG, 5MG ***(montelukast sodium)***	3	-
SINGULAIR GRANULE PACK 4MG ***(montelukast sodium)***	3	-
SINGULAIR TAB 10MG ***(montelukast sodium)***	3	-
zafirlukast tab 10MG, 20MG (ACCOLATE Equiv)	1	-
STEROID INHALANTS - Drugs to treat asthma and COPD		
ARNUITY ELLIPTA INHALER 100MCG/ACT, 200MCG/ACT, 50MCG/ACT ***(fluticasone furoate (inhalation))***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ASMANEX HFA INHALER 100MCG/ACT, 200MCG/ACT, 50MCG/ACT ***(mometasone furoate (inhalation))***	2	-
ASMANEX INHALER 110MCG/INH, 220MCG/INH ***(mometasone furoate (inhalation))***	2	-
ASMANEX INHALER ***(mometasone furoate (inhalation))***	2	-
budesonide inh susp .25MG/2ML, .5MG/2ML, 1MG/2ML (PULMICORT Equiv)	1	-
FLOVENT DISKUS INHALER 100MCG/BLIST, 250MCG/BLIST, 50MCG/BLIST ***(fluticasone propionate (inhalation))***	2	-
FLOVENT HFA INHALER 110MCG/ACT, 220MCG/ACT, 44MCG/ACT ***(fluticasone propionate hfa)***	2	-
PULMICORT INH SUSP .25MG/2ML, .5MG/2ML, 1MG/2ML ***(budesonide (inhalation))***	3	-
SYMPATHOMIMETICS - Drugs to treat asthma and COPD		
ACCUNEB NEB SOLN ***(albuterol sulfate)***	3	-
ADVAIR DISKUS INHALER 50MCG/DOSE-100MCG/DOSE, 50MCG/DOSE-250MCG/DOSE, 50MCG/DOSE-500MCG/DOSE ***(fluticasone-salmeterol)***	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ADVAIR HFA INHALER 21MCG/ACT-115MCG/ACT, 21MCG/ACT-230MCG/ACT, 21MCG/ACT-45MCG/ACT ***(fluticasone-salmeterol)***	2	-
albuterol neb soln .083%, .5%, .63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML	1	-
albuterol sulfate ER tab (VOSPIRE ER Equiv)	1	-
albuterol sulfate syrup 2MG/5ML	1	-
albuterol sulfate tab 2MG, 4MG	1	-
albuterol/ipratropium neb soln .5MG/3ML-2.5MG/3ML (DUONEB Equiv)	1	-
ANORO ELLIPTA INHALER 25MCG/INH-62.5MCG/INH ***(umeclidinium-vilanterol)***	2	-
arformoterol tartrate neb soln 15MCG/2ML (BROVANA Equiv)	1	-
BREO ELLIPTA INHALER 25MCG/INH-100MCG/INH, 25MCG/INH-200MCG/INH ***(fluticasone furoate-vilanterol)***	2	-
BREZTRI AEROSPHERE INHALER 4.8MCG/ACT-9MCG/ACT-160MCG/ACT ***(budesonide-glycopyrrolate-formoterol fumarate)***	2	-
BROVANA NEB SOLN 15MCG/2ML ***(arformoterol tartrate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
COMBIVENT INHALER ***(ipratropium-albuterol)***	2	-
COMBIVENT RESPIMAT INHALER 20MCG/ACT-100MCG/ACT ***(ipratropium-albuterol)***	2	-
DULERA INHALER 5MCG/ACT-100MCG/ACT, 5MCG/ACT-200MCG/ACT, 5MCG/ACT-50MCG/ACT ***(mometasone furoate-formoterol fumarate dihydrate)***	2	-
DULERA INHALER 5MCG/ACT-100MCG/ACT, 5MCG/ACT-200MCG/ACT ***(mometasone furoate-formoterol fumarate dihydrate)***	2	-
DUONEB NEB SOLN ***(ipratropium-albuterol)***	3	-
FLUTICASONE/SALMETEROL INHALER 14MCG/ACT-113MCG/ACT, 14MCG/ACT-232MCG/ACT, 14MCG/ACT-55MCG/ACT ***(fluticasone-salmeterol)***	1	-
formoterol fumarate neb soln 20MCG/2ML (PERFOROMIST Equiv)	1	-
LEVALBUTEROL INHALER, XOPENEX HFA INHALER 45MCG/ACT ***(levalbuterol tartrate)***	3	QL-ST QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA
levalbuterol neb soln .31MG/3ML, .63MG/3ML, 1.25MG/0.5ML, 1.25MG/3ML (XOPENEX Equiv)	1	-
METAPROTERENOL SYRUP 10MG/5ML ***(metaproterenol sulfate)***	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PERFOROMIST NEB SOLN 20MCG/2ML ***(formoterol fumarate)***	3	-
SEREVENT DISKUS INHALER 50MCG/DOSE ***(salmeterol xinafoate)***	2	-
STIOLTO INHALER 2.5MCG/ACT ***(tiotropium bromide-olodaterol hcl)***	3	-
STRIVERDI RESPIMAT INHALER 2.5MCG/ACT ***(olodaterol hcl)***	3	QL QL= 1 inhaler/30 days
SYMBICORT INHALER 4.5MCG/ACT-160MCG/ACT, 4.5MCG/ACT-80MCG/ACT ***(budesonide-formoterol fumarate dihydrate)***	2	-
terbutaline sulfate tab 2.5MG, 5MG (BRETHINE Equiv)	1	-
TRELEGY ELLIPTA INHALER 25MCG/INH-62.5MCG/INH-100MCG/INH, 25MCG/INH-62.5MCG/INH-200MCG/INH ***(fluticasone-umeclidinium-vilanterol)***	2	-
VENTOLIN HFA INHALER 108MCG/ACT ***(albuterol sulfate)***	1	QL QL= 2 inhalers/30 days
VOSPIRE ER TAB ***(albuterol sulfate)***	3	-
XOPENEX NEB SOLN .31MG/3ML, .63MG/3ML, 1.25MG/0.5ML, 1.25MG/3ML ***(levalbuterol hcl)***	3	-
XANTHINES - Drugs to treat asthma and COPD		
aminophylline tab	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ELIXOPHYLLIN ELIXIR 80MG/15ML ***(theophylline)***	2	-
LUFYLLIN TAB ***(dyphylline)***	3	-
THEO-24 CAP 100MG, 200MG, 300MG, 400MG ***(theophylline)***	3	-
THEOPHYLLINE ER TAB 100MG, 200MG, 300MG, 450MG ***(theophylline)***	2	-
theophylline ER tab 400MG, 600MG (UNIPHYL Equiv)	1	-
theophylline soln 80MG/15ML	1	-
UNIPHYL TAB ***(theophylline tab sr 24hr)***	3	-
ANTICOAGULANTS - Drugs to thin the blood		
COUMARIN ANTICOAGULANTS - Drugs to thin the blood		
COUMADIN TAB 10MG, 1MG, 2.5MG, 2MG, 3MG, 4MG, 5MG, 6MG, 7.5MG ***(warfarin sodium)***	3	-
warfarin tab 10MG, 1MG, 2.5MG, 2MG, 3MG, 4MG, 5MG, 6MG, 7.5MG (COUMADIN Equiv)	1	-
DIRECT FACTOR XA INHIBITORS - Drugs to thin the blood		
ELIQUIS TAB, ELIQUIS STARTER PACK 2.5MG, 5MG ***(apixaban)***	2	-
XARELTO STARTER PACK ***(rivaroxaban)***	2	-
XARELTO TAB 10MG, 15MG, 2.5MG, 20MG ***(rivaroxaban)***	2	-
HEPARINS AND HEPARINOID-LIKE AGENTS - Drugs to thin the blood		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ARIXTRA INJ 10MG/0.8ML, 2.5MG/0.5ML, 5MG/0.4ML, 7.5MG/0.6ML ***(fondaparinux sodium)***	3	PA
enoxaparin inj 100MG/ML, 120MG/0.8ML, 150MG/ML, 300MG/3ML, 30MG/0.3ML, 40MG/0.4ML, 60MG/0.6ML, 80MG/0.8ML (LOVENOX Equiv)	1	QL QL= 17 days supply
fondaparinux inj 10MG/0.8ML, 2.5MG/0.5ML, 5MG/0.4ML, 7.5MG/0.6ML (ARIXTRA Equiv)	1	PA
FRAGMIN INJ ***(dalteparin sodium)***	3	-
FRAGMIN INJ 10000UNIT/ML, 12500UNIT/0.5ML, 15000UNIT/0.6ML, 18000UNT/0.72ML, 2500UNIT/0.2ML, 5000UNIT/0.2ML, 7500UNIT/0.3ML, 95000UNIT/3.8ML ***(dalteparin sodium)***	3	-
heparin porcine inj 10000UNIT/ML, 1000UNIT/ML, 20000UNIT/ML, 5000UNIT/0.5ML, 5000UNIT/ML	M	M
LOVENOX INJ 100MG/ML, 120MG/0.8ML, 150MG/ML, 300MG/3ML, 30MG/0.3ML, 40MG/0.4ML, 60MG/0.6ML, 80MG/0.8ML ***(enoxaparin sodium)***	3	QL QL= 17 days supply
THROMBIN INHIBITORS - Drugs to thin the blood		
PRADAXA CAP 110MG, 150MG, 75MG ***(dabigatran etexilate mesylate)***	2	-
ANTICONVULSANTS - Drugs to treat seizures		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ANTICONVULSANTS - BENZODIAZEPINES - Drugs to treat seizures		
clobazam tab 10MG, 20MG (ONFI Equiv)	1	PA
clonazepam ODT .125MG, .25MG, .5MG, 1MG, 2MG (KLONOPIN Equiv)	1	-
clonazepam tab .5MG, 1MG, 2MG (KLONOPIN Equiv)	1	-
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL 10MG, 2.5MG, 20MG ***(diazepam (anticonvulsant))***	2	QL QL= 2 packs/fill
KLONOPIN TAB .5MG, 1MG, 2MG ***(clonazepam)***	3	-
NAYZILAM SPRAY 5MG/0.1ML ***(midazolam (anticonvulsant))***	3	QL-RS QL= 2 packs/fill; Restricted to Neurology Specialist
ONFI TAB 10MG, 20MG ***(clobazam)***	3	PA
VALTOCO NASAL SPRAY 10MG/0.1ML, 5MG/0.1ML ***(diazepam (anticonvulsant))***	3	QL-RS QL= 2 packs/fill; Restricted to Neurology Specialist
ANTICONVULSANTS - MISC. - Miscellaneous anti-convulsant drugs		
BANZEL SUSP 40MG/ML ***(rufinamide)***	3	PA
carbamazepine chew tab 100MG (TEGRETOL Equiv)	1	-
carbamazepine ER cap 100MG, 200MG, 300MG (CARBATROL Equiv)	1	-
carbamazepine ER tab 100MG, 200MG, 400MG (TEGRETOL XR Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
carbamazepine susp 100MG/5ML, 200MG/10ML (TEGRETOL Equiv)	1	-
carbamazepine tab 200MG (TEGRETOL Equiv)	1	-
CARBATROL CAP 100MG, 200MG, 300MG ***(carbamazepine)***	3	-
DIACOMIT CAP 250MG, 500MG ***(stiripentol)***	4	LD-PA Only available through US Bioservices 888-518-7246
DIACOMIT POWDER PACK 250MG, 500MG ***(stiripentol)***	4	LD-PA Only available through US Bioservices 888-518-7246
EPIDIOLEX SOLN 100MG/ML ***(cannabidiol)***	4	LD-PA Only available through Lumicera 855-847-3553
FINTEPLA SOLN 2.2MG/ML ***(fenfluramine hcl (anticonvulsant))***	4	LD-PA-QL QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007
gabapentin cap 300MG, 400MG (NEURONTIN Equiv)	1	QL QL= 3 caps/day
gabapentin cap 100mg 100MG (NEURONTIN Equiv)	1	QL QL= 6 caps/day
gabapentin soln 250MG/5ML, 300MG/6ML (NEURONTIN Equiv)	1	QL QL= 72 mls/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
gabapentin tab 600mg 600MG (NEURONTIN Equiv)	1	QL QL= 6 tabs/day
gabapentin tab 800mg 800MG (NEURONTIN Equiv)	1	QL QL= 4.5 tabs/day
KEPPRA SOLN 100MG/ML ***(levetiracetam)***	3	-
KEPPRA TAB 1000MG, 250MG, 500MG, 750MG ***(levetiracetam)***	3	-
KEPPRA XR TAB 500MG, 750MG ***(levetiracetam)***	3	-
LAMICTAL CHEW TAB 25MG, 5MG ***(lamotrigine)***	3	-
LAMICTAL CHEW TAB 2MG ***(lamotrigine)***	2	-
LAMICTAL ODT 100MG, 200MG, 25MG, 50MG ***(lamotrigine)***	3	-
LAMICTAL ODT KIT ***(lamotrigine)***	3	-
LAMICTAL ODT KIT, LAMICTAL XR KIT ***(lamotrigine)***	3	-
LAMICTAL STARTER KIT 25MG ***(lamotrigine)***	3	-
LAMICTAL TAB 100MG, 150MG, 200MG, 25MG ***(lamotrigine)***	3	-
LAMICTAL XR TAB 100MG, 200MG, 250MG, 25MG, 300MG, 50MG ***(lamotrigine)***	3	-
lamotrigine chew tab 25MG, 5MG (LAMICTAL Equiv)	1	-
lamotrigine ER tab 100MG, 200MG, 250MG, 25MG, 300MG, 50MG (LAMICTAL XR Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
lamotrigine ODT 100MG, 200MG, 25MG, 50MG (LAMICTAL Equiv)	1	-
lamotrigine ODT kit 25MG (LAMICTAL ODT KIT Equiv)	1	-
lamotrigine tab 100MG, 150MG, 200MG, 25MG (LAMICTAL Equiv)	1	-
levetiracetam ER tab 500MG, 750MG (KEPPRA XR Equiv)	1	-
levetiracetam soln 100MG/ML, 500MG/5ML (KEPPRA Equiv)	1	-
levetiracetam tab 1000MG, 250MG, 500MG, 750MG (KEPPRA Equiv)	1	-
MYSOLINE TAB 250MG, 50MG ***(primidone)***	3	-
NEURONTIN CAP 300MG, 400MG ***(gabapentin)***	3	QL
NEURONTIN CAP 100MG 100MG ***(gabapentin)***	3	QL
NEURONTIN SOLN 250MG/5ML ***(gabapentin)***	3	QL QL= 72 mls/day
NEURONTIN TAB 600MG 600MG ***(gabapentin)***	3	QL QL= 6 tabs/day
NEURONTIN TAB 800MG 800MG ***(gabapentin)***	3	QL QL= 4.5 tabs/day
oxcarbazepine susp 300MG/5ML, 60MG/ML (TRILEPTAL Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
oxcarbazepine tab 150MG, 300MG, 600MG (TRILEPTAL Equiv)	1	-
pregabalin cap 100MG, 150MG, 200MG, 25MG, 50MG, 75MG (LYRICA Equiv)	1	QL QL= 3 caps/day
pregabalin cap 225mg 225MG (LYRICA Equiv)	1	QL QL= 2 caps/day
pregabalin cap 300mg 300MG (LYRICA Equiv)	1	QL QL= 2 caps/day
pregabalin soln 20MG/ML (LYRICA Equiv)	1	QL QL= 30ml/day
primidone tab 250MG, 50MG (MYSOLINE Equiv)	1	-
rufinamide susp 40MG/ML (BANZEL Equiv)	1	PA
rufinamide tab 200MG, 400MG (BANZEL Equiv)	1	PA
TEGRETOL CHEW TAB ***(carbamazepine)***	3	-
TEGRETOL SUSP 100MG/5ML ***(carbamazepine)***	3	-
TEGRETOL TAB 200MG ***(carbamazepine)***	3	-
TEGRETOL XR TAB 100MG, 200MG, 400MG ***(carbamazepine)***	3	-
TOPAMAX SPRINKLE CAP 15MG, 25MG ***(topiramate)***	3	-
TOPAMAX TAB 100MG, 200MG, 25MG, 50MG ***(topiramate)***	3	-
topiramate sprinkle cap 15MG, 25MG (TOPAMAX Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
topiramate tab 100MG, 200MG, 25MG, 50MG (TOPAMAX Equiv)	1	-
TRILEPTAL SUSP 300MG/5ML ***(oxcarbazepine)***	3	-
TRILEPTAL TAB 150MG, 300MG, 600MG ***(oxcarbazepine)***	3	-
VIMPAT SOLN 10MG/ML ***(lacosamide)***	2	-
VIMPAT TAB 100MG, 150MG, 200MG, 50MG ***(lacosamide)***	2	QL QL= 2 tabs/day
ZONEGRAN CAP 100MG, 25MG ***(zonisamide)***	3	-
zonisamide cap 100MG, 25MG, 50MG (ZONEGRAN Equiv)	1	-
CARBAMATES - Drugs to treat seizures		
felbamate susp 600MG/5ML (FELBATOL Equiv)	1	-
felbamate tab 400MG, 600MG (FELBATOL Equiv)	1	-
FELBATOL SUSP 600MG/5ML ***(felbamate)***	3	-
FELBATOL TAB 400MG, 600MG ***(felbamate)***	3	-
XCOPRI PAK 100-150MG ***(cenobamate)***	2	QL QL= 2 tabs/day
XCOPRI PAK 150-200MG ***(cenobamate)***	2	QL QL= 2 tabs/day
XCOPRI PAK 50-200MG ***(cenobamate)***	2	QL QL= 2 tabs/day
XCOPRI TAB 150MG, 200MG 150MG, 200MG ***(cenobamate)***	2	QL QL= 2 tabs/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
XCOPRI TAB 50MG, 100MG 100MG, 50MG ***(cenobamate)***	2	QL QL= 1 tab/day
XCOPRI TITRATION PAK 12.5-25MG ***(cenobamate)***	2	QL QL= 1 tab/day
XCOPRI TITRATION PAK 150-200MG ***(cenobamate)***	2	QL QL= 1 tab/day
XCOPRI TITRATION PAK 50-100MG ***(cenobamate)***	2	QL QL= 1 tab/day
GABA MODULATORS - Drugs to treat seizures		
GABITRIL TAB 12MG, 16MG, 2MG, 4MG ***(tiagabine hcl)***	3	-
tiagabine tab 12MG, 16MG, 2MG, 4MG (GABITRIL Equiv)	1	-
vigabatrin powder pack 500MG (SABRIL POWDER Equiv)	4	LD-PA Only available through Lumicera 855-847-3553
vigabatrin tab 500MG (SABRIL Equiv)	4	LD-PA Only available through Lumicera 855-847-3553
vigadrone powder pack 500MG	4	LD-PA Only available through PantheRx 855-726-8479
HYDANTOINS - Drugs to treat seizures		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DILANTIN CAP 100MG 100MG, 200MG, 300MG ***(phenytoin sodium extended)***	3	-
DILANTIN CAP 30MG 30MG ***(phenytoin sodium extended)***	2	-
DILANTIN INFATABS 50MG ***(phenytoin)***	3	-
DILANTIN SUSP 125MG/5ML ***(phenytoin)***	3	-
phenytoin cap 100MG, 200MG, 300MG (DILANTIN Equiv)	1	-
phenytoin chew tab 50MG (DILANTIN Equiv)	1	-
phenytoin susp 100MG/4ML, 125MG/5ML (DILANTIN Equiv)	1	-
SUCCINIMIDES - Drugs to treat seizures		
CELONTIN CAP 300MG ***(methsuximide)***	2	-
ethosuximide cap 250MG (ZARONTIN Equiv)	1	-
ethosuximide soln 250MG/5ML (ZARONTIN Equiv)	1	-
ZARONTIN CAP 250MG ***(ethosuximide)***	3	-
ZARONTIN SOLN 250MG/5ML ***(ethosuximide)***	3	-
VALPROIC ACID - Drugs to treat seizures		
DEPAKENE CAP 250MG ***(valproic acid)***	3	-
DEPAKENE SYRUP 250MG/5ML ***(valproate sodium)***	3	-
DEPAKOTE ER TAB 250MG, 500MG ***(divalproex sodium)***	3	-
DEPAKOTE SPRINKLE CAP 125MG ***(divalproex sodium)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DEPAKOTE TAB 125MG, 250MG, 500MG ***(divalproex sodium)***	3	-
divalproex ER tab 250MG, 500MG (DEPAKOTE ER Equiv)	1	-
divalproex sodium DR tab 125MG, 250MG, 500MG (DEPAKOTE Equiv)	1	-
divalproex sprinkle cap 125MG (DEPAKOTE Equiv)	1	-
valproic acid cap 250MG (DEPAKENE Equiv)	1	-
valproic acid syrup 250MG/5ML (DEPAKENE Equiv)	1	-
ANTIDEPRESSANTS - Drugs to treat depression disorder		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS) - Drugs to treat depression		
mirtazapine ODT 15MG, 30MG, 45MG (REMERON Equiv)	1	-
mirtazapine tab 15MG, 30MG, 45MG, 7.5MG (REMERON Equiv)	1	-
REMERON SOLUTAB 15MG, 30MG, 45MG ***(mirtazapine)***	3	-
REMERON TAB ***(mirtazapine tab)***	3	-
ANTIDEPRESSANTS - MISC. - Miscellaneous anti-depressant drugs		
bupropion ER tab 100MG, 150MG, 200MG (WELLBUTRIN Equiv)	1	-
bupropion tab 100MG, 75MG (WELLBUTRIN Equiv)	1	-
bupropion XL tab 150MG, 300MG (WELLBUTRIN XL Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
MAPROTILINE TAB 25MG, 50MG, 75MG ***(maprotiline hcl)***	1	-
WELLBUTRIN SR TAB 100MG, 150MG, 200MG ***(bupropion hcl)***	3	-
WELLBUTRIN XL TAB 150MG, 300MG ***(bupropion hcl)***	3	-
MONOAMINE OXIDASE INHIBITORS (MAOIS) - Drugs to treat depression		
EMSAM PATCH 12MG/24HR, 6MG/24HR, 9MG/24HR ***(selegiline)***	3	-
MARPLAN TAB 10MG ***(isocarboxazid)***	2	-
NARDIL TAB 15MG ***(phenelzine sulfate)***	3	-
PARNATE TAB 10MG ***(tranylcypromine sulfate)***	3	-
phenelzine tab 15MG (NARDIL Equiv)	1	-
tranylcypromine tab 10MG (PARNATE Equiv)	1	-
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS) - Drugs to treat depression		
CELEXA SOLN ***(citalopram hydrobromide)***	3	-
CELEXA TAB 10MG, 20MG, 40MG ***(citalopram hydrobromide)***	3	-
citalopram soln 10MG/5ML (CELEXA Equiv)	1	-
citalopram tab 10MG, 20MG, 40MG (CELEXA Equiv)	1	-
escitalopram soln 5MG/5ML (LEXAPRO Equiv)	1	-
escitalopram tab 10MG, 20MG, 5MG (LEXAPRO Equiv)	1	-
fluoxetine cap 10MG, 20MG, 40MG (PROZAC Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
fluoxetine soln 20MG/5ML (PROZAC Equiv)	1	-
fluvoxamine ER cap 100MG, 150MG (LUVOX CR Equiv)	1	ST Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
fluvoxamine tab 100MG, 25MG, 50MG (LUVOX Equiv)	1	-
LEXAPRO SOLN ***(escitalopram oxalate)***	3	-
LEXAPRO TAB 10MG, 20MG, 5MG ***(escitalopram oxalate)***	3	-
LUVOX CR CAP ***(fluvoxamine maleate)***	3	ST Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
paroxetine ER tab 12.5MG, 25MG, 37.5MG (PAXIL CR Equiv)	1	-
paroxetine oral susp 10MG/5ML (PAXIL Equiv)	1	-
paroxetine tab 10MG, 20MG, 30MG, 40MG (PAXIL Equiv)	1	-
PAXIL CR TAB 12.5MG, 25MG, 37.5MG ***(paroxetine hcl)***	3	-
PAXIL ORAL SUSP 10MG/5ML ***(paroxetine hcl)***	3	-
PAXIL TAB 10MG, 20MG, 30MG, 40MG ***(paroxetine hcl)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PEXEVA TAB 10MG, 20MG, 30MG, 40MG ***(paroxetine mesylate)***	3	ST Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
PROZAC CAP 10MG, 20MG, 40MG ***(fluoxetine hcl)***	3	-
PROZAC SOLN ***(fluoxetine hcl)***	3	-
sertraline conc 20MG/ML (ZOLOFT Equiv)	1	-
sertraline tab 100MG, 25MG, 50MG (ZOLOFT Equiv)	1	-
ZOLOFT CONC 20MG/ML ***(sertraline hcl)***	3	-
ZOLOFT TAB 100MG, 25MG, 50MG ***(sertraline hcl)***	3	-
SEROTONIN MODULATORS - Drugs to treat depression		
NEFAZODONE TAB 100MG, 150MG, 200MG, 250MG, 50MG ***(nefazodone hcl)***	1	-
nefazodone tab 50mg, 250mg 250MG, 50MG	1	-
OLEPTRO TAB ***(trazodone hcl)***	3	-
trazodone tab 100MG, 150MG, 50MG (DESYREL Equiv)	1	-
TRINTELLIX TAB 10MG, 20MG, 5MG ***(vortioxetine hbr)***	3	PA-QL QL= 1 tab/day
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS) - Drugs to treat depression		
desvenlafaxine ER tab 100MG, 25MG, 50MG (PRISTIQ Equiv)	1	-
duloxetine EC cap 20MG, 30MG, 60MG (CYMBALTA Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
EFFEXOR TAB ***(venlafaxine hcl)***	3	-
EFFEXOR XR CAP 150MG, 37.5MG, 75MG ***(venlafaxine hcl)***	3	-
FETZIMA CAP 120MG, 20MG, 40MG, 80MG ***(levomilnacipran hcl)***	3	PA-QL QL= 1 cap/day
FETZIMA TITRATION PACK ***(levomilnacipran hcl)***	3	PA-QL QL= 1 cap/day
PRISTIQ TAB 100MG, 25MG, 50MG ***(desvenlafaxine succinate)***	3	-
venlafaxine ER cap 150MG, 37.5MG, 75MG (EFFEXOR XR Equiv)	1	-
venlafaxine tab 100MG, 25MG, 37.5MG, 50MG, 75MG (EFFEXOR Equiv)	1	-
TRICYCLIC AGENTS - Drugs to treat depression		
amitriptyline tab (ELAVIL Equiv)	1	-
AMOXAPINE TAB 100MG, 150MG, 25MG, 50MG ***(amoxapine)***	1	-
ANAFRANIL CAP 25MG, 50MG, 75MG ***(clomipramine hcl)***	3	-
clomipramine cap 25MG, 50MG, 75MG (ANAFRANIL Equiv)	1	-
desipramine tab (NORPRAMIN Equiv)	1	-
DOXEPIN CAP 150MG ***(doxepin hcl)***	1	-
doxepin cap 100MG, 10MG, 25MG, 50MG, 75MG	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
doxepin conc 10MG/ML (SINEQUAN Equiv)	1	-
imipramine pamoate cap 100MG, 125MG, 150MG, 75MG (TOFRANIL PM Equiv)	1	-
imipramine tab 10MG, 25MG, 50MG (TOFRANIL Equiv)	1	-
NORPRAMIN TAB 10MG, 25MG ***(desipramine hcl)***	3	-
nortriptyline cap 10MG, 25MG, 50MG, 75MG (PAMELOR Equiv)	1	-
nortriptyline oral soln 10MG/5ML (NORTRIPTYLINE Equiv)	1	-
NORTRIPTYLINE SOLN 10MG/5ML ***(nortriptyline hcl)***	2	-
PAMELOR CAP 10MG, 25MG, 50MG, 75MG ***(nortriptyline hcl)***	3	-
protriptyline tab 10MG, 5MG (VIVACTIL Equiv)	1	-
SURMONTIL CAP 100MG, 25MG, 50MG ***(trimipramine maleate)***	3	-
TOFRANIL PM CAP ***(imipramine pamoate)***	3	-
TOFRANIL TAB 10MG, 25MG, 50MG ***(imipramine hcl)***	3	-
trimipramine cap 100MG, 25MG, 50MG (SURMONTIL Equiv)	1	-
VIVACTIL TAB ***(protriptyline hcl)***	3	-
ANTIDIABETICS - Drugs to regulate blood sugar		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ALPHA-GLUCOSIDASE INHIBITORS - Drugs to regulate blood sugar		
acarbose tab 100MG, 25MG, 50MG (PRECOSE Equiv)	1	-
GLYSET TAB 100MG, 25MG, 50MG ***(miglitol)***	3	-
miglitol tab 100MG, 25MG, 50MG (MIGLITOL Equiv)	1	-
PRECOSE TAB 100MG, 25MG, 50MG ***(acarbose)***	3	-
ANTIDIABETIC COMBINATIONS - Drugs to regulate blood sugar		
ACTOPLUS MET XR TAB 15MG-1000MG, 30MG-1000MG ***(pioglitazone hcl-metformin hcl)***	3	-
ALOGLIPTIN-METFORMIN TAB 12.5MG-1000MG, 12.5MG-500MG ***(alogliptin-metformin hcl)***	2	QL QL= 2 tabs/day
ALOGLIPTIN-PIOGLITAZONE TAB 12.5MG-15MG, 12.5MG-30MG, 12.5MG-45MG, 15MG-25MG, 25MG-30MG, 25MG-45MG ***(alogliptin-pioglitazone)***	2	QL QL= 1 tab/day
AVANDAMET TAB ***(rosiglitazone maleate-metformin hcl)***	2	-
AVANDARYL TAB ***(rosiglitazone maleate-glimepiride)***	2	-
glipizide/metformin tab 2.5MG-250MG, 2.5MG-500MG, 5MG-500MG (METAGLIP Equiv)	1	-
GLUCOVANCE TAB 2.5MG-500MG, 5MG-500MG ***(glyburide-metformin)***	3	-
glyburide/metformin tab 1.25MG-250MG, 2.5MG-500MG, 5MG-500MG (GLUCOVANCE Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
JANUMET TAB 50MG-1000MG, 50MG-500MG ***(sitagliptin-metformin hcl)***	2	QL QL= 2 tabs/day
JANUMET XR TAB 100MG-1000MG, 50MG-1000MG, 50MG-500MG ***(sitagliptin-metformin hcl)***	2	QL QL= 2 tabs/day
METAGLIP TAB ***(glipizide-metformin hcl)***	3	-
SYNJARDY TAB 12.5MG-1000MG, 12.5MG-500MG, 5MG-1000MG, 5MG-500MG ***(empagliflozin-metformin hcl)***	2	QL QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG 10MG-1000MG, 25MG-1000MG ***(empagliflozin-metformin hcl)***	2	QL QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG 12.5MG-1000MG, 5MG-1000MG ***(empagliflozin-metformin hcl)***	2	QL QL= 2 tabs/day
BIGUANIDES - Drugs to regulate blood sugar		
GLUCOPHAGE TAB 1000MG, 500MG, 850MG ***(metformin hcl)***	3	-
GLUCOPHAGE XR TAB 500MG, 750MG ***(metformin hcl)***	3	-
metformin ER tab 500MG, 750MG (GLUCOPHAGE XR Equiv)	1	-
metformin soln 500MG/5ML (RIOMET Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
metformin tab 1000MG, 500MG, 850MG (GLUCOPHAGE Equiv)	1	-
RIOMET ER SUSP 500MG/5ML ***(metformin hcl)***	3	-
RIOMET SOLN 500MG/5ML ***(metformin hcl)***	3	-
DIABETIC OTHER - Drugs to regulate blood sugar		
BAQSIMI NASAL POWDER 3MG/DOSE ***(glucagon)***	2	QL QL= 2 inhalations/fill
diazoxide susp 50MG/ML (PROGLYCEM Equiv)	1	-
GLUCAGEN HYPOKIT INJ 1MG ***(glucagon hcl (rdna))***	2	QL QL= 2 inj/fill
glucagon (rdna) for inj kit 1MG (GLUCAGON Equiv)	1	QL QL= 2 inj/fill
GLUCAGON EMR INJ 1MG/ML ***(glucagon hcl)***	2	QL QL= 2 inj/fill
GLUCAGON INJ KIT 1MG ***(glucagon (rdna))***	2	QL QL= 2 inj/fill
GVOKE INJ .5MG/0.1ML ***(glucagon)***	2	QL QL= 2 inj/fill
GVOKE INJ KIT ***(glucagon)***	2	QL QL= 2 inj/fill
GVOKE PFS INJ 1MG/0.2ML ***(glucagon)***	2	QL QL= 2 inj/fill

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
KORLYM TAB 300MG ***(mifepristone (hyperglycemia))***	4	LD-PA-QL QL= 4 tabs/day; Only available through Korlym SPARK program 855-4Korlym (855-456-7596)
PROGLYCEM SUSP 50MG/ML ***(diazoxide)***	3	-
ZEGALOGUE INJ .6MG/0.6ML ***(dasiglucagon hcl)***	2	QL QL= 2 inj/fill
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS - Drugs to regulate blood sugar		
ALOGLIPTIN TAB 12.5MG, 25MG, 6.25MG ***(alogliptin benzoate)***	2	QL QL= 1 tab/day
JANUVIA TAB 100MG, 25MG, 50MG ***(sitagliptin phosphate)***	2	QL QL= 1 tab/day
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC - drugs to regulate blood sugar		
CYCLOSET TAB .8MG ***(bromocriptine mesylate (diabetes))***	3	-
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS) - Drugs to regulate blood sugar		
BYDUREON BCISE AUTO INJ 2MG/0.85ML ***(exenatide)***	2	QL QL= 4 inj/28 days
BYDUREON INJ 2MG ***(exenatide)***	2	QL QL= 4 inj/28 days
BYDUREON PEN INJ 2MG ***(exenatide)***	2	QL QL= 4 inj/28 days
BYETTA INJ 10MCG/0.04ML ***(exenatide)***	3	QL QL= 1 pen/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
OZEMPIC INJ 2MG/1.5ML, 4MG/3ML ***(semaglutide)***	2	QL QL= 1 pack/28 days
RYBELSUS TAB 14MG, 3MG, 7MG ***(semaglutide)***	2	QL QL=1 tab/day
TRULICITY INJ .75MG/0.5ML, 1.5MG/0.5ML, 3MG/0.5ML, 4.5MG/0.5ML ***(dulaglutide)***	2	QL QL= 4 pens/28 days
VICTOZA INJ 18MG/3ML ***(liraglutide)***	2	QL QL= 9ml/30 days
INSULIN - Drugs to regulate blood sugar		
ADMELOG INJ, INSULIN LISPRO INJ 100UNIT/ML ***(insulin lispro)***	3	ST Step Therapy requires trial of NOVOLOG or INSULIN ASPART
ADMELOG SOLOSTAR INJ, INSULIN LISPRO KWIKPEN INJ (JUNIOR) 100UNIT/ML, 200UNIT/ML ***(insulin lispro)***	3	ST Step Therapy requires trial of NOVOLOG or INSULIN ASPART
APIDRA INJ 100UNIT/ML ***(insulin glulisine)***	3	ST Step Therapy requires trial of NOVOLOG or INSULIN ASPART
APIDRA SOLOSTAR INJ 100UNIT/ML ***(insulin glulisine)***	3	ST Step Therapy requires trial of NOVOLOG or INSULIN ASPART
BASAGLAR INJ 100UNIT/ML, 300UNIT/ML ***(insulin glargine)***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FIASP FLEXTOUCH INJ 100UNIT/ML ***(insulin aspart (with niacinamide))***	2	-
FIASP INJ 100UNIT/ML ***(insulin aspart (with niacinamide))***	2	-
FIASP PENFILL INJ 20.8MG/ML-100UNIT/ML ***(insulin aspart (with niacinamide))***	2	-
HUMALOG MIX INJ ***(insulin lispro protamine & lispro (human))***	3	ST Step Therapy requires trial of NOVOLOG or INSULIN ASPART
HUMALOG MIX KWIKPEN INJ, INSULIN LISPRO PROTAMINE INJ 50UNIT/ML ***(insulin lispro protamine & lispro (human))***	3	ST Step Therapy requires trial of NOVOLOG or INSULIN ASPART
HUMULIN MIX INJ 30UNIT/ML-70UNIT/ML ***(insulin nph isophane & reg (human))***	3	OTC-ST Step Therapy requires trial of NOVOLIN
HUMULIN MIX PEN INJ 30UNIT/ML-70UNIT/ML ***(insulin nph isophane & reg (human))***	3	OTC-ST Step Therapy requires trial of NOVOLIN
HUMULIN N INJ 100UNIT/ML ***(insulin nph (human) (isophane))***	3	OTC-ST Step Therapy requires trial of NOVOLIN
HUMULIN N PEN INJ 100UNIT/ML ***(insulin nph (human) (isophane))***	3	OTC-ST Step Therapy requires trial of NOVOLIN

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
HUMULIN R INJ 100UNIT/ML ***(insulin regular (human))***	3	OTC-ST Step Therapy requires trial of NOVOLIN
HUMULIN R INJ U-500 500UNIT/ML ***(insulin regular (human))***	2	-
HUMULIN R U-500 KWIKPEN INJ 500UNIT/ML ***(insulin regular (human))***	2	-
INSULIN ASPART FLEXPEN INJ 100UNIT/ML (NOVOLOG Equiv) ***(insulin aspart)***	2	-
INSULIN ASPART INJ 100UNIT/ML (NOVOLOG Equiv) ***(insulin aspart)***	2	-
INSULIN ASPART MIX FLEXPEN INJ 30UNIT/ML-70UNIT/ML (NOVOLOG Equiv) ***(insulin aspart protamine & aspart (human))***	2	-
INSULIN ASPART MIX INJ 30%-70%, 30UNIT/ML-70UNIT/ML (NOVOLOG Equiv) ***(insulin aspart protamine & aspart (human))***	2	-
INSULIN ASPART PENFILL INJ 100UNIT/ML (NOVOLOG Equiv) ***(insulin aspart)***	2	-
NOVOLIN 70/30 FLEXPEN INJ 30UNIT/ML-70UNIT/ML ***(insulin nph isophane & reg (human))***	2	OTC
NOVOLIN 70/30 INJ 30UNIT/ML-70UNIT/ML ***(insulin nph isophane & reg (human))***	2	OTC

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NOVOLIN N FLEXPEN INJ 100UNIT/ML ***(insulin nph (human) (isophane))***	2	OTC
NOVOLIN N INJ 100UNIT/ML ***(insulin nph (human) (isophane))***	2	OTC
NOVOLIN R FLEXPEN INJ 100UNIT/ML ***(insulin regular (human))***	2	OTC
NOVOLIN R INJ 100UNIT/ML ***(insulin regular (human))***	2	OTC
NOVOLOG FLEXPEN INJ 100UNIT/ML ***(insulin aspart)***	2	-
NOVOLOG INJ 100UNIT/ML ***(insulin aspart)***	2	-
NOVOLOG MIX FLEXPEN INJ 30UNIT/ML-70UNIT/ML ***(insulin aspart protamine & aspart (human))***	2	-
NOVOLOG MIX INJ 30UNIT/ML-70UNIT/ML ***(insulin aspart protamine & aspart (human))***	2	-
NOVOLOG PENFILL INJ 100UNIT/ML ***(insulin aspart)***	2	-
INSULIN SENSITIZING AGENTS - Drugs to regulate blood sugar		
ACTOS TAB 15MG, 30MG, 45MG ***(pioglitazone hcl)***	3	-
AVANDIA TAB 2MG, 4MG ***(rosiglitazone maleate)***	2	-
pioglitazone tab 15MG, 30MG, 45MG (ACTOS Equiv)	1	-
MEGLITINIDE ANALOGUES - Drugs to regulate blood sugar		
nateglinide tab 120MG, 60MG (STARLIX Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PRANDIN TAB 1MG, 2MG ***(repaglinide)***	3	-
repaglinide tab .5MG, 1MG, 2MG (PRANDIN Equiv)	1	-
STARLIX TAB 120MG, 60MG ***(nateglinide)***	3	-
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS - Drugs to regulate blood sugar		
JARDIANCE TAB 10MG, 25MG ***(empagliflozin)***	2	QL QL= 1 tab/day
STEGLATRO TAB 15MG, 5MG ***(ertugliflozin l-pyroglutamic acid)***	2	QL QL= 1 tab/day
SULFONYLUREAS - Drugs to regulate blood sugar		
AMARYL TAB 1MG, 2MG, 4MG ***(glimepiride)***	3	-
DIABETA TAB ***(glyburide)***	3	-
glimepiride tab 1MG, 2MG, 4MG (AMARYL Equiv)	1	-
glipizide ER tab 10MG, 2.5MG, 5MG (GLUCOTROL XL Equiv)	1	-
glipizide tab 10MG, 5MG (GLUCOTROL Equiv)	1	-
GLUCOTROL TAB 10MG, 5MG ***(glipizide)***	3	-
GLUCOTROL XL TAB 10MG, 2.5MG, 5MG ***(glipizide)***	3	-
glyburide micronized tab 1.5MG, 3MG, 6MG (GLYNASE Equiv)	1	-
glyburide tab 1.25MG, 2.5MG, 5MG (MICRONASE Equiv)	1	-
GLYNASE TAB 1.5MG, 3MG, 6MG ***(glyburide micronized)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TOLAZAMIDE TAB 250MG ***(tolazamide)***	1	-
TOLBUTAMIDE TAB 500MG ***(tolbutamide)***	2	-
ANTIDIARRHEAL/PROBIOTIC AGENTS - Drugs to treat diarrhea		
ANTIPERISTALTIC AGENTS - Drugs to treat diarrhea		
DIPHENOXYLATE/ATROPINE LIQUID .025MG/5ML-2.5MG/5ML ***(diphenoxylate w/ atropine)***	1	-
ANTIDIARRHEALS - Drugs to treat diarrhea		
ANTIPERISTALTIC AGENTS - Drugs to treat diarrhea		
diphenoxylate/atropine tab .025MG-2.5MG (LOMOTIL Equiv)	1	-
LOMOTIL LIQUID ***(diphenoxylate w/ atropine)***	3	-
LOMOTIL TAB ***(diphenoxylate w/ atropine tab)***	3	-
MOTOFEN TAB .025MG-1MG ***(difenoxin w/ atropine)***	3	-
ANTIDOTES - Drugs to treat overdose or toxicity		
ANTIDOTES - CHELATING AGENTS - Drugs to treat overdose or toxicity		
CHEMET CAP 100MG ***(succimer)***	2	-
FERRIPROX SOLN 100MG/ML ***(deferiprone)***	4	LD-PA Only available through Ferriprox Total Care 866-758-7071
FERRIPROX TAB 1000MG ***(deferiprone)***	4	LD-PA Only available through Ferriprox Total Care 866-758-7071

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
OPIOID ANTAGONISTS - Drugs to treat opioid overdose or toxicity		
naloxone inj .4MG/ML, 4MG/10ML	1	-
naltrexone tab 50MG (REVIA Equiv)	1	-
NARCAN NASAL SPRAY 4MG/0.1ML ***(naloxone hcl)***	2	-
REVIA TAB ***(naltrexone hcl)***	3	-
ANTIDOTES AND SPECIFIC ANTAGONISTS - Drugs to treat overdose or toxicity		
ANTIDOTES - CHELATING AGENTS - Drugs to treat overdose or toxicity		
deferasirox granules packet 180MG, 360MG, 90MG (JADENU Equiv)	4	LMSP
deferasirox tab 125MG, 250MG, 500MG (EXJADE Equiv)	4	LMSP
deferasirox tab 180mg 180MG (JADENU Equiv)	4	LMSP
deferasirox tab 90mg, 360mg 360MG, 90MG (JADENU Equiv)	4	LMSP
deferiprone tab 500MG (FERRIPROX Equiv)	4	LD-PA Only available through Lumicera 855-847-3553
OPIOID ANTAGONISTS - Drugs to treat opioid overdose or toxicity		
KLOXXADO NASAL SPRAY 8MG/0.1ML ***(naloxone hcl)***	2	-
naloxone hcl nasal spray 4MG/0.1ML (NARCAN Equiv)	1	-
NALOXONE PREFILLED INJ .4MG/ML ***(naloxone hcl)***	$0	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
naloxone prefilled inj 2MG/2ML	$0	-
NARCAN NASAL SPRAY 4MG/0.1ML ***(naloxone hcl)***	2	-
ANTIEMETICS - Drugs to treat nausea and vomiting		
5-HT3 RECEPTOR ANTAGONISTS - Drugs to treat nausea and vomiting		
ANZEMET TAB 100MG, 50MG ***(dolasetron mesylate)***	4	QL QL= 9 tabs/fill
granisetron tab 1MG (KYTRIL Equiv)	1	QL QL= 9 tabs/fill
GRANISOL SOLN ***(granisetron hcl)***	4	QL QL= 60ml/fill
ondansetron ODT 4MG, 8MG (ZOFRAN Equiv)	1	-
ondansetron soln 4MG/5ML (ZOFRAN Equiv)	1	-
ONDANSETRON TAB 24MG (ZOFRAN Equiv) ***(ondansetron hcl)***	1	-
ondansetron tab 24MG, 4MG, 8MG (ZOFRAN Equiv)	1	-
SANCUSO PATCH 3.1MG/24HR ***(granisetron)***	4	QL QL= 4 patchs/fill
ZOFRAN ODT 4MG, 8MG ***(ondansetron)***	3	-
ZOFRAN SOLN 4MG/5ML ***(ondansetron hcl)***	3	-
ZOFRAN TAB 4MG, 8MG ***(ondansetron hcl)***	3	-
ANTIEMETICS - ANTICHOLINERGIC - Drugs to treat nausea and vomiting		
maldemar tab (SCOPACE Equiv)	1	-
meclizine chew tab 25MG (BONINE Equiv)	1	OTC
meclizine tab 12.5MG, 25MG (ANTIVERT Equiv)	1	OTC

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
scopolamine patch 1.5MG, 1MG/3DAYS (TRANSDERM-SCOP Equiv)	1	-
TIGAN CAP 300MG ***(trimethobenzamide hcl)***	3	-
TRANSDERM-SCOP PATCH 1.5MG, 1MG/3DAYS ***(scopolamine)***	3	-
trimethobenzamide cap 300MG (TIGAN Equiv)	1	-
ANTIEMETICS - MISCELLANEOUS - Miscellaneous anti-emetics		
AKYNZEO CAP .5MG-300MG ***(netupitant-palonosetron)***	2	QL-RS QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
CESAMET CAP 1MG ***(nabilone)***	3	-
dronabinol cap 10MG, 2.5MG, 5MG (MARINOL Equiv)	1	PA
MARINOL CAP 10MG, 2.5MG, 5MG ***(dronabinol)***	3	PA
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS - Drugs to treat nausea and vomiting		
aprepitant pak (EMEND Equiv)	1	QL-RS QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
EMEND CAP 125MG, 40MG, 80MG	1	QL-RS QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
VARUBI TAB 90MG ***(rolapitant hcl)***	2	QL-RS QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
ANTIFUNGALS - Drugs to treat fungal infection		
ANTIFUNGALS - Drugs to treat fungal infection		
ANCOBON CAP 250MG, 500MG ***(flucytosine)***	3	-
flucytosine cap 250MG, 500MG (ANCOBON Equiv)	1	-
GRIFULVIN V TAB ***(griseofulvin microsize)***	3	-
griseofulvin micro tab 500MG (GRIFULVIN V Equiv)	1	-
griseofulvin susp 125MG/5ML (GRIFULVIN Equiv)	1	-
griseofulvin tab 125MG, 250MG (GRIS-PEG Equiv)	1	-
GRIS-PEG TAB 125MG, 250MG ***(griseofulvin ultramicrosize)***	3	-
LAMISIL TAB 250MG ***(terbinafine hcl)***	3	-
nystatin powder	1	-
nystatin tab 500000UNIT	1	-
terbinafine tab 250MG (LAMISIL Equiv)	1	-
IMIDAZOLE-RELATED ANTIFUNGALS - Drugs to treat fungal infections		
DIFLUCAN SUSP 10MG/ML, 40MG/ML ***(fluconazole)***	3	-
DIFLUCAN TAB 100MG, 150MG, 200MG, 50MG ***(fluconazole)***	3	-
fluconazole susp 10MG/ML, 40MG/ML (DIFLUCAN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
fluconazole tab 100MG, 150MG, 200MG, 50MG (DIFLUCAN Equiv)	1	-
itraconazole cap 100MG (SPORANOX Equiv)	1	PA
itraconazole soln 10MG/ML (SPORANOX Equiv)	1	PA
ketoconazole tab 200MG (NIZORAL Equiv)	1	-
NOXAFIL SUSP 40MG/ML ***(posaconazole)***	2	-
NOXAFIL TAB 100MG ***(posaconazole)***	3	-
posaconazole DR tab 100MG (NOXAFIL Equiv)	1	-
SPORANOX CAP 100MG ***(itraconazole)***	3	PA
SPORANOX SOLN 10MG/ML ***(itraconazole)***	3	PA
VFEND SUSP 40MG/ML ***(voriconazole)***	3	RS Restricted to Infectious Disease Specialist
VFEND TAB 200MG, 50MG ***(voriconazole)***	3	RS Restricted to Infectious Disease Specialist
voriconazole susp 40MG/ML (VFEND Equiv)	1	RS Restricted to Infectious Disease Specialist
voriconazole tab 200MG, 50MG (VFEND Equiv)	1	RS Restricted to Infectious Disease Specialist
ANTIHISTAMINES - Drugs to treat allergies		
ANTIHISTAMINES - ALKYLAMINES - Drugs to treat cough, cold, and allergy symptoms		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
chlorpheniramine ER cap	1	-
CPM CAP ***(chlorpheniramine maleate)***	3	-
ANTIHISTAMINES - ETHANOLAMINES - Drugs to treat cough, cold, and allergy symptoms		
CARBINOXAMINE SOLN 4MG/5ML (PALGIC Equiv) ***(carbinoxamine maleate)***	1	-
carbinoxamine soln 4MG/5ML (PALGIC Equiv)	1	-
carbinoxamine tab 4MG (PALGIC Equiv)	1	-
clemastine syrup (TAVIST Equiv)	1	-
diphenhydramine cap 50mg 50MG (BENADRYL Equiv)	1	Only 50mg covered
diphenhydramine inj 50MG/ML (BENADRYL Equiv)	M	-
PALGIC SOLN ***(carbinoxamine maleate)***	3	-
PALGIC TAB ***(carbinoxamine maleate)***	3	-
ANTIHISTAMINES - NON-SEDATING - Drugs to treat cough, cold, and allergy symptoms		
ALLEGRA ODT 30MG ***(fexofenadine hcl)***	EXC	OTC
CLARINEX REDITAB ***(desloratadine)***	EXC	-
CLARINEX SYRUP .5MG/ML ***(desloratadine)***	EXC	-
CLARINEX TAB 5MG ***(desloratadine)***	EXC	-
DESLORATADINE ODT 2.5MG, 5MG ***(desloratadine)***	EXC	-
desloratadine tab 5MG (CLARINEX Equiv)	EXC	-
loratadine cap 10MG (CLARITIN Equiv)	EXC	OTC
ANTIHISTAMINES - PHENOTHIAZINES - Drugs to treat cough, cold, and allergy symptoms		
promethazine supp 12.5MG, 25MG, 50MG (PHENERGAN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
promethazine syrup 6.25MG/5ML	1	-
promethazine tab 12.5MG, 25MG, 50MG (PHENERGAN Equiv)	1	-
PROMETHEGAN SUPP 50MG ***(promethazine hcl)***	1	-
ANTIHISTAMINES - PIPERIDINES - Drugs to treat cough, cold, and allergy symptoms		
cyproheptadine syrup 2MG/5ML	1	-
cyproheptadine tab 4MG	1	-
ANTIHYPERLIPIDEMICS - Drugs to treat high cholesterol		
ANTIHYPERLIPIDEMICS - COMBINATIONS - drugs to treat high cholesterol		
ezetimibe/simvastatin tab 10MG, 10MG-20MG, 10MG-40MG (VYTORIN Equiv)	1	QL QL= 1 tab/day (10-80mg is Not Covered)
LIPTRUZET TAB ***(ezetimibe-atorvastatin)***	3	-
VYTORIN TAB 10MG, 10MG-20MG, 10MG-40MG ***(ezetimibe-simvastatin)***	3	QL QL= 1 tab/day (10/80mg is Not Covered)
ANTIHYPERLIPIDEMICS - MISC. - Miscellaneous anti-hyperlipidemics		
LOVAZA CAP 1GM-375MG-465MG ***(omega-3-acid ethyl esters)***	3	-
omega-3-acid ethyl esters cap 1GM-375MG-465MG (LOVAZA Equiv)	1	-
BILE ACID SEQUESTRANTS - Drugs to treat high cholesterol		
cholestyramine lite powder 4GM/DOSE (QUESTRAN LITE Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
cholestyramine lite powder pack 4GM (QUESTRAN LITE Equiv)	1	-
cholestyramine powder 4GM/DOSE (QUESTRAN Equiv)	1	-
cholestyramine powder pack 4GM (QUESTRAN Equiv)	1	-
colesevelam pack 3.75GM (WELCHOL Equiv)	1	-
colesevelam tab 625MG (WELCHOL Equiv)	1	-
COLESTID GRANULE 5GM ***(colestipol hcl)***	3	-
COLESTID POWDER PACK 5GM, 5GM/7.5GM ***(colestipol hcl)***	3	-
COLESTID TAB 1GM ***(colestipol hcl)***	3	-
colestipol granule 5GM (COLESTID Equiv)	1	-
colestipol powder packet 5GM (COLESTID Equiv)	1	-
colestipol tab 1GM (COLESTID Equiv)	1	-
QUESTRAN LITE POWDER 4GM/DOSE ***(cholestyramine light)***	3	-
QUESTRAN LITE POWDER PACK ***(cholestyramine light)***	3	-
QUESTRAN POWDER 4GM/DOSE ***(cholestyramine)***	3	-
QUESTRAN POWDER PACK 4GM ***(cholestyramine)***	3	-
FIBRIC ACID DERIVATIVES - Drugs to treat high cholesterol		
fenofibrate cap 67mg, 134mg, 200mg 134MG, 200MG, 67MG (LOFIBRA Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
fenofibrate tab 48mg, 54mg, 145mg, 160mg 145MG, 160MG, 48MG, 54MG (TRICOR Equiv)	1	-
fenofibric acid DR cap 135MG, 45MG (TRILIPIX Equiv)	1	-
FENOFIBRIC TAB, FIBRICOR TAB 105MG, 35MG ***(fenofibric acid)***	3	-
gemfibrozil tab 600MG (LOPID Equiv)	1	-
LOPID TAB 600MG ***(gemfibrozil)***	3	-
TRICOR TAB 145MG, 48MG ***(fenofibrate)***	3	-
HMG COA REDUCTASE INHIBITORS - Drugs to treat high cholesterol		
ALTOPREV TAB 20MG, 40MG, 60MG ***(lovastatin)***	3	-
atorvastatin tab 10mg 10MG (LIPITOR Equiv)	$0	-
atorvastatin tab 20mg 20MG (LIPITOR Equiv)	$0	-
atorvastatin tab 40mg 40MG (LIPITOR Equiv)	1	-
atorvastatin tab 80mg 80MG (LIPITOR Equiv)	1	-
CRESTOR TAB 10MG, 40MG, 5MG ***(rosuvastatin calcium)***	3	QL QL= 1 tab/day
CRESTOR TAB 20MG 20MG ***(rosuvastatin calcium)***	3	QL QL= 1.5 tabs/day
fluvastatin ER tab 80MG (LESCOL XL Equiv)	$0	-
LESCOL XL TAB 80MG ***(fluvastatin sodium)***	3	-
LIPITOR TAB 10MG, 20MG, 40MG, 80MG ***(atorvastatin calcium)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
LIVALO TAB 1MG, 2MG, 4MG ***(pitavastatin calcium)***	3	ST Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
lovastatin tab 10MG, 20MG, 40MG (MEVACOR Equiv)	$0	-
MEVACOR TAB ***(lovastatin)***	3	-
PRAVACHOL TAB 20MG, 40MG, 80MG ***(pravastatin sodium)***	3	-
pravastatin tab 10MG, 20MG, 40MG, 80MG (PRAVACHOL Equiv)	$0	-
rosuvastatin tab 10mg 10MG (CRESTOR Equiv)	$0	QL QL= 1 tab/day
rosuvastatin tab 20mg 20MG (CRESTOR Equiv)	1	QL QL= 1.5 tabs/day
rosuvastatin tab 40mg 40MG (CRESTOR Equiv)	1	QL QL= 1 tab/day
rosuvastatin tab 5mg 5MG (CRESTOR Equiv)	$0	QL QL= 1 tab/day
simvastatin tab 10MG, 20MG, 40MG, 5MG (ZOCOR Equiv)	$0	80mg is Not Covered
ZOCOR TAB 10MG, 20MG, 40MG, 5MG ***(simvastatin)***	3	-
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS - Drugs to treat high cholesterol		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ezetimibe tab 10MG (ZETIA Equiv)	1	-
NICOTINIC ACID DERIVATIVES - Drugs to treat high cholesterol		
niacin ER tab 1000MG, 500MG, 750MG (NIASPAN Equiv)	1	-
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS - Drugs to treat high cholesterol		
PRALUENT INJ 150MG/ML, 75MG/ML ***(alirocumab)***	4	LMSP-PA-QL QL= 2 inj/28 days
REPATHA INJ 140MG/ML ***(evolocumab)***	4	LMSP-PA-QL QL= 2 inj/28 days
REPATHA PUSHTRONEX INJ 420MG/3.5ML ***(evolocumab)***	4	LMSP-PA-QL QL= 1 inj/28 days
ANTIHYPERTENSIVES - Drugs to treat high blood pressure		
ACE INHIBITORS - Drugs to treat high blood pressure		
ACCUPRIL TAB 10MG, 20MG, 40MG, 5MG ***(quinapril hcl)***	3	-
ALTACE CAP 1.25MG, 10MG, 2.5MG, 5MG ***(ramipril)***	3	-
ALTACE TAB ***(ramipril)***	3	-
benazepril tab (LOTENSIN Equiv)	1	-
captopril tab 100MG, 12.5MG, 25MG, 50MG (CAPOTEN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
enalapril maleate oral soln 1MG/ML (EPANED Equiv)	1	PA Prior Authorization required for members age 9 or older
enalapril tab 10MG, 2.5MG, 20MG, 5MG (VASOTEC Equiv)	1	-
EPANED SOLN ***(enalapril maleate)***	3	PA
fosinopril tab 10MG, 20MG, 40MG (MONOPRIL Equiv)	1	-
lisinopril tab 10MG, 2.5MG, 20MG, 30MG, 40MG, 5MG (PRINIVIL/ZESTRIL Equiv)	1	-
LOTENSIN TAB 10MG, 20MG, 40MG ***(benazepril hcl)***	3	-
MONOPRIL TAB ***(fosinopril sodium)***	3	-
PRINIVIL TAB, ZESTRIL TAB 10MG, 2.5MG, 20MG, 30MG, 40MG, 5MG ***(lisinopril)***	3	-
QBRELIS SOLN 1MG/ML ***(lisinopril)***	3	PA Prior Authorization required for members age 9 or older
quinapril tab 10MG, 20MG, 40MG, 5MG (ACCUPRIL Equiv)	1	-
ramipril cap 1.25MG, 10MG, 2.5MG, 5MG (ALTACE Equiv)	1	-
VASOTEC TAB 10MG, 2.5MG, 20MG, 5MG ***(enalapril maleate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
AGENTS FOR PHEOCHROMOCYTOMA - Drugs to treat high blood pressure		
DIBENZYLINE CAP 10MG ***(phenoxybenzamine hcl)***	3	LMSP
phenoxybenzamine cap 10MG (DIBENZYLINE Equiv)	1	LMSP
ANGIOTENSIN II RECEPTOR ANTAGONISTS - Drugs to treat high blood pressure		
AVAPRO TAB 150MG, 300MG, 75MG ***(irbesartan)***	3	-
COZAAR TAB 100MG, 25MG, 50MG ***(losartan potassium)***	3	-
DIOVAN TAB 160MG, 320MG, 40MG, 80MG ***(valsartan)***	3	-
EDARBI TAB 40MG, 80MG ***(azilsartan medoxomil)***	3	-
EPROSARTAN TAB 600MG ***(eprosartan mesylate)***	3	-
irbesartan tab 150MG, 300MG, 75MG (AVAPRO Equiv)	1	-
losartan tab 100MG, 25MG, 50MG (COZAAR Equiv)	1	-
MICARDIS TAB 20MG, 40MG, 80MG ***(telmisartan)***	3	-
olmesartan tab 20MG, 40MG, 5MG (BENICAR Equiv)	1	-
telmisartan tab 20MG, 40MG, 80MG (MICARDIS Equiv)	1	-
TEVETEN TAB ***(eprosartan mesylate)***	3	-
valsartan tab 160MG, 320MG, 40MG, 80MG (DIOVAN Equiv)	1	-
ANTIADRENERGIC ANTIHYPERTENSIVES - Drugs to treat high blood pressure		
CARDURA TAB 1MG, 2MG, 4MG, 8MG ***(doxazosin mesylate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CATAPRES TAB .1MG, .2MG, .3MG ***(clonidine hcl)***	3	-
CATAPRES-TTS PATCH .1MG/24HR, .2MG/24HR, .3MG/24HR ***(clonidine)***	3	-
clonidine patch .1MG/24HR, .2MG/24HR, .3MG/24HR (CATAPRES-TTS Equiv)	1	-
clonidine tab (CATAPRES Equiv)	1	-
doxazosin tab 1MG, 2MG, 4MG, 8MG (CARDURA Equiv)	1	-
GUANABENZ TAB ***(guanabenz acetate)***	3	-
guanfacine IR tab 1MG, 2MG (TENEX Equiv)	1	-
HYTRIN CAP ***(terazosin hcl)***	3	-
METHYLDOPA TAB 250MG, 500MG (ALDOMET Equiv) ***(methyldopa)***	1	-
methyldopa tab 250MG, 500MG (ALDOMET Equiv)	1	-
MINIPRESS CAP 1MG, 2MG, 5MG ***(prazosin hcl)***	3	-
NEXICLON XR SUSP ***(clonidine hcl)***	3	-
NEXICLON XR TAB ***(clonidine hcl)***	3	-
prazosin cap 1MG, 2MG, 5MG (MINIPRESS Equiv)	1	-
RESERPINE TAB ***(reserpine)***	3	-
TENEX TAB ***(guanfacine hcl)***	3	-
terazosin cap 10MG, 1MG, 2MG, 5MG (HYTRIN Equiv)	1	-
ANTIHYPERTENSIVE COMBINATIONS - Drugs to treat high blood pressure		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ACCURETIC TAB 10MG-12.5MG, 12.5MG-20MG, 20MG-25MG ***(quinapril-hydrochlorothiazide)***	3	-
amlodipine/benazepril cap 10MG-20MG, 10MG-40MG, 2.5MG-10MG, 5MG-10MG, 5MG-20MG, 5MG-40MG (LOTREL Equiv)	1	-
amlodipine/olmesartan tab 10MG-20MG, 10MG-40MG, 5MG-20MG, 5MG-40MG (AZOR TAB Equiv)	1	-
amlodipine/valsartan tab 10MG-160MG, 10MG-320MG, 5MG-160MG, 5MG-320MG (EXFORGE Equiv)	1	-
amlodipine/valsartan/hydrochlorothiazide tab 10MG-12.5MG-160MG, 10MG-25MG-160MG, 10MG-25MG-320MG, 5MG-12.5MG-160MG, 5MG-25MG-160MG (EXFORGE HCT Equiv)	1	-
AMTURNIDE TAB ***(aliskiren-amlodipine-hydrochlorothiazide)***	3	-
atenolol/chlorthalidone tab 25MG-100MG, 25MG-50MG (TENORETIC Equiv)	1	-
AVALIDE TAB 12.5MG-150MG, 12.5MG-300MG ***(irbesartan-hydrochlorothiazide)***	3	-
AZOR TAB 10MG-20MG, 10MG-40MG, 5MG-20MG, 5MG-40MG ***(amlodipine besylate-olmesartan medoxomil)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
BENAZEPRIL/HCT TAB 5MG-6.25MG ***(benazepril & hydrochlorothiazide)***	1	-
benazepril/hydrochlorothiazide tab 10MG-12.5MG, 12.5MG-20MG, 20MG-25MG, 5MG-6.25MG (LOTENSIN HCT Equiv)	1	-
BENICAR HCT TAB 12.5MG-20MG, 12.5MG-40MG, 25MG-40MG ***(olmesartan medoxomil-hydrochlorothiazide)***	3	-
bisoprolol/hydrochlorothiazide tab 2.5MG-6.25MG, 5MG-6.25MG, 6.25MG-10MG (ZIAC Equiv)	1	-
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB 15MG-25MG, 15MG-50MG, 25MG, 25MG-50MG ***(captopril & hydrochlorothiazide)***	1	-
CORZIDE TAB 5MG-40MG ***(nadolol & bendroflumethiazide)***	3	-
CORZIDE TAB 80-5MG 5MG-40MG, 5MG-80MG ***(nadolol & bendroflumethiazide)***	3	-
DIOVAN HCT TAB 12.5MG-160MG, 12.5MG-320MG, 12.5MG-80MG, 25MG-160MG, 25MG-320MG ***(valsartan-hydrochlorothiazide)***	3	-
EDARBYCLOR TAB 12.5MG-40MG, 25MG-40MG ***(azilsartan medoxomil-chlorthalidone)***	3	-
enalapril/hydrochlorothiazide tab 10MG-25MG, 5MG-12.5MG (VASERETIC Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
EXFORGE HCT TAB 10MG-12.5MG-160MG, 10MG-25MG-160MG, 10MG-25MG-320MG, 5MG-12.5MG-160MG, 5MG-25MG-160MG ***(amlodipine-valsartan-hydrochlorothiazide)***	3	-
EXFORGE TAB 10MG-160MG, 10MG-320MG, 5MG-160MG, 5MG-320MG ***(amlodipine besylate-valsartan)***	3	-
fosinopril/hydrochlorothiazide tab 10MG-12.5MG, 12.5MG-20MG (MONOPRIL HCT Equiv)	1	-
HYZAAR TAB 12.5MG-100MG, 12.5MG-50MG, 25MG-100MG ***(losartan potassium & hydrochlorothiazide)***	3	-
irbesartan/hydrochlorothiazide tab 12.5MG-150MG, 12.5MG-300MG (AVALIDE Equiv)	1	-
lisinopril/hydrochlorothiazide tab 10MG-12.5MG, 12.5MG-20MG, 20MG-25MG (ZESTORETIC Equiv)	1	-
LOPRESSOR HCT TAB 25MG-50MG ***(metoprolol & hydrochlorothiazide)***	3	-
losartan/hydrochlorothiazide tab 12.5MG-100MG, 12.5MG-50MG, 25MG-100MG (HYZAAR Equiv)	1	-
LOTENSIN HCT TAB 10MG-12.5MG, 12.5MG-20MG, 20MG-25MG ***(benazepril & hydrochlorothiazide)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
LOTREL CAP 10MG-20MG, 10MG-40MG, 5MG-10MG, 5MG-20MG ***(amlodipine besylate-benazepril hcl)***	3	-
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB 15MG-250MG, 25MG-250MG ***(methyldopa & hydrochlorothiazide)***	1	-
METOPROLOL/HYDROCHLOROTHIAZIDE TAB 50MG-100MG ***(metoprolol & hydrochlorothiazide)***	1	-
metoprolol/hydrochlorothiazide tab 25MG-100MG, 25MG-50MG	1	-
MONOPRIL HCT TAB ***(fosinopril sodium & hydrochlorothiazide)***	3	-
nadolol/bendroflumethiazide tab (CORZIDE Equiv)	1	-
olmesartan/hydrochlorothiazide tab 12.5MG-20MG, 12.5MG-40MG, 25MG-40MG (BENICAR HCT Equiv)	1	-
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB 25MG-40MG, 25MG-80MG ***(propranolol & hydrochlorothiazide)***	1	-
quinapril/hydrochlorothiazide tab 10MG-12.5MG, 12.5MG-20MG, 20MG-25MG (ACCURETIC Equiv)	1	-
TEKAMLO TAB ***(aliskiren-amlodipine)***	3	-
TEKTURNA HCT TAB 12.5MG-150MG, 12.5MG-300MG, 25MG-150MG, 25MG-300MG ***(aliskiren-hydrochlorothiazide)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TENORETIC TAB 25MG-100MG, 25MG-50MG ***(atenolol & chlorthalidone)***	3	-
TEVETEN HCT TAB ***(eprosartan mesylate-hydrochlorothiazide)***	3	-
valsartan/hydrochlorothiazide tab 12.5MG-160MG, 12.5MG-320MG, 12.5MG-80MG, 25MG-160MG, 25MG-320MG (DIOVAN HCT Equiv)	1	-
VALTURNA TAB ***(aliskiren-valsartan)***	3	-
VASERETIC TAB 10MG-25MG ***(enalapril maleate & hydrochlorothiazide)***	3	-
ZESTORETIC TAB 10MG-12.5MG, 12.5MG-20MG, 20MG-25MG ***(lisinopril & hydrochlorothiazide)***	3	-
ZIAC TAB 2.5MG-6.25MG, 5MG-6.25MG, 6.25MG-10MG ***(bisoprolol & hydrochlorothiazide)***	3	-
DIRECT RENIN INHIBITORS - Drugs to treat high blood pressure		
aliskiren tab 150MG, 300MG (TEKTURNA Equiv)	1	-
TEKTURNA TAB 150MG, 300MG ***(aliskiren fumarate)***	3	-
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS) - Drugs to treat high blood pressure		
eplerenone tab 25MG, 50MG (INSPRA Equiv)	1	-
INSPRA TAB 25MG, 50MG ***(eplerenone)***	3	-
VASODILATORS - Drugs to treat high blood pressure		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
hydralazine tab 100MG, 10MG, 25MG, 50MG (APRESOLINE Equiv)	1	-
minoxidil tab 10MG, 2.5MG (LONITEN Equiv)	1	-
ANTI-INFECTIVE AGENTS - MISC. - Miscellaneous anti-infective drugs		
ANTI-INFECTIVE AGENTS - MISC. - Miscellaneous anti-infective drugs		
FIRST METRONIDAZOLE SUSP 100MG/ML, 50MG/ML ***(metronidazole benzoate)***	3	-
FLAGYL ER TAB ***(metronidazole)***	3	-
FLAGYL TAB 250MG, 500MG ***(metronidazole)***	3	-
IMPAVIDO CAP 50MG ***(miltefosine)***	4	PA
metronidazole tab 250MG, 500MG (FLAGYL Equiv)	1	-
pentamidine neb soln 300MG (NEBUPENT Equiv)	1	LMSP
PRIMSOL SOLN 50MG/5ML ***(trimethoprim hcl)***	3	-
PRIMSOL SOLN 50MG/5ML ***(trimethoprim hcl)***	3	-
TINDAMAX TAB 500MG ***(tinidazole)***	3	-
tinidazole tab 250MG, 500MG (TINDAMAX Equiv)	1	-
TRIMETHOPRIM TAB 100MG ***(trimethoprim)***	1	-
trimethoprim tab 100MG	1	-
XIFAXAN TAB 200MG 200MG ***(rifaximin)***	3	QL QL= 9 tabs/3 days
XIFAXAN TAB 550MG 550MG ***(rifaximin)***	3	PA-QL QL= 2 tabs/day
ANTI-INFECTIVE MISC. - COMBINATIONS - Miscellaneous anti-infective drug combinations		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
BACTRIM DS TAB 160MG-800MG, 80MG-400MG ***(sulfamethoxazole-trimethoprim)***	3	-
erythromycin/sulfisoxazole susp (PEDIAZOLE Equiv)	1	-
PEDIAZOLE SUSP ***(erythromycin-sulfisoxazole)***	3	-
smz/tmp (DS) tab 160MG-800MG, 80MG-400MG (BACTRIM DS Equiv)	1	-
smz/tmp susp 40MG/5ML-200MG/5ML (BACTRIM, SEPTRA Equiv)	1	-
ANTIPROTOZOAL AGENTS - Drugs to treat protozoan infections		
ALINIA SUSP 100MG/5ML ***(nitazoxanide)***	2	PA-QL QL= 60ml/3 days
ALINIA TAB 500MG ***(nitazoxanide)***	3	PA-QL QL= 6 tabs/3 days
atovaquone susp 750MG/5ML (MEPRON Equiv)	1	-
LAMPIT TAB 120MG, 30MG ***(nifurtimox)***	2	PA
MEPRON SUSP 750MG/5ML ***(atovaquone)***	3	-
nitazoxanide tab 500MG (ALINIA Equiv)	1	PA-QL QL= 6 tabs/3 days
CARBAPENEMS - Drugs to treat bacterial infections		
DORIBAX INJ ***(doripenem)***	M	M
DORIPENEM INJ 250MG, 500MG ***(doripenem)***	M	M
ertapenem inj 1GM (INVANZ Equiv)	M	M
INVANZ INJ 1GM ***(ertapenem sodium)***	M	M
INVANZ INJ 1GM ***(ertapenem sodium)***	M	M

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
meropenem inj 1GM, 500MG (MERREM Equiv)	M	M
GLYCOPEPTIDES - Drugs to treat bacterial infections		
FIRST-VANCOMYCIN SOLN 25MG/ML, 50MG/ML ***(vancomycin hcl)***	1	-
FIRVANQ SOLN 25MG/ML, 50MG/ML ***(vancomycin hcl)***	1	-
VANCOCIN CAP 125MG, 250MG ***(vancomycin hcl)***	3	QL QL= 56 caps/fill
vancomycin cap 125MG, 250MG (VANCOCIN Equiv)	1	QL QL= 56 caps/fill
LEPROSTATICS - Drugs to treat Leprosy (bacterial infections)		
dapsone tab 100MG, 25MG	1	-
LINCOSAMIDES - Drugs to treat bacterial infections		
CLEOCIN CAP 150MG, 300MG, 75MG ***(clindamycin hcl)***	3	-
CLEOCIN SOLN 75MG/5ML ***(clindamycin palmitate hydrochloride)***	3	-
clindamycin cap 150MG, 300MG, 75MG (CLEOCIN Equiv)	1	-
clindamycin soln 75MG/5ML (CLEOCIN Equiv)	1	-
MONOBACTAMS - Drugs to treat bacterial infections		
CAYSTON INH SOLN 75MG ***(aztreonam lysine)***	4	KMSP-RS
OXAZOLIDINONES - Drugs to treat bacterial infections		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
linezolid susp 100MG/5ML (ZYVOX Equiv)	1	RS Restricted to Infectious Disease Specialist
linezolid tab 600MG (ZYVOX Equiv)	1	RS Restricted to Infectious Disease Specialist
SIVEXTRO TAB 200MG ***(tedizolid phosphate)***	2	QL-RS QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
ZYVOX SUSP 100MG/5ML ***(linezolid)***	3	RS Restricted to Infectious Disease Specialist
ZYVOX TAB 600MG ***(linezolid)***	3	RS Restricted to Infectious Disease Specialist
PLEUROMUTILINS - drugs to treat infections		
XENLETA TAB 600MG ***(lefamulin acetate)***	2	QL-RS QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist
URINARY ANTI-INFECTIVES - Drugs to treat bladder/kidney infections		
HIPREX TAB 1GM ***(methenamine hippurate)***	3	-
MACROBID CAP 100MG ***(nitrofurantoin monohyd macro)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
MACRODANTIN CAP 100MG, 50MG ***(nitrofurantoin macrocrystal)***	3	-
methenamine hippurate tab 1GM (HIPREX Equiv)	1	-
nitrofurantoin macrocrystals cap 100MG, 50MG (MACRODANTIN Equiv)	1	-
nitrofurantoin monohydrate cap 100MG (MACROBID Equiv)	1	-
ANTIMALARIALS - Drugs to treat malaria (parasitic infections)		
ANTIMALARIAL COMBINATIONS - Drugs to treat malaria (parasitic infections)		
atovaquone/proguanil tab 100MG-250MG, 25MG-62.5MG (MALARONE Equiv)	1	-
COARTEM TAB 20MG-120MG ***(artemether-lumefantrine)***	3	-
FANSIDAR TAB ***(sulfadoxine & pyrimethamine)***	3	-
MALARONE TAB 100MG-250MG, 25MG-62.5MG ***(atovaquone-proguanil hcl)***	3	-
ANTIMALARIALS - Drugs to treat malaria (parasitic infections)		
ARALEN TAB ***(chloroquine phosphate)***	3	-
CHLOROQUINE TAB 500MG ***(chloroquine phosphate)***	2	-
chloroquine tab 250MG, 500MG (ARALEN Equiv)	1	-
hydroxychloroquine tab 200MG (PLAQUENIL Equiv)	1	-
HYDROXYCHLOROQUINE TAB 100MG 100MG ***(hydroxychloroquine sulfate)***	2	QL QL= 1 tab/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
KRINTAFEL TAB 150MG ***(tafenoquine succinate)***	2	-
LARIAM TAB ***(mefloquine hcl)***	3	-
mefloquine tab 250MG (LARIAM Equiv)	1	-
PLAQUENIL TAB 200MG ***(hydroxychloroquine sulfate)***	3	-
PRIMAQUINE TAB 26.3MG ***(primaquine phosphate)***	3	-
primaquine tab 26.3MG (PRIMAQUINE Equiv)	1	-
pyrimethamine tab 25MG (DARAPRIM Equiv)	4	LD-PA-QL QL= 3 tabs/day; Only available through Walgreens 888-347-3416
QUALAQUIN CAP 324MG ***(quinine sulfate)***	3	-
quinine sulfate cap 324MG (QUALAQUIN Equiv)	1	-
ANTIMYASTHENIC/CHOLINERGIC AGENTS - Drugs to treat neurological disorders		
ANTIMYASTHENIC/CHOLINERGIC AGENTS - Drugs to treat neurological disorders		
GUANIDINE TAB 125MG ***(guanidine hcl)***	3	-
MESTINON TAB 60MG ***(pyridostigmine bromide)***	3	-
MESTINON TIMESPAN TAB 180MG ***(pyridostigmine bromide)***	3	-
MYTELASE TAB ***(ambenonium chloride)***	3	-
PROSTIGMIN TAB ***(neostigmine bromide)***	2	-
pyridostigmine CR tab 180MG (MESTINON Equiv)	1	-
pyridostigmine tab 60MG (MESTINON Equiv)	1	-
pyridstigmine soln 60MG/5ML (MESTINON Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
RUZURGI TAB 10MG ***(amifampridine)***	4	LD-PA Only available through PantheRx Pharmacy 855-726-8479
ANTIMYCOBACTERIAL AGENTS - Drugs to treat Tuberculosis (bacterial infections)		
ANTI TB COMBINATIONS - Drugs to treat Tuberculosis (bacterial infections)		
RIFAMATE CAP 150MG-300MG ***(isoniazid & rifampin)***	2	-
RIFATER TAB 50MG-120MG-300MG ***(isoniazid-rifampin w/ pyrazinamide)***	3	PA
ANTIMYCOBACTERIAL AGENTS - Drugs to treat Tuberculosis (bacterial infections)		
ethambutol tab 100MG, 400MG (MYAMBUTOL Equiv)	1	-
ISONIAZID SYRUP 50MG/5ML ***(isoniazid)***	1	-
ISONIAZID TAB 100MG ***(isoniazid)***	1	-
isoniazid tab 100MG, 300MG	1	-
MYAMBUTOL TAB 100MG, 400MG ***(ethambutol hcl)***	3	-
MYCOBUTIN CAP 150MG ***(rifabutin)***	3	-
PRETOMANID TAB 200MG ***(pretomanid)***	2	QL-RS QL= 1 tab/day; Restricted to Infectious Disease Specialist
PRIFTIN TAB 150MG ***(rifapentine)***	2	-
pyrazinamide tab 500MG	1	-
rifabutin cap 150MG (MYCOBUTIN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
RIFADIN CAP 150MG, 300MG ***(rifampin)***	3	-
rifampin cap 150MG, 300MG (RIFADIN Equiv)	1	-
TRECATOR TAB 250MG ***(ethionamide)***	3	PA
ANTINEOPLASTICS - Drugs to treat cancer		
ANTINEOPLASTICS MISC. - Miscellaneous drugs to treat cancer		
tretinoin cap 10MG (VESANOID Equiv)	4	LMSP-ONC
TOPOISOMERASE I INHIBITORS - Drugs to treat cancer		
HYCAMTIN CAP .25MG, 1MG ***(topotecan hcl)***	4	LMSP-ONC-PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - Drugs to treat cancer		
ALKYLATING AGENTS - Drugs to treat cancer		
ALKERAN TAB 2MG ***(melphalan)***	3	LMSP-ONC
busulfan inj 6MG/ML	M	M
BUSULFEX INJ ***(busulfan)***	M	M
BUSULFEX INJ 6MG/ML ***(busulfan)***	M	M
CYCLOPHOSPHAMIDE CAP 25MG, 50MG ***(cyclophosphamide)***	3	ONC
cyclophosphamide cap 25MG, 50MG	1	ONC
CYCLOPHOSPHAMIDE TAB 25MG, 50MG ***(cyclophosphamide)***	2	-
GLEOSTINE/LOMUSTINE CAP 100MG, 10MG, 40MG, 5MG ***(lomustine)***	2	ONC
HEXALEN CAP 50MG ***(altretamine)***	4	LMSP-ONC
LEUKERAN TAB 2MG ***(chlorambucil)***	4	LMSP-ONC
melphalan inj 50MG (ALKERAN Equiv)	M	M

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
melphalan tab 2MG (ALKERAN Equiv)	1	LMSP-ONC
MYLERAN TAB 2MG ***(busulfan)***	4	LMSP-ONC
temozolomide cap 100MG, 140MG, 180MG, 20MG, 250MG, 5MG (TEMODAR Equiv)	4	LMSP-ONC
ZANOSAR INJ 1GM ***(streptozocin)***	M	M
ANTIMETABOLITES - Drugs to treat cancer		
capecitabine tab 150MG, 500MG (XELODA Equiv)	4	LMSP-ONC
mercaptopurine tab 50MG (PURINETHOL Equiv)	1	ONC
methotrexate inj 1GM/40ML, 250MG/10ML, 50MG/2ML	1	-
methotrexate tab 2.5MG (TREXALL Equiv)	1	ONC
PURINETHOL TAB ***(mercaptopurine)***	3	ONC
TABLOID TAB 40MG ***(thioguanine)***	2	ONC
XATMEP SOLN 2.5MG/ML ***(methotrexate)***	3	PA Prior Authorization required for members age 9 or older
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS - Drugs to treat cancer		
INLYTA TAB 1MG, 5MG ***(axitinib)***	4	KMSP-ONC-PA-QL-SF QL= 8 tabs/day
LENVIMA CAP 10MG, 4MG ***(lenvatinib mesylate)***	4	LD-ONC-PA-QL QL= 3 caps/day; Only available through Accredo 800-803-2523
ANTINEOPLASTIC - ANTIBODIES - Drugs to treat cancer		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
RITUXAN INJ 100MG/10ML, 500MG/50ML ***(rituximab)***	M	M
ANTINEOPLASTIC - ANTI-HER2 AGENTS - Drugs to treat cancer		
TUKYSA TAB 150MG, 50MG ***(tucatinib)***	4	LD-PA-QL-SF QL= 4 tabs/day; Only available through Biologics 800-850-4306
ANTINEOPLASTIC - BCL-2 INHIBITORS - Drugs to treat cancer		
VENCLEXTA STARTER PACK ***(venetoclax)***	4	LD-ONC-PA Only available through Diplomat Pharmacy 877-977-9118
VENCLEXTA TAB 100MG, 10MG, 50MG ***(venetoclax)***	4	LD-ONC-PA Only available through Diplomat Pharmacy 877-977-9118
ANTINEOPLASTIC - EGFR INHIBITORS - Drugs to treat cancer		
erlotinib tab 100MG, 150MG, 25MG (TARCEVA Equiv)	4	LMSP-ONC-PA-SF
GILOTRIF TAB 20MG, 30MG, 40MG ***(afatinib dimaleate)***	4	LD-ONC-PA-QL QL= 1 tab/day; Only available through Accredo 800-803-2523
IRESSA TAB 250MG ***(gefitinib)***	4	LD-ONC-PA Only available through Diplomat Pharmacy 877-977-9118

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TAGRISSO TAB 40MG, 80MG ***(osimertinib mesylate)***	4	LD-ONC-PA-QL-SF QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
VIZIMPRO TAB 15MG, 30MG, 45MG ***(dacomitinib)***	4	KMSP-ONC-PA-QL-SF QL= 1 tab/day
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS - Drugs to treat cancer		
ERIVEDGE CAP 150MG ***(vismodegib)***	4	LD-ONC-PA-SF Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566
ODOMZO CAP 200MG ***(sonidegib phosphate)***	4	LMSP-ONC-PA-SF
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS - Drugs to treat cancer		
abiraterone tab 250mg 250MG (ZYTIGA Equiv)	1	LMSP-ONC-QL QL= 4 tabs/day
anastrozole tab 1MG (ARIMIDEX Equiv)	$0	ONC Covered at $0 for women 35 years or older; All other members covered at generic copay
ARIMIDEX TAB 1MG ***(anastrozole)***	3	ONC
AROMASIN TAB 25MG ***(exemestane)***	3	ONC
bicalutamide tab 50MG (CASODEX Equiv)	1	ONC
CASODEX TAB 50MG ***(bicalutamide)***	3	ONC

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated 1/3/2022

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
EMCYT CAP 140MG ***(estramustine phosphate sodium)***	2	ONC
ERLEADA TAB 60MG ***(apalutamide)***	4	LMSP-ONC-PA-QL QL= 4 tabs/day
exemestane tab 25MG (AROMASIN Equiv)	$0	ONC Covered at $0 for women 35 years or older; All other members covered at generic copay
FARESTON TAB 60MG ***(toremifene citrate)***	3	ONC
FEMARA TAB 2.5MG ***(letrozole)***	3	ONC
FLUTAMIDE CAP 125MG ***(flutamide)***	2	ONC
flutamide cap 125MG (EULEXIN Equiv)	1	ONC
letrozole tab 2.5MG (FEMARA Equiv)	1	ONC
leuprolide inj 1MG/0.2ML (LUPRON Equiv)	M	M
LUPRON DEPOT INJ 3.75MG, 7.5MG ***(leuprolide acetate)***	M	M
LYSODREN TAB 500MG ***(mitotane)***	4	LD-ONC Only available through Walgreens 888-347-3416
MEGACE SUSP ***(megestrol acetate)***	3	ONC
megestrol susp 400MG/10ML, 40MG/ML (MEGACE Equiv)	1	ONC
megestrol tab 20MG, 40MG (MEGACE Equiv)	1	ONC
nilutamide tab 150MG (NILANDRON Equiv)	4	LMSP-ONC

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NUBEQA TAB 300MG ***(darolutamide)***	4	MSP-PA-QL-SF QL= 4 tabs/day
ORGOVYX TAB 120MG ***(relugolix)***	4	LD-PA-QL QL= 30 tabs/28 days; Only available through Biologics 800-850-4306 or US Bioservices 888-518-7246
tamoxifen tab 10MG, 20MG (NOLVADEX Equiv)	$0	ONC Covered at $0 for women 35 years or older; All other members covered at generic copay
toremifene tab 60MG (FARESTON Equiv)	1	ONC
TRELSTAR INJ 11.25MG, 22.5MG, 3.75MG ***(triptorelin pamoate)***	M	M
ANTINEOPLASTIC - IMMUNOMODULATORS - Drugs to treat cancer		
POMALYST CAP 1MG, 2MG, 3MG, 4MG ***(pomalidomide)***	4	KMSP-PA-QL QL= 21 caps/28 days
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS - Drugs to treat cancer		
AYVAKIT TAB 100MG, 200MG, 25MG, 300MG, 50MG ***(avapritinib)***	4	LD-PA-QL-SF QL= 1 tab/day; Only available through Biologics 800-850-4306
ANTINEOPLASTIC - XPO1 INHIBITORS - Drugs to treat cancer		
XPOVIO PAK 20MG, 40MG, 50MG, 60MG ***(selinexor)***	4	LD-PA-QL-SF QL= 32 tabs/28 days; Only available through Biologics 800-850-4306

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ANTINEOPLASTIC COMBINATIONS - Drugs to treat cancer		
INQOVI TAB 35MG-100MG ***(decitabine-cedazuridine)***	4	LD-PA-QL QL= 5 tabs/28 days; Only available through Walgreens 888-347-3416
LONSURF TAB 6.14MG-15MG, 8.19MG-20MG ***(trifluridine-tipiracil)***	4	LD-ONC-PA Only available through Walgreens 888-347-3416
ANTINEOPLASTIC ENZYME INHIBITORS - Drugs to treat cancer		
ALECENSA CAP 150MG ***(alectinib hcl)***	4	LMSP-ONC-PA-QL QL= 8 caps/day
ALUNBRIG TAB 30MG 30MG ***(brigatinib)***	4	LD-ONC-PA-QL-SF QL= 4 tabs/day; Only available through Biologics 800-850-4306
ALUNBRIG TAB 90MG, 180MG 180MG, 90MG ***(brigatinib)***	4	LD-ONC-PA-QL-SF QL= 1 tab/day; Only available through Biologics 800-850-4306
BALVERSA TAB 3MG 3MG ***(erdafitinib)***	4	LD-ONC-PA-QL-SF QL= 3 tabs/day; Only available through US Bioservices 888-518-7246
BALVERSA TAB 4MG 4MG ***(erdafitinib)***	4	LD-ONC-PA-QL-SF QL= 2 tabs/day; Only available through US Bioservices 888-518-7246
BALVERSA TAB 5MG 5MG ***(erdafitinib)***	4	LD-ONC-PA-QL-SF QL= 1 tab/day; Only available through US Bioservices 888-518-7246

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
BOSULIF TAB 100MG, 400MG, 500MG ***(bosutinib)***	4	KMSP-ONC-PA-SF
BRAFTOVI CAP 75MG 75MG ***(encorafenib)***	4	LD-ONC-PA-QL QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118
BRUKINSA CAP 80MG ***(zanubrutinib)***	4	LD-PA-QL-SF QL= 4 caps/day; Only available through Biologics 800-850-4306
CABOMETYX TAB 20MG, 40MG, 60MG ***(cabozantinib s-malate)***	4	MSP-ONC-PA-QL-SF QL= 1 tab/day
CALQUENCE CAP 100MG ***(acalabrutinib)***	4	LD-ONC-PA-QL-SF QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
CAPRELSA TAB 100MG, 300MG ***(vandetanib)***	4	LD-ONC-PA Only available through Biologics 800-850-4306
COMETRIQ KIT 20MG ***(cabozantinib s-malate)***	4	LD-ONC-PA Only available through Diplomat Pharmacy 877-977-9118
COPIKTRA CAP 15MG, 25MG ***(duvelisib)***	4	LD-ONC-PA-QL QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
COTELLIC TAB 20MG ***(cobimetinib fumarate)***	4	MSP-ONC-PA-QL QL= 3 tabs/day
everolimus tab 10MG, 2.5MG, 7.5MG (AFINITOR Equiv)	4	LMSP-ONC-PA-QL-SF QL= 1 tab/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
everolimus tab 5mg 5MG (AFINITOR Equiv)	4	LMSP-ONC-PA-QL-SF QL= 2 tabs/day
everolimus tab for oral susp 2MG, 3MG, 5MG (AFINITOR DISPERZ Equiv)	4	LMSP-ONC-PA-QL-SF QL= 1 tab/day
FARYDAK CAP 10MG, 15MG, 20MG ***(panobinostat lactate)***	4	MSP-ONC-PA-QL QL= 6 caps/21 days
FOTIVDA CAP .89MG, 1.34MG ***(tivozanib hcl)***	4	LD-PA-QL QL= 21 caps/28 days; Only available through Biologics 800-850-4306
GAVRETO CAP 100MG ***(pralsetinib)***	4	LD-PA-QL-SF QL= 4 caps/day; Only available through Biologics 800-850-4306
IBRANCE CAP 100MG, 125MG, 75MG ***(palbociclib)***	4	KMSP-ONC-PA-QL QL= 21 caps/28 days
IBRANCE TAB 100MG, 125MG, 75MG ***(palbociclib)***	4	KMSP-ONC-PA-QL QL= 21 caps/28 days
ICLUSIG TAB 10MG, 15MG, 30MG, 45MG ***(ponatinib hcl)***	4	LD-ONC-PA-QL-SF QL= 1 tab/day; Only available through AcariaHealth 800-511-5144
IDHIFA TAB 100MG, 50MG ***(enasidenib mesylate)***	4	MSP-ONC-PA-QL QL= 1 tab/day
imatinib tab 100MG, 400MG (GLEEVEC Equiv)	4	LMSP-ONC-PA-QL QL= 3 tabs/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
IMBRUVICA CAP 140MG 140MG ***(ibrutinib)***	4	LD-ONC-PA-QL QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA CAP 70MG 70MG ***(ibrutinib)***	4	LD-ONC-PA-QL QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA TAB 420MG, 560MG 420MG, 560MG ***(ibrutinib)***	4	LD-ONC-PA-QL QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
JAKAFI TAB 10MG, 15MG, 20MG, 25MG, 5MG ***(ruxolitinib phosphate)***	4	MSP-ONC-PA-QL-SF QL= 2 tabs/day
KOSELUGO CAP 10MG, 25MG ***(selumetinib sulfate)***	4	LD-PA-QL QL= 4 caps/day; Only available through Onco360 877-662-6633
lapatinib ditosylate tab 250MG (TYKERB Equiv)	4	LMSP-ONC-PA
LORBRENA TAB 100MG 100MG ***(lorlatinib)***	4	KMSP-ONC-PA-QL-SF QL= 1 tab/day
LORBRENA TAB 25MG 25MG ***(lorlatinib)***	4	KMSP-ONC-PA-QL-SF QL= 3 tabs/day
LUMAKRAS TAB 120MG ***(sotorasib)***	4	LD-PA-QL-SF QL= 8 tabs/day; Only available through Biologics 800-850-4306
LYNPARZA CAP 50MG ***(olaparib)***	4	LD-ONC-PA-QL-SF Only available through Biologics 800-850-4306, QL= 16 caps/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
LYNPARZA TAB 100MG, 150MG ***(olaparib)***	4	LD-ONC-PA-QL-SF Only available through Biologics 800-850-4306, QL= 4 tabs/day
MEKINIST TAB 0.5MG .5MG ***(trametinib dimethyl sulfoxide)***	4	LMSP-ONC-PA-QL QL= 3 tabs/day
MEKINIST TAB 2MG 2MG ***(trametinib dimethyl sulfoxide)***	4	LMSP-ONC-PA-QL QL= 1 tab/day
MEKTOVI TAB 15MG ***(binimetinib)***	4	LD-ONC-PA-QL QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
NERLYNX TAB 40MG ***(neratinib maleate)***	4	LD-ONC-PA-QL-SF QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
NEXAVAR TAB 200MG ***(sorafenib tosylate)***	4	MSP-ONC-PA-SF
NINLARO CAP 2.3MG, 3MG, 4MG ***(ixazomib citrate)***	4	LD-PA Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566
PEMAZYRE TAB 13.5MG, 4.5MG, 9MG ***(pemigatinib)***	4	LD-PA-QL QL= 14 tabs/21 days; Only available through Biologics 800-850-4306
PIQRAY TAB 150MG, 200MG ***(alpelisib)***	4	LMSP-PA-SF

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
QINLOCK TAB 50MG ***(ripretinib)***	4	LD-PA-QL QL= 3 tabs/day; Only available through Biologics 800-850-4306
RETEVMO CAP 40MG, 80MG ***(selpercatinib)***	4	LMSP-PA-QL-SF QL= 4 caps/day
ROZLYTREK CAP 100MG, 200MG ***(entrectinib)***	4	MSP-PA-QL-SF QL= 3 caps/day
RUBRACA TAB 200MG, 250MG, 300MG ***(rucaparib camsylate)***	4	LD-ONC-PA-QL-SF QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779
RYDAPT CAP 25MG ***(midostaurin)***	4	LMSP-ONC-PA
SPRYCEL TAB 100MG, 140MG, 20MG, 50MG, 70MG, 80MG ***(dasatinib)***	3	LMSP-ONC-PA-SF
STIVARGA TAB 40MG ***(regorafenib)***	4	MSP-ONC-PA-QL-SF QL= 4 tabs/day
sunitinib malate cap 12.5MG, 25MG, 37.5MG, 50MG (SUTENT Equiv)	4	LMSP-ONC-PA-SF
TABRECTA TAB 150MG, 200MG ***(capmatinib hcl)***	4	LMSP-PA-QL-SF QL= 4 tabs/day
TAFINLAR CAP 50MG, 75MG ***(dabrafenib mesylate)***	4	LMSP-ONC-PA-QL QL= 4 caps/day
TALZENNA CAP 0.25MG .25MG ***(talazoparib tosylate)***	4	KMSP-ONC-PA-QL-SF QL= 3 caps/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TALZENNA CAP 1MG 1MG ***(talazoparib tosylate)***	4	KMSP-ONC-PA-QL-SF QL= 1 cap/day
TASIGNA CAP 150MG, 200MG, 50MG ***(nilotinib hcl)***	4	LMSP-ONC-PA-SF
TAZVERIK TAB 200MG ***(tazemetostat hbr)***	4	LD-PA-QL QL= 8 tabs/day; Only available through Onco360 877-662-6633
TEPMETKO TAB 225MG ***(tepotinib hcl)***	4	LD-PA-QL-SF QL= 2 tabs/day; Only available through Biologics 800-850-4306
TIBSOVO TAB 250MG ***(ivosidenib)***	4	LD-ONC-PA-QL QL= 2 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
TRUSELTIQ PACK 100MG 100MG ***(infigratinib phosphate)***	4	LD-PA-QL QL= 21 caps/28 days; Only available through Biologics 800-850-4306
TRUSELTIQ PACK 50MG, 125MG 25MG ***(infigratinib phosphate)***	4	LD-PA-QL QL= 42 caps/28 days; Only available through Biologics 800-850-4306
TRUSELTIQ PACK 75MG 25MG ***(infigratinib phosphate)***	4	LD-PA-QL QL= 63 caps/28 days; Only available through Biologics 800-850-4306
TURALIO CAP 200MG ***(pexidartinib hcl)***	4	LD-PA-QL-SF QL= 4 caps/day; Only available through Biologics 800-850-4306

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
UKONIQ TAB 200MG ***(umbralisib tosylate)***	4	LD-PA-QL-SF QL= 4 tabs/day; Only available through Onco360 877-662-6633
VERZENIO TAB 100MG, 150MG, 200MG, 50MG ***(abemaciclib)***	4	LMSP-ONC-PA-QL-SF QL= 2 tabs/day
VITRAKVI CAP 100MG 100MG ***(larotrectinib sulfate)***	4	LD-ONC-PA-QL-SF QL= 2 caps/day; Only available through US Bioservices 888-518-7246
VITRAKVI CAP 25MG 25MG ***(larotrectinib sulfate)***	4	LD-ONC-PA-QL-SF QL= 6 caps/day; Only available through US Bioservices 888-518-7246
VITRAKVI SOLN 20MG/ML ***(larotrectinib sulfate)***	4	LD-ONC-PA-QL-SF QL= 10ml/day; Only available through US Bioservices 888-518-7246
VOTRIENT TAB 200MG ***(pazopanib hcl)***	4	LMSP-ONC-PA-SF
XALKORI CAP 200MG, 250MG ***(crizotinib)***	4	KMSP-ONC-PA-QL-SF QL= 2 caps/day
XOSPATA TAB 40MG ***(gilteritinib fumarate)***	4	LD-ONC-PA-QL-SF QL= 3 tabs/day; Only available through Biologics 800-850-4306
ZEJULA CAP 100MG ***(niraparib tosylate)***	4	LD-ONC-PA-QL-SF QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
ZELBORAF TAB 240MG ***(vemurafenib)***	4	MSP-ONC-PA-QL
ZOLINZA CAP 100MG ***(vorinostat)***	4	LMSP-ONC-PA-SF

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ZYDELIG TAB 100MG, 150MG ***(idelalisib)***	4	LD-ONC-PA Only available through Diplomat Pharmacy 877-977-9118
ZYKADIA CAP 150MG ***(ceritinib)***	4	LMSP-ONC-PA-QL-SF QL= 3 caps/day
ZYKADIA TAB 150MG ***(ceritinib)***	4	LMSP-ONC-PA-QL-SF QL= 3 tabs/day
ANTINEOPLASTICS MISC. - Miscellaneous drugs to treat cancer		
ACTIMMUNE INJ 2000000UNIT/0.5ML ***(interferon gamma-1b)***	4	LD-PA Only available through Walgreens 888-347-3416
ALFERON-N INJ 5MU/ML ***(interferon alfa-n3)***	4	LMSP
bexarotene cap 75MG (TARGRETIN Equiv)	4	LMSP-ONC-PA-SF
HYDREA CAP 500MG ***(hydroxyurea)***	3	ONC
hydroxyurea cap 500MG (HYDREA Equiv)	1	ONC
INTRON-A INJ 10MU/ML, 6000000UNIT/ML ***(interferon alfa-2b)***	4	KMSP
MATULANE CAP 50MG ***(procarbazine hcl)***	2	ONC
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS - Drugs to protect against chemotherapy drugs		
leucovorin tab 10MG, 15MG, 25MG, 5MG	1	ONC
MESNEX TAB 400MG ***(mesna)***	4	LMSP-ONC
MITOTIC INHIBITORS - Drugs to treat cancer		
ETOPOSIDE CAP 50MG ***(etoposide)***	4	LMSP-ONC
ANTIPARKINSON AGENTS - Drugs to treat Parkinson's disease		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated 1/3/2022

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ANTIPARKINSON ADJUVANTS - Drugs to treat parkinson's disease		
carbidopa tab 25MG (LODOSYN Equiv)	1	-
LODOSYN TAB 25MG ***(carbidopa)***	3	-
ANTIPARKINSON ANTICHOLINERGICS - Drugs to treat parkinson's disease		
benztropine tab .5MG, 1MG, 2MG	1	-
trihexyphenidyl tab 2MG, 5MG (ARTANE Equiv)	1	-
ANTIPARKINSON COMT INHIBITORS - Drugs to treat parkinson's disease		
COMTAN TAB 200MG ***(entacapone)***	3	-
entacapone tab 200MG (COMTAN Equiv)	1	-
TASMAR TAB 100MG ***(tolcapone)***	3	-
tolcapone tab 100MG (TASMAR Equiv)	1	-
ANTIPARKINSON DOPAMINERGICS - Drugs to treat parkinson's disease		
amantadine cap 100MG (SYMMETREL Equiv)	1	-
amantadine syrup 50MG/5ML (SYMMETREL Equiv)	1	-
amantadine tab 100MG	1	-
bromocriptine cap 5MG (PARLODEL Equiv)	1	-
bromocriptine tab 2.5MG (PARLODEL Equiv)	1	-
carbidopa/levodopa ER tab 25MG-100MG, 50MG-200MG (SINEMET CR Equiv)	1	-
carbidopa/levodopa ODT 10MG-100MG, 25MG-100MG, 25MG-250MG (PARCOPA Equiv)	1	-
carbidopa/levodopa tab (SINEMET Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CARBIDOPA/LEVODOPA/ENTACAPONE TAB 12.5MG-50MG-200MG, 18.75MG-75MG-200MG, 25MG-100MG-200MG, 31.25MG-125MG-200MG, 37.5MG-150MG-200MG, 50MG-200MG (STALEVO Equiv) ***(carbidopa-levodopa-entacapone)***	2	-
MIRAPEX TAB .125MG, .25MG, .5MG, .75MG, 1.5MG, 1MG ***(pramipexole dihydrochloride)***	3	-
NEUPRO PATCH 1MG/24HR, 2MG/24HR, 3MG/24HR, 4MG/24HR, 6MG/24HR, 8MG/24HR ***(rotigotine)***	3	-
PARLODEL CAP 5MG ***(bromocriptine mesylate)***	3	-
PARLODEL TAB 2.5MG ***(bromocriptine mesylate)***	3	-
pramipexole tab .125MG, .25MG, .5MG, .75MG, 1.5MG, 1MG (MIRAPEX Equiv)	1	-
REQUIP TAB .25MG, .5MG, 1MG, 2MG, 3MG, 4MG, 5MG ***(ropinirole hydrochloride)***	3	-
ropinirole tab .25MG, .5MG, 1MG, 2MG, 3MG, 4MG, 5MG (REQUIP Equiv)	1	-
SINEMET CR TAB 25MG-100MG, 50MG-200MG ***(carbidopa-levodopa)***	3	-
SINEMET TAB 10MG-100MG, 25MG-100MG, 25MG-250MG ***(carbidopa-levodopa)***	3	-
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS - Drugs to treat parkinson's disease		
AZILECT TAB .5MG, 1MG ***(rasagiline mesylate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ELDEPYRL CAP 5MG ***(selegiline hcl)***	3	-
rasagiline tab .5MG, 1MG (AZILECT Equiv)	1	-
selegiline cap 5MG (ELDEPRYL Equiv)	1	-
selegiline tab 5MG (ELDEPRYL Equiv)	1	-
XADAGO TAB 100MG, 50MG ***(safinamide mesylate)***	3	PA-QL QL= 1 tab/day
ZELAPAR ODT 1.25MG ***(selegiline hcl)***	3	-
ANTIPARKINSON AND RELATED THERAPY AGENTS - Drugs to treat Parkinson's disease		
ANTIPARKINSON ANTICHOLINERGICS - Drugs to treat parkinson's disease		
trihexyphenidyl elixir .4MG/ML (ARTANE Equiv)	1	-
ANTIPARKINSON COMT INHIBITORS - Drugs to treat parkinson's disease		
ONGENTYS CAP 25MG, 50MG ***(opicapone)***	2	PA-QL QL= 1 tab/day, 30 tabs per fill
ANTIPARKINSON DOPAMINERGICS - Drugs to treat parkinson's disease		
CARBIDOPA/LEVODOPA ODT 10MG-100MG, 25MG-100MG, 25MG-250MG ***(carbidopa-levodopa)***	1	-
INBRIJA INH POWDER 42MG ***(levodopa)***	3	PA-QL QL= 10 caps/day
ANTIPSYCHOTICS/ANTIMANIC AGENTS - Drugs to treat mood disorders		
ANTIMANIC AGENTS - Drugs to treat mental and emotional conditions		
LITHIUM CARBONATE CAP 150MG, 300MG, 600MG ***(lithium carbonate)***	1	-
lithium carbonate cap	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
lithium carbonate ER tab 300MG, 450MG (LITHOBID Equiv)	1	-
lithium carbonate tab 300MG	1	-
LITHIUM CITRATE SOLN 8MEQ/5ML ***(lithium)***	1	-
lithium citrate soln	1	-
LITHOBID TAB 300MG ***(lithium carbonate)***	3	-
ANTIPSYCHOTICS - MISC. - Miscellaneous anti-psychotic drugs		
EQUETRO CAP ***(carbamazepine (antipsychotic))***	2	-
GEODON CAP 20MG, 40MG, 60MG, 80MG ***(ziprasidone hcl)***	3	-
ziprasidone cap 20MG, 40MG, 60MG, 80MG (GEODON Equiv)	1	-
BENZISOXAZOLES - Drugs to treat mood disorders		
FANAPT TAB 10MG, 12MG, 1MG, 2MG, 4MG, 6MG, 8MG ***(iloperidone)***	3	PA-QL QL= 2 tabs/day
FANAPT TITRATION PACK ***(iloperidone)***	3	PA-QL QL= 1 pack/plan year
INVEGA TAB 1.5MG, 3MG, 6MG, 9MG ***(paliperidone)***	3	-
paliperidone ER tab 1.5MG, 3MG, 6MG, 9MG (INVEGA Equiv)	1	-
RISPERDAL CONSTA INJ 12.5MG, 25MG, 37.5MG, 50MG ***(risperidone microspheres)***	4	MSP

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
RISPERDAL M ODT .5MG, 1MG, 3MG, 4MG ***(risperidone)***	3	-
RISPERDAL SOLN 1MG/ML ***(risperidone)***	3	-
RISPERDAL TAB .25MG, .5MG, 1MG, 2MG, 3MG, 4MG ***(risperidone)***	3	-
RISPERIDONE ODT .25MG ***(risperidone)***	2	-
risperidone ODT .5MG, 1MG, 2MG, 3MG, 4MG (RISPERDAL M Equiv)	1	-
risperidone soln 1MG/ML (RISPERDAL Equiv)	1	-
risperidone tab .25MG, .5MG, 1MG, 2MG, 3MG, 4MG (RISPERDAL Equiv)	1	-
BUTYROPHENONES - Drugs to treat mood disorders		
haloperidol lactate conc 2MG/ML (HALDOL Equiv)	1	-
haloperidol tab .5MG, 10MG, 1MG, 20MG, 2MG, 5MG (HALDOL Equiv)	1	-
DIBENZAPINES - Drugs to treat mood disorders		
asenapine maleate SL tab 10MG, 2.5MG, 5MG (SAPHRIS Equiv)	1	PA-QL QL= 2 tabs/day
clozapine tab 100MG, 200MG, 25MG, 50MG (CLOZARIL Equiv)	1	-
CLOZARIL TAB 100MG, 200MG, 25MG, 50MG ***(clozapine)***	3	-
loxapine cap 10MG, 25MG, 50MG, 5MG (LOXITANE Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
LOXITANE CAP ***(loxapine succinate)***	3	-
olanzapine ODT 10MG, 15MG, 20MG, 5MG (ZYPREXA Equiv)	1	-
olanzapine tab 10MG, 15MG, 2.5MG, 20MG, 5MG, 7.5MG (ZYPREXA Equiv)	1	-
quetiapine tab 100MG, 200MG, 25MG, 300MG, 400MG, 50MG (SEROQUEL Equiv)	1	-
quetiapine XR tab 150MG, 200MG, 300MG, 400MG, 50MG (SEROQUEL XR Equiv)	1	-
SAPHRIS SL TAB 10MG, 2.5MG, 5MG ***(asenapine maleate)***	3	PA-QL QL= 2 tabs/day
SEROQUEL TAB 100MG, 200MG, 25MG, 300MG, 400MG, 50MG ***(quetiapine fumarate)***	3	-
SEROQUEL XR TAB 150MG, 200MG, 300MG, 400MG, 50MG ***(quetiapine fumarate)***	3	-
ZYPREXA TAB 10MG, 15MG, 2.5MG, 20MG, 5MG, 7.5MG ***(olanzapine)***	3	-
ZYPREXA ZYDIS TAB 10MG, 15MG, 20MG, 5MG ***(olanzapine)***	3	-
PHENOTHIAZINES - Drugs to treat mood disorders		
chlorpromazine tab 100MG, 10MG, 200MG, 25MG, 50MG (THORAZINE Equiv)	1	-
fluphenazine tab 10MG, 1MG, 2.5MG, 5MG (PROLIXIN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
perphenazine tab 16MG, 2MG, 4MG, 8MG (TRILAFON Equiv)	1	-
prochlorperazine supp 25MG (COMPAZINE Equiv)	1	-
prochlorperazine tab 10MG, 5MG (COMPAZINE Equiv)	1	-
thioridazine tab 100MG, 10MG, 25MG, 50MG (MELLARIL Equiv)	1	-
trifluoperazine tab 10MG, 1MG, 2MG, 5MG (STELAZINE Equiv)	1	-
QUINOLINONE DERIVATIVES - Drugs to treat mood disorders		
ABILIFY TAB 10MG, 15MG, 20MG, 2MG, 30MG, 5MG ***(aripiprazole)***	3	-
aripiprazole soln 1MG/ML (ABILIFY Equiv)	1	PA
aripiprazole tab 10MG, 15MG, 20MG, 2MG, 30MG, 5MG (ABILIFY Equiv)	1	-
THIOXANTHENES - Drugs to treat mood disorders		
NAVANE CAP ***(thiothixene)***	3	-
thiothixene cap 10MG, 1MG, 2MG, 5MG (NAVANE Equiv)	1	-
ANTISEPTICS & DISINFECTANTS - Drugs to treat bacterial infections		
CHLORINE ANTISEPTICS - Drugs to treat bacterial infections		
PHISOHEX LIQUID ***(hexachlorophene)***	3	-
ANTIVIRALS - Drugs to treat viral infection		
ANTIRETROVIRALS - Drugs to treat viral infections		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
abacavir soln 20MG/ML (ZIAGEN Equiv)	1	-
abacavir tab 300MG (ZIAGEN Equiv)	1	-
abacavir/lamivudine tab 300MG-600MG (EPZICOM Equiv)	1	-
abacavir/lamivudine/zidovudine tab 150MG-300MG (TRIZIVIR Equiv)	1	-
APTIVUS CAP 250MG ***(tipranavir)***	4	-
APTIVUS SOLN 100MG/ML ***(tipranavir)***	4	-
atazanavir cap 150MG, 200MG, 300MG (REYATAZ Equiv)	1	-
BIKTARVY TAB 15MG-30MG-120MG, 25MG-50MG-200MG ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	4	QL QL= 1 tab/ day
CIMDUO TAB 300MG ***(lamivudine-tenofovir disoproxil fumarate)***	4	QL QL= 1 tab/day
COMPLERA TAB 25MG-200MG-300MG ***(emtricitabine-rilpivirine-tenofovir disoproxil fumarate)***	4	QL QL= 1 tab/day
CRIXIVAN CAP 200MG, 400MG ***(indinavir sulfate)***	4	-
DELSTRIGO TAB 100MG-300MG ***(doravirine-lamivudine-tenofovir disoproxil fumarate)***	4	QL QL= 1 tab/day
DESCOVY TAB 25MG-200MG ***(emtricitabine-tenofovir alafenamide fumarate)***	$0	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
didanosine DR cap 200MG, 250MG, 400MG (VIDEX EC Equiv)	1	-
DOVATO TAB 50MG-300MG ***(dolutegravir sodium-lamivudine)***	4	QL QL= 1 tab/day
EDURANT TAB 25MG ***(rilpivirine hcl)***	4	-
efavirenz cap 200MG, 50MG (SUSTIVA Equiv)	1	-
efavirenz tab 600MG (SUSTIVA Equiv)	1	-
efavirenz/emtricitabine/tenofovir df tab 200MG-300MG-600MG (ATRIPLA Equiv)	1	QL QL= 1 tab/day
efavirenz/lamivudine/tenofovir df (lo) tab 300MG-400MG, 300MG-600MG (SYMFI (LO) Equiv)	1	QL QL= 1 tab/day
emtricitabine cap 200MG (EMTRIVA Equiv)	1	-
emtricitabine/tenofovir disoproxil fumarate tab 100MG-150MG, 133MG-200MG, 167MG-250MG, 200MG-300MG (TRUVADA Equiv)	$0	-
EMTRIVA SOLN 10MG/ML ***(emtricitabine)***	4	-
etravirine tab 100MG, 200MG	1	-
EVOTAZ TAB 150MG-300MG ***(atazanavir sulfate-cobicistat)***	4	-
fosamprenavir tab 700MG (LEXIVA Equiv)	1	-
FUZEON INJ 90MG ***(enfuvirtide)***	4	-
GENVOYA TAB 10MG-150MG-200MG ***(elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide)***	4	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
INTELENCE TAB 25MG 100MG, 200MG, 25MG ***(etravirine)***	4	-
INVIRASE CAP 200MG ***(saquinavir mesylate)***	4	-
INVIRASE TAB 500MG ***(saquinavir mesylate)***	4	-
ISENTRESS (HD) TAB 400MG, 600MG ***(raltegravir potassium)***	3	-
ISENTRESS CHEW TAB 100MG, 25MG ***(raltegravir potassium)***	3	-
ISENTRESS POWDER PACK 100MG ***(raltegravir potassium)***	3	-
JULUCA TAB 25MG-50MG ***(dolutegravir sodium-rilpivirine hcl)***	4	QL QL= 1 tab/ day
lamivudine soln 10MG/ML (EPIVIR Equiv)	1	-
lamivudine tab 150MG, 300MG (EPIVIR Equiv)	1	-
lamivudine/zidovudine tab 150MG-300MG (COMBIVIR Equiv)	1	-
LEXIVA SUSP 50MG/ML ***(fosamprenavir calcium)***	4	-
lopinavir/ritonavir soln 100MG/5ML-400MG/5ML (KALETRA Equiv)	1	-
lopinavir/ritonavir tab 25MG-100MG, 50MG-200MG (KALETRA Equiv)	1	-
NEVIRAPINE ER TAB 100MG 100MG ***(nevirapine)***	1	-
nevirapine ER tab 400mg 100MG, 400MG (VIRAMUNE XR Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NEVIRAPINE SUSP 50MG/5ML ***(nevirapine)***	1	-
nevirapine tab 200MG (VIRAMUNE Equiv)	1	-
NORVIR CAP 100MG ***(ritonavir)***	3	-
NORVIR POWDER PACK 100MG ***(ritonavir)***	3	-
NORVIR SOLN 80MG/ML ***(ritonavir)***	3	-
NORVIR TAB 100MG ***(ritonavir)***	3	-
ODEFSEY TAB 25MG-200MG ***(emtricitabine-rilpivirine-tenofovir alafenamide fumarate)***	4	QL QL= 1 tab/day
PIFELTRO TAB 100MG ***(doravirine)***	4	QL QL= 1 tab/day
PREZCOBIX TAB 150MG-800MG ***(darunavir-cobicistat)***	4	-
PREZISTA SUSP 100MG/ML ***(darunavir ethanolate)***	4	-
PREZISTA TAB 150MG, 600MG, 75MG, 800MG ***(darunavir ethanolate)***	4	-
RESCRIPTOR TAB 100MG, 200MG ***(delavirdine mesylate)***	4	-
REYATAZ POWDER PACK 50MG ***(atazanavir sulfate)***	4	-
ritonavir tab 100MG (NORVIR Equiv)	1	-
RUKOBIA ER TAB 600MG ***(fostemsavir tromethamine)***	4	-
SELZENTRY SOLN 20MG/ML ***(maraviroc)***	4	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
SELZENTRY TAB 150MG, 25MG, 300MG, 75MG ***(maraviroc)***	4	-
STAVUDINE CAP 15MG, 20MG, 30MG, 40MG (ZERIT Equiv) ***(stavudine)***	1	-
stavudine cap 15MG, 20MG, 30MG, 40MG (ZERIT Equiv)	1	-
stavudine soln (ZERIT Equiv)	1	-
STRIBILD TAB 150MG-200MG-300MG ***(elvitegravir-cobicistat-emtricitabine-tenofovir df)***	4	-
SYMTUZA TAB 10MG-150MG-200MG-800MG ***(darunavir-cobicistat-emtricitabine-tenofovir alafenamide)***	4	-
tenofovir disoproxil fumarate tab 300MG (VIREAD Equiv)	1	-
TIVICAY PD TAB 5MG ***(dolutegravir sodium)***	4	-
TIVICAY TAB 10MG, 25MG, 50MG ***(dolutegravir sodium)***	4	-
TRIUMEQ TAB 50MG-300MG-600MG ***(abacavir-dolutegravir-lamivudine)***	4	-
VIDEX SOLN 2GM, 4GM ***(didanosine)***	4	-
VIRACEPT POWDER ***(nelfinavir mesylate)***	4	-
VIRACEPT TAB 250MG, 625MG ***(nelfinavir mesylate)***	4	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
VIREAD TAB 150MG, 200MG, 250MG 150MG, 200MG, 250MG ***(tenofovir disoproxil fumarate)***	4	-
VITEKTA TAB ***(elvitegravir)***	3	-
ZERIT SOLN 1MG/ML ***(stavudine)***	4	-
zidovudine cap 100MG (RETROVIR Equiv)	1	-
zidovudine syrup 50MG/5ML (RETROVIR Equiv)	1	-
zidovudine tab 300MG (RETROVIR Equiv)	1	-
CMV AGENTS - Drugs to treat viral infections		
foscarnet sodium inj 6000MG/250ML (FOSCAVIR Equiv)	M	M
FOSCAVIR INJ 6000MG/250ML ***(foscarnet sodium)***	M	M
GANCICLOVIR CAP ***(ganciclovir)***	4	-
VALCYTE TAB 450MG ***(valganciclovir hcl)***	3	-
valganciclovir soln 50MG/ML (VALCYTE Equiv)	1	-
valganciclovir tab 450MG (VALCYTE Equiv)	1	-
HEPATITIS AGENTS - Drugs to treat viral infections		
adefovir dipivoxil tab 10MG (HEPSERA Equiv)	4	LMSP
BARACLUDE SOLN .05MG/ML ***(entecavir)***	3	PA Members age 9 or older require Prior Authorization
entecavir tab .5MG, 1MG (BARACLUDE Equiv)	4	LMSP-QL QL= 1 tab/day
EPIVIR HBV SOLN 5MG/ML ***(lamivudine (hbv))***	4	-
lamivudine tab 100mg 100MG (EPIVIR HBV Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
LEDIPASVIR/SOFOSBUVIR TAB 90MG-400MG ***(ledipasvir-sofosbuvir)***	4	LMSP-PA-QL QL= 1 tab/ day
MAVYRET PAK 20MG-50MG ***(glecaprevir-pibrentasvir)***	4	LMSP-PA-QL QL= 5 packs/day
MAVYRET TAB 40MG-100MG ***(glecaprevir-pibrentasvir)***	4	LMSP-PA-QL QL= 3 tabs/day
PEGASYS INJ 180MCG/0.5ML ***(peginterferon alfa-2a)***	4	LMSP
PEG-INTRON INJ 50MCG/0.5ML ***(peginterferon alfa-2b)***	4	LMSP
REBETOL SOLN 40MG/ML ***(ribavirin (hepatitis c))***	4	LMSP
ribavirin cap 200MG (REBETOL Equiv)	1	LMSP
ribavirin tab 200MG (COPEGUS Equiv)	1	LMSP
SOFOSBUVIR/VELPATASVIR TAB 100MG-400MG ***(sofosbuvir-velpatasvir)***	4	LMSP-PA-QL QL= 1 tab/ day
VEMLIDY TAB 25MG ***(tenofovir alafenamide fumarate)***	4	LMSP
VICTRELIS CAP ***(boceprevir)***	4	MSP-PA-SF
VOSEVI TAB 100MG-400MG ***(sofosbuvir-velpatasvir-voxilaprevir)***	4	LMSP-PA-QL QL= 1 tab/day
HERPES AGENTS - Drugs to treat viral infections		
acyclovir cap 200MG (ZOVIRAX Equiv)	1	-
acyclovir susp 200MG/5ML (ZOVIRAX Equiv)	1	-
acyclovir tab 400MG, 800MG (ZOVIRAX Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
famciclovir tab 125MG, 250MG, 500MG (FAMVIR Equiv)	1	-
FAMVIR TAB ***(famciclovir)***	3	-
valacyclovir tab 1000MG, 1GM, 500MG (VALTREX Equiv)	1	-
VALTREX TAB 1GM, 500MG ***(valacyclovir hcl)***	3	-
ZOVIRAX CAP 200MG ***(acyclovir)***	3	-
ZOVIRAX SUSP 200MG/5ML ***(acyclovir)***	3	-
ZOVIRAX TAB 400MG, 800MG ***(acyclovir)***	3	-
INFLUENZA AGENTS - Drugs to treat viral infections		
FLUMADINE TAB 100MG ***(rimantadine hydrochloride)***	3	-
oseltamivir cap 45MG, 75MG (TAMIFLU Equiv)	1	QL QL= 10 caps/fill
oseltamivir cap 30mg 30MG (TAMIFLU Equiv)	1	QL QL= 20 caps/fill
oseltamivir susp 6MG/ML (TAMIFLU Equiv)	1	QL QL= 250ml/fill
RELENZA DISKHALER 5MG/BLISTER ***(zanamivir)***	2	QL QL= 1 inhaler/fill
RIMANTADINE TAB 100MG ***(rimantadine hydrochloride)***	1	-
TAMIFLU CAP 45MG, 75MG ***(oseltamivir phosphate)***	3	QL QL= 10 caps/fill

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TAMIFLU CAP 30MG 30MG ***(oseltamivir phosphate)***	3	QL QL= 20 caps/fill
MISC. ANTIVIRALS ***		
MOLNUPIRAVIR CAP 200MG ***(molnupiravir)***	$0	QL QL= 40 caps/fill
ASSORTED CLASSES - Drugs to treat assorted conditions		
CHELATING AGENTS - Drugs to treat overdose or toxicity		
D-PENAMINE TAB 125MG ***(penicillamine)***	2	-
IMMUNOMODULATORS - Drugs to treat rheumatoid arthritis, multiple sclerosis, etc.		
REVLIMID CAP 10MG, 15MG, 2.5MG, 20MG, 25MG, 5MG ***(lenalidomide)***	3	KMSP-PA-QL QL= 1 cap/day
THALOMID CAP 100MG, 150MG, 200MG, 50MG ***(thalidomide)***	4	KMSP-PA
IMMUNOSUPPRESSIVE AGENTS - Drugs to treat disorders of the immune system		
azathioprine tab 50MG (IMURAN Equiv)	1	-
cyclosporine cap 100MG, 25MG (SANDIMMUNE Equiv)	1	-
cyclosporine modified cap 100MG, 25MG, 50MG (NEORAL Equiv)	1	-
cyclosporine modified soln 100MG/ML (NEORAL Equiv)	1	-
IMURAN TAB 50MG ***(azathioprine)***	3	-
mycophenolate DR tab 180MG, 360MG (MYFORTIC Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
mycophenolate mofetil cap 250MG (CELLCEPT Equiv)	1	-
mycophenolate mofetil susp 200MG/ML (CELLCEPT SUSP Equiv)	1	-
mycophenolate mofetil tab 500MG (CELLCEPT Equiv)	1	-
SANDIMMUNE SOLN 100MG/ML 100MG/ML ***(cyclosporine)***	4	-
sirolimus tab .5MG, 1MG, 2MG (RAPAMUNE Equiv)	1	-
tacrolimus cap .5MG, 1MG, 5MG (PROGRAF Equiv)	1	-
POTASSIUM REMOVING RESINS - Drugs to manage potassium levels		
KAYEXALATE POWDER ***(sodium polystyrene sulfonate)***	3	-
sodium polystyrene powder (KAYEXALATE Equiv)	1	-
sodium polystyrene susp 15GM/60ML, 30GM/120ML, 50GM/200ML (SPS Equiv)	1	-
BETA BLOCKERS - Drugs to treat high blood pressure		
ALPHA-BETA BLOCKERS - Drugs to treat high blood pressure		
carvedilol tab 12.5MG, 25MG, 3.125MG, 6.25MG (COREG Equiv)	1	-
COREG TAB 12.5MG, 25MG, 3.125MG, 6.25MG ***(carvedilol)***	3	-
labetalol tab 100MG, 200MG, 300MG (NORMODYNE Equiv)	1	-
TRANDATE TAB ***(labetalol hcl)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
BETA BLOCKERS CARDIO-SELECTIVE - Drugs to treat high blood pressure		
acebutolol cap 200MG, 400MG (SECTRAL Equiv)	1	-
atenolol tab 100MG, 25MG, 50MG (TENORMIN Equiv)	1	-
bisoprolol tab 10MG, 5MG (ZEBETA Equiv)	1	-
LOPRESSOR TAB 100MG, 50MG ***(metoprolol tartrate)***	3	-
metoprolol ER tab 100MG, 200MG, 25MG, 50MG (TOPROL XL Equiv)	1	-
metoprolol tab 100MG, 25MG, 50MG (LOPRESSOR Equiv)	1	-
nebivolol hcl tab 10MG, 2.5MG, 20MG, 5MG (BYSTOLIC Equiv)	1	-
SECTRAL CAP ***(acebutolol hcl)***	3	-
TENORMIN TAB 100MG, 25MG, 50MG ***(atenolol)***	3	-
TOPROL XL TAB 100MG, 200MG, 25MG, 50MG ***(metoprolol succinate)***	3	-
ZEBETA TAB ***(bisoprolol fumarate)***	3	-
BETA BLOCKERS NON-SELECTIVE - Drugs to treat high blood pressure		
BETAPACE AF TAB 120MG, 160MG, 80MG ***(sotalol hcl (afib/afl))***	3	-
BETAPACE TAB 120MG, 160MG, 80MG ***(sotalol hcl)***	3	-
CORGARD TAB 20MG, 40MG, 80MG ***(nadolol)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
INDERAL LA CAP 120MG, 160MG, 60MG, 80MG ***(propranolol hcl)***	3	-
LEVATOL TAB ***(penbutolol sulfate)***	3	-
nadolol tab (CORGARD Equiv)	1	-
pindolol tab 10MG, 5MG (VISKEN Equiv)	1	-
propranolol ER cap 120MG, 160MG, 60MG, 80MG (INDERAL LA Equiv)	1	-
propranolol oral soln 20mg/5ml 20MG/5ML (PROPRANOLOL Equiv)	1	-
PROPRANOLOL SOLN 40MG/5ML ***(propranolol hcl)***	1	-
propranolol tab 10MG, 20MG, 40MG, 60MG, 80MG (INDERAL Equiv)	1	-
sotalol AF tab 120MG, 160MG, 80MG (BETAPACE AF Equiv)	1	-
sotalol tab 120MG, 160MG, 240MG, 80MG (BETAPACE Equiv)	1	-
SOTYLIZE SOLN 5MG/ML 5MG/ML ***(sotalol hcl)***	3	PA Prior Authorization required for members age 9 or older
TIMOLOL MALEATE TAB 20MG ***(timolol maleate)***	1	-
timolol maleate tab 10MG, 20MG, 5MG	1	-
BIOLOGICALS MISC - Miscellaneous biological drugs		
BIOLOGICALS MISC - Miscellaneous biological drugs		
ADAGEN INJ 250UNIT/ML ***(pegademase bovine)***	M	M

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CALCIUM CHANNEL BLOCKERS - Drugs to treat high blood pressure		
CALCIUM CHANNEL BLOCKERS - Drugs to treat heart disease		
ADALAT CC TAB 30MG, 60MG, 90MG ***(nifedipine)***	3	-
amlodipine tab 10MG, 2.5MG, 5MG (NORVASC Equiv)	1	-
CALAN SR TAB 120MG, 180MG, 240MG ***(verapamil hcl)***	3	-
CALAN TAB 120MG, 80MG ***(verapamil hcl)***	3	-
CARDENE SR CAP ***(nicardipine hcl)***	3	-
CARDIZEM CD CAP 120MG, 180MG, 240MG, 300MG, 360MG ***(diltiazem hcl coated beads)***	3	-
CARDIZEM TAB ***(diltiazem hcl tab)***	3	-
COVERA-HS TAB ***(verapamil hcl)***	3	-
diltiazem ER cap 120MG, 180MG, 240MG, 300MG, 360MG, 420MG (TIAZAC Equiv)	1	-
diltiazem tab 120MG, 30MG, 60MG, 90MG (CARDIZEM Equiv)	1	-
DYNACIRC CR TAB ***(isradipine)***	3	-
felodipine ER tab 10MG, 2.5MG, 5MG (PLENDIL Equiv)	1	-
KATERZIA SUSP 1MG/ML ***(amlodipine benzoate)***	3	PA Prior Authorization required for members age 9 or older
nifedipine cap 10MG, 20MG (PROCARDIA Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
nifedipine ER tab 30MG, 60MG, 90MG (ADALAT CC Equiv)	1	-
nimodipine cap 30MG (NIMOTOP Equiv)	1	-
NIMOTOP CAP ***(nimodipine)***	3	-
NORVASC TAB 10MG, 2.5MG, 5MG ***(amlodipine besylate)***	3	-
PLENDIL TAB ***(felodipine)***	3	-
PROCARDIA CAP 10MG ***(nifedipine)***	3	-
TIAZAC CAP 120MG, 180MG, 240MG, 300MG, 360MG, 420MG ***(diltiazem hcl extended release beads)***	3	-
verapamil SR cap 100MG, 120MG, 180MG, 200MG, 240MG, 300MG (VERELAN Equiv)	1	-
VERAPAMIL SR CAP 360mg 360MG ***(verapamil hcl)***	1	-
verapamil SR tab 120MG, 180MG, 240MG (CALAN SR, ISOPTIN SR Equiv)	1	-
verapamil tab 120MG, 40MG, 80MG (CALAN Equiv)	1	-
VERELAN CAP 120MG, 180MG, 240MG ***(verapamil hcl)***	3	-
VERELAN PM CAP ***(verapamil hcl)***	3	-
VERELAN PM ER CAP 100MG, 300MG 100MG, 200MG, 300MG ***(verapamil hcl)***	3	-
VERELAN SR CAP 360mg 360MG ***(verapamil hcl)***	3	-
CARDIOTONICS - Drugs to treat heart failure and abnormal heart rhythm		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CARDIAC GLYCOSIDES - Drugs to treat heart failure and abnormal heart rhythm		
DIGOXIN SOLN .05MG/ML (LANOXIN Equiv) ***(digoxin)***	1	-
digoxin soln .05MG/ML (LANOXIN Equiv)	1	-
digoxin tab .125MG, .25MG, 125MCG, 250MCG (LANOXIN Equiv)	1	-
LANOXIN TAB 125MCG, 250MCG ***(digoxin)***	3	-
CARDIOVASCULAR AGENTS - MISC. - Drugs to treat heart and circulation conditions		
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS - Miscellaneous cardiovascular combination drugs		
amlodipine/atorvastatin tab 10MG, 10MG-20MG, 10MG-40MG, 10MG-80MG, 2.5MG-10MG, 2.5MG-20MG, 2.5MG-40MG, 5MG-10MG, 5MG-20MG, 5MG-40MG, 5MG-80MG (CADUET Equiv)	1	-
CADUET TAB 10MG, 10MG-20MG, 10MG-40MG, 10MG-80MG, 5MG-10MG, 5MG-20MG, 5MG-40MG, 5MG-80MG ***(amlodipine besylate-atorvastatin calcium)***	3	-
IMPOTENCE AGENTS - drugs to treat erectile dysfunction		
CAVERJECT INJ 10MCG, 20MCG ***(alprostadil (vasodilator))***	2	QL QL= 6 inj/30 days
EDEX INJ 10MCG, 20MCG, 40MCG ***(alprostadil (vasodilator))***	2	QL QL= 6 inj/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
MUSE SUPP 1000MCG, 125MCG, 250MCG, 500MCG ***(alprostadil (vasodilator))***	2	QL QL= 6 inj/30 days
sildenafil tab 100MG, 25MG, 50MG (VIAGRA Equiv)	1	QL QL= 6 tabs/30 days
STENDRA TAB 100MG, 200MG, 50MG ***(avanafil)***	2	QL QL= 6 tabs/30 days
tadalafil tab 10MG, 20MG (CIALIS Equiv)	1	QL QL= 6 tabs/30 days
tadalafil tab 2.5mg, 5mg 2.5MG, 5MG (CIALIS Equiv)	1	QL QL= 6 tabs/30 days
vardenafil ODT 10MG (STAXYN Equiv)	1	QL QL= 6 tabs/30 days
vardenafil tab 10MG, 2.5MG, 20MG, 5MG (LEVITRA Equiv)	1	QL QL= 6 tabs/30 days
PERIPHERAL VASODILATORS - Drugs to treat heart and circulation conditions		
ISOXSUPRINE TAB 10MG, 20MG ***(isoxsuprine hcl)***	2	-
isoxsuprine tab 10MG, 20MG	1	-
PROSTAGLANDIN VASODILATORS - Drugs to treat pulmonary hypertension		
ORENITRAM TAB .125MG, .25MG, 1MG, 2.5MG, 5MG ***(treprostinil diolamine)***	4	LD-PA Only available through CVS Specialty 800-237-2767
TYVASO INH SOLN .6MG/ML ***(treprostinil)***	4	LD-PA-QL QL= 1 ampule/day; Only available through Accredo 800-803-2523

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
VENTAVIS INH SOLN 10MCG/ML, 20MCG/ML ***(iloprost)***	4	LD-PA-QL QL= 9 ampules/day; Only available through Accredo 800-803-2523
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS - Drugs to treat pulmonary hypertension		
ambrisentan tab 10MG, 5MG (LETAIRIS Equiv)	4	LMSP-PA-QL QL= 1 tab/day
bosentan tab 125MG, 62.5MG (TRACLEER Equiv)	4	LMSP-PA-QL QL= 2 tabs/day
OPSUMIT TAB 10MG ***(macitentan)***	4	LD-PA-QL QL= 1 tab/day; Only available through CVS Specialty 800-237-2767
TRACLEER TAB 32MG 32MG ***(bosentan)***	4	LD-PA-QL QL=4 tabs/day; Only available through Walgreens 888-347-3416
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS - Drugs to treat pulmonary hypertension		
REVATIO TAB 20MG ***(sildenafil citrate (pulmonary hypertension))***	3	PA
sildenafil tab 20mg 20MG (REVATIO Equiv)	1	PA
tadalafil tab (PAH) 20MG (ADCIRCA Equiv)	4	LMSP-PA
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST - Drugs to treat pulmonary hypertension		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
UPTRAVI TAB 1000MCG, 1200MCG, 1400MCG, 1600MCG, 200MCG, 400MCG, 600MCG, 800MCG ***(selexipag)***	4	LD-PA-QL QL= 2 tabs/day; Only available through Accredo 800-803-2523
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR - Drugs to treat pulmonary hypertension		
ADEMPAS TAB .5MG, 1.5MG, 1MG, 2.5MG, 2MG ***(riociguat)***	4	LD-PA-QL QL= 3 tabs/day; Only available through Accredo 800-803-2523
SINUS NODE INHIBITORS - Drugs to control heart rhythm		
CORLANOR TAB 5MG, 7.5MG ***(ivabradine hcl)***	3	PA
TRANSTHYRETIN STABILIZERS - drugs to treat heart problems due to transthyretin amyloidosis		
VYNDAMAX CAP 61MG ***(tafamidis)***	4	MSP-PA-QL QL= 1 cap/day
VYNDAQEL CAP 20MG ***(tafamidis meglumine (cardiac))***	4	MSP-PA-QL QL= 4 caps/day
CEPHALOSPORINS - Drugs to treat bacterial infections		
CEPHALOSPORINS - 1ST GENERATION - Drugs to treat bacterial infections		
cefazolin inj 10GM, 1GM, 500MG	M	M
CEFAZOLIN INJ 100GM, 1GM, 20GM, 300GM ***(cefazolin sodium)***	M	M
cephalexin cap 250MG, 500MG (KEFLEX Equiv)	1	-
cephalexin susp 125MG/5ML, 250MG/5ML (KEFLEX Equiv)	1	-
KEFLEX CAP 250MG, 500MG ***(cephalexin)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CEPHALOSPORINS - 2ND GENERATION - Drugs to treat bacterial infections		
CEFACLOR CAP 250MG, 500MG ***(cefaclor)***	1	-
cefaclor cap 250MG, 500MG	1	-
CEFACLOR ER TAB 500MG ***(cefaclor monohydrate)***	3	-
CEFACLOR SUSP 125MG/5ML, 250MG/5ML, 375MG/5ML ***(cefaclor)***	3	-
cefaclor susp (CEFACLOR Equiv)	1	-
cefoxitin inj 10GM, 1GM, 2GM	M	M
CEFTIN TAB ***(cefuroxime axetil)***	3	-
cefuroxime tab 250MG, 500MG (CEFTIN Equiv)	1	-
CEPHALOSPORINS - 3RD GENERATION - Drugs to treat bacterial infections		
CEDAX CAP 400MG ***(ceftibuten)***	3	-
CEDAX SUSP 180MG/5ML ***(ceftibuten)***	3	-
CEDAX SUSP ***(ceftibuten)***	3	-
cefdinir cap 300MG (OMNICEF Equiv)	1	-
cefdinir susp 125MG/5ML, 250MG/5ML (OMNICEF Equiv)	1	-
CEFDITOREN TAB 200MG, 400MG ***(cefditoren pivoxil)***	3	-
cefixime cap 400MG (SUPRAX Equiv)	1	-
cefixime susp 100MG/5ML, 200MG/5ML (SUPRAX Equiv)	1	-
CEFOTAXIME INJ 10GM, 1GM, 2GM, 500MG (CLAFORAN Equiv) ***(cefotaxime sodium)***	M	M

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
cefotaxime inj 1GM (CLAFORAN Equiv)	M	M
cefpodoxime proxetil susp 100MG/5ML, 50MG/5ML (VANTIN Equiv)	1	-
cefpodoxime proxetil tab 100MG, 200MG (VANTIN Equiv)	1	-
ceftriaxone inj 10GM, 1GM, 250MG, 2GM, 500MG	M	M
OMNICEF SUSP ***(cefdinir)***	3	-
SPECTRACEF TAB 400MG ***(cefditoren pivoxil)***	3	-
SUPRAX CAP 400MG ***(cefixime)***	3	-
SUPRAX CAP 400MG ***(cefixime)***	3	-
SUPRAX CHEW TAB 100MG, 200MG ***(cefixime)***	3	-
SUPRAX SUSP 100MG/5ML, 200MG/5ML ***(cefixime)***	3	-
SUPRAX SUSP 500MG/5ML 500MG/5ML ***(cefixime)***	3	-
SUPRAX TAB ***(cefixime)***	3	-
VANTIN TAB ***(cefpodoxime proxetil)***	3	-
CONTRACEPTIVES - Drugs to prevent pregnancy		
COMBINATION CONTRACEPTIVES - ORAL - Drugs to prevent pregnancy		
amethyst tab 20MCG-90MCG (LYBREL Equiv)	$0	-
aranelle tab (TRI-NORINYL Equiv)	$0	-
aviane tab .03MG-.15MG, .15MG-30MCG, .1MG-20MCG (ALESSE Equiv)	$0	-
cesia tab (CYCLESSA Equiv)	$0	-
cryselle tab .3MG-30MCG	$0	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CYCLESSA TAB ***(desogestrel-ethinyl estradiol (triphasic))***	3	-
DESOGEN TAB .15MG-30MCG ***(desogestrel & ethinyl estradiol)***	3	-
enpresse tab (TRI-LEVELEN Equiv)	$0	-
ESTROSTEP FE TAB 1MG-75MG ***(norethindrone acetate-ethinyl estradiol-fe)***	3	-
FEMCON FE CHEW TAB .8MG-25MCG-75MG ***(norethindrone & ethinyl estradiol-fe)***	3	-
gianvi tab, ocella tab .02MG-3MG, .03MG-3MG (YASMIN, YAZ Equiv)	$0	-
isibloom tab, enskyce tab, apri tab (DESOGEN Equiv)	$0	-
jolessa tab, amethia tab .03MG-.15MG (SEASONALE, SEASONIQUE Equiv)	$0	3 copays per Rx
junel FE tab 1.5MG-30MCG-75MG, 1MG-20MCG-75MG (LOESTRIN FE Equiv)	$0	-
junel tab 1.5MG-30MCG, 1MG-20MCG (LOESTRIN Equiv)	$0	-
kelnor tab 1MG-35MCG, 1MG-50MCG (DEMULEN Equiv)	$0	-
LO LOESTRIN TAB 1MG-10MCG-75MG ***(norethindrone acetate-ethinyl estradiol-fe fum (biphasic))***	$0	-
LOESTRIN 24 FE TAB ***(norethin acet & estrad-fe)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
LOESTRIN FE TAB 1.5MG-30MCG-75MG, 1MG-20MCG-75MG ***(norethin acet & estrad-fe)***	3	-
LOESTRIN TAB ***(norethindrone acet & eth estra)***	3	-
mibelas chew tab 1MG-20MCG-75MG (MINASTRIN Equiv)	1	-
MINASTRIN CHEW TAB 1MG-20MCG-75MG ***(norethin acet & estrad-fe)***	3	-
MIRCETTE TAB ***(desogestrel-ethinyl estradiol (biphasic))***	3	-
NATAZIA TAB ***(estradiol valerate-dienogest)***	3	-
NECON TAB ***(norethindrone-eth estradiol (biphasic))***	$0	-
norethindrone/ethinyl estradiol 21 tab 1.5MG-30MCG (LOESTRIN 21 Equiv)	1	-
norethindrone/ethinyl estradiol FE tab 1.5MG-30MCG-75MG (LOESTRIN FE Equiv)	1	-
nortrel tab .4MG-35MCG, .5MG-35MCG, 1MG-35MCG (OVCON 35 Equiv)	$0	-
OGESTREL TAB .5MG-50MCG ***(norgestrel & ethinyl estradiol)***	3	-
ORTHO TRI-CYCLEN (LO) TAB ***(norgestimate-ethinyl estradiol (triphasic))***	3	-
ORTHO-CYCLEN TAB .25MG-35MCG ***(norgestimate-ethinyl estradiol)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
OVCON 35 TAB 1MG-35MCG ***(norethindrone & eth estradiol)***	3	-
SEASONIQUE TAB ***(levonorgestrel-ethinyl estradiol (91-day))***	3	-
sprintec 28 tab .25MG-35MCG (ORTHO-CYCLEN Equiv)	$0	-
tri-legest tab 1MG-75MG (ESTROSTEP FE Equiv)	$0	-
TRI-NORINYL TAB ***(norethindrone-eth estradiol (triphasic))***	3	-
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) Equiv)	$0	-
TYBLUME TAB .1MG-20MCG ***(levonorgestrel & eth estradiol)***	$0	-
viorele tab, kariva tab (MIRCETTE Equiv)	$0	-
wymzya FE tab .4MG-35MCG, .8MG-25MCG-75MG (FEMCON FE Equiv)	$0	-
COMBINATION CONTRACEPTIVES - TRANSDERMAL - Drugs to prevent pregnancy		
ORTHO-EVRA PATCH ***(norelgestromin-ethinyl estradiol)***	3	-
zafemy patch 35MCG/24HR-150MCG/24HR (XULANE Equiv)	$0	-
COMBINATION CONTRACEPTIVES - VAGINAL - Drugs to prevent pregnancy		
NUVARING .015MG/24HR-.12MG/24HR ***(etonogestrel-ethinyl estradiol)***	$0	-
COPPER CONTRACEPTIVES - IUD- Devices to prevent pregnancy		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PARAGARD IUD ***(copper (iud))***	EXC	-
EMERGENCY CONTRACEPTIVES - Drugs to prevent pregnancy		
ELLA TAB 30MG ***(ulipristal acetate)***	$0	-
levonorgestrel tab 1.5MG (PLAN B Equiv)	$0	OTC
LEVONORGESTREL TAB 0.75MG ***(levonorgestrel (emergency oc))***	$0	-
PLAN B TAB 1.5MG ***(levonorgestrel (emergency oc))***	$0	OTC
PROGESTIN CONTRACEPTIVES - IMPLANTS - Devices to prevent pregnancy		
NEXPLANON IMPLANT 68MG ***(etonogestrel)***	EXC	-
PROGESTIN CONTRACEPTIVES - INJECTABLE - Drugs to replace female hormones		
DEPO-PROVERA INJ 150MG/ML ***(medroxyprogesterone acetate (contraceptive))***	EXC	-
DEPO-PROVERA SC INJ 104MG 104MG/0.65ML ***(medroxyprogesterone acetate (contraceptive))***	EXC	-
medroxyprogesterone inj 150MG/ML (DEPO-PROVERA Equiv)	EXC	-
PROGESTIN CONTRACEPTIVES - IUD - Devices to prevent pregnancy		
MIRENA IUD 13.5MG, 19.5MCG/DAY, 19.5MG, 20MCG/24HR ***(levonorgestrel (iud))***	EXC	-
PROGESTIN CONTRACEPTIVES - ORAL - Drugs to replace female hormones		
norethindrone tab .35MG (NORA-QD Equiv)	$0	-
NOR-QD TAB .35MG ***(norethindrone (contraceptive))***	3	-
CORTICOSTEROIDS - Drugs to treat systemic swelling conditions		
GLUCOCORTICOSTEROIDS - Drugs to treat systemic swelling conditions		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
budesonide ER tab 9MG (UCERIS Equiv)	1	PA-QL QL=1 tab/day
budesonide SR cap 3MG (ENTOCORT EC Equiv)	1	-
CORTEF TAB 10MG, 20MG, 5MG ***(hydrocortisone)***	3	-
DEXAMETHASONE CONC 1MG/ML ***(dexamethasone)***	1	-
dexamethasone elixir .5MG/5ML	1	-
DEXAMETHASONE SOLN .5MG/5ML ***(dexamethasone)***	1	-
DEXAMETHASONE TAB 1MG, 2MG (DECADRON Equiv) ***(dexamethasone)***	1	-
dexamethasone tab .5MG, .75MG, 1.5MG, 4MG, 6MG (DECADRON Equiv)	1	-
hydrocortisone tab 10MG, 20MG, 5MG (CORTEF Equiv)	1	-
MEDROL DOSE PACK 4MG ***(methylprednisolone)***	3	-
MEDROL TAB 2MG ***(methylprednisolone)***	2	-
MEDROL TAB 16MG, 32MG, 4MG, 8MG ***(methylprednisolone)***	3	-
methylprednisolone dose pack 4MG (MEDROL Equiv)	1	-
methylprednisolone tab 16MG, 32MG, 4MG, 8MG (MEDROL Equiv)	1	-
ORAPRED ODT TAB 10MG, 15MG, 30MG ***(prednisolone sodium phosphate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ORAPRED SOLN 10MG/5ML, 20MG/5ML, 6.7MG/5ML ***(prednisolone sodium phosphate)***	3	-
prednisolone ODT 10MG, 15MG, 30MG (ORAPRED Equiv)	1	-
PREDNISOLONE ODT TAB 10MG, 15MG, 30MG ***(prednisolone sodium phosphate)***	2	-
PREDNISOLONE SOLN 25MG/5ML ***(prednisolone sodium phosphate)***	3	-
prednisolone soln 10MG/5ML, 15MG/5ML, 20MG/5ML, 5MG/5ML, 6.7MG/5ML (PEDIAPRED Equiv)	1	-
PREDNISOLONE SYRUP 15MG/5ML (PRELONE Equiv) ***(prednisolone)***	1	-
prednisolone syrup 15MG/5ML (PRELONE Equiv)	1	-
PREDNISONE SOLN 5MG/5ML ***(prednisone)***	2	-
prednisone tab 10MG, 1MG, 2.5MG, 20MG, 50MG, 5MG (DELTASONE Equiv)	1	-
UCERIS TAB 9MG ***(budesonide)***	3	PA-QL QL= 1 tab/day
MINERALOCORTICOIDS - Drugs to treat systemic swelling conditions		
fludrocortisone tab .1MG (FLORINEF Equiv)	1	-
COUGH/COLD/ALLERGY - Drugs to treat cough, cold, and allergy symptoms		
ANTITUSSIVES - Drugs to treat cough		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
benzonatate cap 100mg, 200mg 100MG, 200MG (TESSALON Equiv)	1	-
HYCODAN SYRUP 1.5MG/5ML-5MG/5ML ***(hydrocodone w/ homatropine)***	3	-
hydrocodone/homatropine syrup 1.5MG/5ML-5MG/5ML (HYCODAN Equiv)	1	-
TESSALON CAP 100MG ***(benzonatate)***	3	-
tussigon tab 1.5MG-5MG (HYCODAN Equiv)	1	-
COUGH/COLD/ALLERGY COMBINATIONS - Drugs to treat cough, cold, and allergy symptoms		
ALBATUSSIN LIQUID ***(phenyleph-dm-pyril-pot guai-sod cit-citric acid)***	3	-
BRONCOPECTOL SYRUP ***(phenylephrine-chlorpheniramine w/ dm-gg)***	3	-
BROVEX PEB LIQUID 2MG/10ML-5MG/10ML, 2MG/5ML-5MG/5ML, 2MG/ML-5MG/ML, 4MG/5ML-10MG/5ML ***(brompheniramine & phenyleph)***	EXC	OTC
CLARINEX-D TAB 2.5MG-120MG ***(desloratadine-pseudoephedrine)***	EXC	-
CLARINEX-D TAB ***(desloratadine-pseudoephedrine)***	EXC	-
DECON-A LIQUID ***(brompheniramine & phenyleph)***	EXC	OTC
GILTUSS LIQUID ***(phenylephrine w/ codeine-gg)***	3	-
GILTUSS TR TAB ***(phenylephrine w/ dm-gg)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
guaifenesin/codeine soln 7.5MG/5ML-225MG/5ML (BRONTEX Equiv)	1	OTC
GUAIFENESIN/CODEINE SYRUP 6.3MG/5ML-100MG/5ML ***(guaifenesin-codeine)***	1	OTC-QL QL= 240ml/fill
guaifenesin/codeine syrup 10MG/5ML-100MG/5ML, 6.3MG/5ML-100MG/5ML	1	OTC-QL QL= 240ml/fill
hydrocodone/chlorpheniramine CR susp 8MG/5ML-10MG/5ML (TUSSIONEX Equiv)	1	QL QL= 120ml/fill; 2 fills/30 days
HYDROCODONE/CHLORPHENIRAMINE/PSEUDOEPHEDRINE LIQUID 4MG/5ML-5MG/5ML-60MG/5ML ***(pseudoephed-cpm w/ hydrocod)***	3	QL QL= 120ml/fill, 2 fills/month
hydrocodone/chlorpheniramine/pseudoephedrine liquid 4MG/5ML-5MG/5ML-60MG/5ML (ZUTRIPRO Equiv)	1	QL QL= 120ml/fill, 2 fills/30 days
lohist liquid 2MG/10ML-5MG/10ML (DECON-A Equiv)	EXC	OTC
NEOTUSS-D LIQUID ***(pseudoephedrine-chlorpheniramine w/ dm-gg)***	3	-
PEDIATEX TDM SUSP ***(pseudoeph-triprolidine-dm)***	3	-
promethazine DM syrup 6.25MG/5ML-15MG/5ML	1	-
promethazine VC syrup 5MG/5ML-6.25MG/5ML (PHENERGAN VC Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
promethazine VC/codeine syrup 5MG/5ML-6.25MG/5ML-10MG/5ML (PHENERGAN VC/CODEINE Equiv)	1	-
promethazine/codeine syrup 6.25MG/5ML-10MG/5ML (PHENERGAN/CODEINE Equiv)	1	-
pseudoephedrine/brompheniramine/codeine liquid (CPB WC LIQUID Equiv)	1	OTC
RESCON TAB ***(dexchlorpheniramine-phenylephrine)***	3	-
REZIRA SOLN ***(pseudoephedrine w/ hydrocodone)***	3	-
SEMPREX-D CAP 8MG-60MG ***(acrivastine & pseudoephedrine)***	EXC	-
SUTTAR SF SYRUP ***(pseudoephedrine w/ codeine-gg)***	3	-
TRIAMINIC SYRUP ***(chlorpheniramine & phenylephrine)***	EXC	OTC
TUSNEL SYRUP 10MG/5ML-30MG/5ML-100MG/5ML ***(pseudoephedrine w/ codeine-gg)***	3	-
TUSSIONEX SUSP 8MG/5ML-10MG/5ML ***(hydrocodone polistirex-chlorpheniramine polistirex)***	3	QL QL= 120ml/fill; 2 fills/30 days
TUSSI-ORGANI SYRUP ***(guaifenesin-codeine)***	3	QL QL= 240ml/fill

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ZUTRIPRO LIQUID 4MG/5ML-5MG/5ML-60MG/5ML ***(pseudoephed-cpm w/ hydrocod)***	3	QL QL= 120ml/fill, 2 fills/30 days
MISC. RESPIRATORY INHALANTS - Miscellaneous respiratory inhalants		
HYPER-SAL NEB SOLN 7% ***(sodium chloride (inhalant))***	3	-
NEBUSAL NEB SOLN 3.5%, 6% ***(sodium chloride (inhalant))***	2	-
sodium chloride neb soln .9%, 10%, 3%, 7% (HYPER-SAL Equiv)	1	-
MUCOLYTICS - Drugs to treat cough, cold, and allergy symptoms		
acetylcysteine soln 10%, 20% (MUCOMYST Equiv)	1	-
DERMATOLOGICALS - Drugs to treat skin conditions		
ACNE PRODUCTS - Drugs to treat skin conditions		
adapalene cream .1% (DIFFERIN Equiv)	1	PA Acne Only – members age 35 or older require Prior Authorization
adapalene gel .1%, .3% (DIFFERIN Equiv)	1	PA Acne Only – members age 35 or older require Prior Authorization
adapalene/benzoyl peroxide gel 0.1-2.5% .1%-2.5% (EPIDUO Equiv)	1	PA Acne Only – members age 35 or older require Prior Authorization
AKNE-MYCIN OINT ***(erythromycin (acne aid))***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap 10MG, 20MG, 30MG, 40MG (ACCUTANE Equiv)	1	-
ATRALIN GEL, RETIN-A GEL .01%, .025%, .05% ***(tretinoin)***	3	PA
BENZACLIN GEL 1%-5%, 1.2%-2.5% ***(clindamycin phosphate-benzoyl peroxide)***	3	-
BENZAMYCIN GEL 3%-5% ***(benzoyl peroxide-erythromycin)***	3	-
CLEOCIN-T LOTION 1% ***(clindamycin phosphate (topical))***	3	-
CLEOCIN-T PAD 1% ***(clindamycin phosphate (topical))***	3	-
CLEOCIN-T SOLN 1% ***(clindamycin phosphate (topical))***	3	-
clindamycin gel 1% (CLEOCIN GEL Equiv)	1	-
clindamycin lotion 1% (CLEOCIN- T Equiv)	1	-
clindamycin pad 1% (CLEOCIN-T Equiv)	1	-
clindamycin topical soln 1% (CLEOCIN-T Equiv)	1	-
clindamycin/benzoyl peroxide gel 1%-5%, 1.2%-2.5% (BENZACLIN Equiv)	1	-
clindamycin/tretinoin gel .025%-1.2% (ZIANA Equiv)	1	-
DIFFERIN CREAM .1% ***(adapalene)***	3	PA
DIFFERIN GEL .1%, .3% ***(adapalene)***	3	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DUAC CS KIT ***(clindamycin phosphate-benzoyl peroxide w/ cleanser)***	3	-
DUAC GEL 1.2%-5% ***(clindamycin phosphate-benzoyl peroxide (refrigerate))***	3	-
EPIDUO FORTE GEL 0.3-2.5% .3%-2.5% ***(adapalene-benzoyl peroxide)***	1	PA Acne Only – members age 35 or older require Prior Authorization
EPIDUO GEL 0.1-2.5% .1%-2.5% ***(adapalene-benzoyl peroxide)***	3	PA
ERY PAD 2% ***(erythromycin (acne aid))***	2	-
erythromycin gel 2%	1	-
erythromycin pad 2%	1	-
erythromycin soln 2%	1	-
erythromycin/benzoyl peroxide gel 3%-5% (BENZAMYCIN Equiv)	1	-
KLARON LOTION 10% ***(sulfacetamide sodium (acne))***	3	-
RETIN-A CREAM .025%, .05%, .1% ***(tretinoin)***	3	PA
sodium sulfacetamide lotion 10% (KLARON Equiv)	1	-
sodium sulfacetamide/sulfur emulsion 10-5%	1	-
sodium sulfacetamide/sulfur wash 9-4.5% 4.5%-9%	1	-
tretinoin cream .025%, .05%, .1%	1	PA Acne Only – members age 35 or older require Prior Authorization

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
tretinoin gel .01%, .025%, .05% (RETIN-A GEL Equiv)	1	PA Acne Only – members age 35 or older require Prior Authorization
TRETIN-X CREAM .075% ***(tretinoin)***	3	PA
ZIANA GEL .025%-1.2% ***(clindamycin phosphate-tretinoin)***	3	-
AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES - drugs for cosmetic uses		
RENOVA CREAM .02%, .05% ***(tretinoin (facial wrinkles))***	EXC	-
ANTIBIOTICS - TOPICAL - Drugs to treat bacterial infections		
BACTROBAN OINT ***(mupirocin)***	3	-
CENTANY OINT 2% ***(mupirocin)***	3	-
CORTISPORIN CREAM .5% -3.5MG/GM-10000UNIT/GM ***(neomycin-polymyxin-hc)***	3	-
CORTISPORIN OINT .5%-1% -400UNIT/GM-5000UNIT/GM ***(bacitracin-polymyxin-neomycin hc)***	3	-
gentamicin sulfate cream	1	-
gentamicin sulfate oint .1%	1	-
mupirocin oint 2% (BACTROBAN OINT Equiv)	1	-
ANTIFUNGALS - TOPICAL - Drugs to treat fungal infections		
ciclopirox cream .77% (LOPROX CREAM Equiv)	1	-
ciclopirox gel .77% (LOPROX GEL Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ciclopirox nail soln 8% (PENLAC Equiv)	1	-
ciclopirox shampoo 1% (LOPROX SHAMPOO Equiv)	1	-
ciclopirox topical susp .77% (LOPROX SUSP Equiv)	1	-
clotrimazole/betamethasone cream .05%-1% (LORTRISONE CREAM Equiv)	1	-
clotrimazole/betamethasone lotion .05%-1% (LOTRISONE LOTION Equiv)	1	-
econazole cream 1% (SPECTAZOLE Equiv)	1	-
EXELDERM SOLN 1% ***(sulconazole nitrate)***	3	-
ketoconazole cream 2% (NIZORAL CREAM Equiv)	1	-
ketoconazole shampoo 2% (NIZORAL SHAMPOO Equiv)	1	-
LOPROX CREAM .77% ***(ciclopirox olamine)***	3	-
LOPROX GEL ***(ciclopirox)***	3	-
LOPROX SHAMPOO 1% ***(ciclopirox)***	3	-
LOTRISONE CREAM .05%-1% ***(clotrimazole w/ betamethasone)***	3	-
LOTRISONE LOTION ***(clotrimazole w/ betamethasone)***	3	-
MENTAX CREAM 1% ***(butenafine hcl)***	3	-
NAFTIFINE CREAM 1% ***(naftifine hcl)***	3	-
naftifine cream 1%, 2% (NAFTIN Equiv)	1	-
naftifine gel 1% (NAFTIN Equiv)	1	-
NAFTIN CREAM 2% ***(naftifine hcl)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NAFTIN GEL 1% ***(naftifine hcl)***	3	-
NAFTIN GEL 1% ***(naftifine hcl)***	3	-
NIZORAL A-D SHAMPOO 1% ***(ketoconazole (topical))***	EXC	OTC
nizoral a-d shampoo 1%	EXC	OTC
NIZORAL SHAMPOO 2% ***(ketoconazole (topical))***	3	-
nystatin cream 100000UNIT/GM (MYCOSTATIN CREAM Equiv)	1	-
nystatin oint 100000UNIT/GM	1	-
nystatin topical powder 100000UNIT/GM	1	-
nystatin/triamcinolone cream .1%-100000UNIT/GM, 1MG/GM-100000UNIT/GM	1	-
nystatin/triamcinolone oint .1%-100000UNIT/GM	1	-
oxiconazole nitrate cream 1% (OXISTAT Equiv)	1	-
ANTI-INFLAMMATORY AGENTS - TOPICAL - Drugs to treat pain and inflammation		
diclofenac gel 1% 1% (VOLTAREN Equiv)	1	OTC-QL QL= 5 tubes/fill
DICLOFENAC PATCH, FLECTOR PATCH 1.3% ***(diclofenac epolamine)***	3	QL QL= 30 patches/fill
VOLTAREN GEL 1% ***(diclofenac sodium (topical))***	EXC	OTC
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL - Drugs to treat cancer		
diclofenac gel 3% (SOLARAZE Equiv)	1	PA-QL QL= 300gm/30 days
EFUDEX CREAM 5% ***(fluorouracil (topical))***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
fluorouracil cream 5% (EFUDEX CREAM Equiv)	1	-
FLUOROURACIL CREAM 0.5% .5% ***(fluorouracil (topical))***	3	-
FLUOROURACIL SOLN 2%, 5% ***(fluorouracil (topical))***	2	-
PANRETIN GEL .1% ***(alitretinoin)***	4	LMSP-PA
PICATO GEL .015% ***(ingenol mebutate)***	3	QL QL= 1 box/fill
SOLARAZE GEL ***(diclofenac sodium (actinic keratoses))***	3	PA-QL QL= 300gm/30 days
TARGRETIN GEL 1% ***(bexarotene (topical))***	4	LMSP-PA
VALCHLOR GEL .016% ***(mechlorethamine hcl (topical))***	4	LD-PA-QL QL= 4 tubes/30 days; Only available through Avella (877) 546-5779
ANTIPRURITICS - TOPICAL - Drugs to treat itching		
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM 5% ***(doxepin hcl (antipruritic))***	3	PA
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM 5% ***(doxepin hcl (antipruritic))***	3	PA
ANTIPSORIATICS - Drugs to treat psoriasis		
8-MOP CAP ***(methoxsalen)***	2	LMSP
acitretin cap 10MG, 17.5MG, 25MG (SORIATANE Equiv)	4	LMSP

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
calcipotriene cream .005% (DOVONEX CREAM Equiv)	1	QL QL= 120gm/30 days
calcipotriene oint .005%	1	-
calcipotriene soln .005% (DOVONEX SOLN Equiv)	1	-
CALCITRIOL OINT 3MCG/GM ***(calcitriol (topical))***	3	-
DOVONEX CREAM .005% ***(calcipotriene)***	3	-
DOVONEX SOLN ***(calcipotriene)***	3	-
DRITHO-SCALP CREAM 1% ***(anthralin)***	3	-
METHOXSALEN CAP 10MG ***(methoxsalen rapid)***	2	LMSP
methoxsalen cap 10MG (OXSORALEN ULTRA Equiv)	1	LMSP
OXSORALEN ULTRA CAP 10MG ***(methoxsalen rapid)***	3	LMSP
SKYRIZI INJ 150MG/ML 150MG/ML ***(risankizumab-rzaa)***	4	LMSP-PA-QL QL= 1 inj/84 days
SKYRIZI INJ 75MG/0.83ML 75MG/0.83ML ***(risankizumab-rzaa)***	4	LMSP-PA-QL QL= 2 inj/84 days
STELARA INJ 45MG/0.5ML ***(ustekinumab)***	4	LMSP-PA-QL QL= 1 inj/84 days
TALTZ INJ 80MG/ML ***(ixekizumab)***	4	LMSP-PA-QL QL= 1 inj/28 days
tazarotene cream 0.1% .1% (TAZORAC Equiv)	1	-
TAZORAC CREAM .1% ***(tazarotene)***	3	-
TAZORAC CREAM 0.05% .05% ***(tazarotene)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TREMFYA INJ 100MG/ML ***(guselkumab)***	4	LMSP-PA-QL QL= 1 inj/56 days
ANTISEBORRHEIC PRODUCTS - Drugs to treat skin conditions		
OVACE PLUS CREAM 10% ***(sulfacetamide sodium)***	3	-
OVACE PLUS GEL 10% ***(sulfacetamide sodium)***	3	-
OVACE PLUS SHAMPOO 10% ***(sulfacetamide sodium)***	3	-
ROSULA PAD ***(sulfacetamide sodium-urea)***	3	-
seb-prev cream (OVACE CREAM Equiv)	1	-
selenium sulfide lotion 1%, 2.5%	EXC	OTC
selenium sulfide shampoo 2.25% (SELSEB Equiv)	1	-
sodium sulfacetamide gel 10% (OVACE PLUS Equiv)	1	-
sodium sulfacetamide shampoo 10%, 9.8% (OVACE Equiv)	1	-
sodium sulfacetamide/urea pad (ROSULA Equiv)	1	-
ANTIVIRALS - TOPICAL - Drugs to treat viral infections		
acyclovir oint 5% (ZOVIRAX OINT Equiv)	1	-
DENAVIR CREAM 1% ***(penciclovir)***	3	-
BURN PRODUCTS - Drugs to treat burns		
SILVADENE CREAM 1% ***(silver sulfadiazine)***	3	-
silver sulfadiazine cream 1% (SILVADENE CREAM Equiv)	1	-
SULFAMYLON CREAM 85MG/GM ***(mafenide acetate)***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CORTICOSTEROIDS - TOPICAL - Drugs to treat itching and inflammation		
ACLOVATE CREAM ***(alclometasone dipropionate)***	3	-
ACLOVATE OINT ***(alclometasone dipropionate)***	3	-
alclometasone cream .05% (ACLOVATE Equiv)	1	-
alclometasone oint .05% (ACLOVATE OINT Equiv)	1	-
betamethasone augmented cream .05% (DIPROLENE AF CREAM Equiv)	1	-
BETAMETHASONE AUGMENTED GEL .05% ***(betamethasone dipropionate augmented)***	2	-
betamethasone augmented gel	1	-
betamethasone augmented lotion .05% (DIPROLENE LOTION Equiv)	1	-
betamethasone augmented oint .05% (DIPROLENE OINT Equiv)	1	-
betamethasone diproprionate cream .05% (DIPROSONE CREAM Equiv)	1	-
betamethasone diproprionate lotion .05%	1	-
betamethasone diproprionate oint .05% (DIPROSONE OINT Equiv)	1	-
betamethasone valerate cream .1%	1	-
betamethasone valerate lotion .1%	1	-
betamethasone valerate oint .1%	1	-
CARMOL-HC CREAM ***(hydrocortisone acetate-urea)***	3	-
clobetasol foam .05% (OLUX Equiv)	1	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
clobetasol lotion .05% (CLOBEX Equiv)	1	PA
clobetasol propionate cream .05% (TEMOVATE Equiv)	1	-
clobetasol propionate emollient cream .05% (TEMOVATE E Equiv)	1	-
clobetasol propionate gel .05% (TEMOVATE GEL Equiv)	1	-
clobetasol propionate oint .05% (TEMOVATE Equiv)	1	-
clobetasol propionate soln .05% (TEMOVATE Equiv)	1	PA
clobetasol shampoo .05% (CLOBEX Equiv)	1	PA
clobetasol spray .05% (CLOBEX Equiv)	1	PA
CLOBEX LOTION .05% ***(clobetasol propionate)***	3	PA
CLOBEX SHAMPOO .05% ***(clobetasol propionate)***	3	PA
CLOBEX SPRAY .05% ***(clobetasol propionate)***	3	PA
CUTIVATE CREAM ***(fluticasone propionate)***	3	-
CUTIVATE OINT ***(fluticasone propionate)***	3	-
DERMA-SMOOTH/FS OIL .01% ***(fluocinolone acetonide)***	2	-
DERMATOP CREAM ***(prednicarbate)***	3	-
DERMATOP OINT ***(prednicarbate)***	3	-
desoximetasone cream .25% (TOPICORT CREAM Equiv)	1	-
desoximetasone oint .25% (TOPICORT Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DIPROLENE AF CREAM .05% ***(betamethasone dipropionate augmented)***	3	-
DIPROLENE LOTION ***(betamethasone dipropionate augmented)***	3	-
DIPROLENE OINT .05% ***(betamethasone dipropionate augmented)***	3	-
ELOCON CREAM .1% ***(mometasone furoate)***	3	-
ELOCON OINT .1% ***(mometasone furoate)***	3	-
ELOCON SOLN ***(mometasone furoate)***	3	-
EPIFOAM AEROSOL 1% ***(pramoxine-hc)***	2	-
fluocinolone acetonide cream .01%, .025%	1	-
fluocinolone acetonide oil .01% (DERMA-SMOOTH/FS Equiv)	1	-
fluocinolone acetonide oint .025%	1	-
fluocinolone acetonide soln .01%	1	-
fluocinonide cream 0.05% .05% (LIDEX Equiv)	1	-
fluocinonide cream 0.1% .1% (VANOS CREAM Equiv)	1	-
fluocinonide emollient cream .05%	1	-
fluocinonide gel .05%	1	-
fluocinonide oint .05%	1	-
fluocinonide soln .05%	1	-
fluticasone propionate cream .05% (CUTIVATE Equiv)	1	-
fluticasone propionate oint .005% (CUTIVATE Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
halobetasol propionate cream .05% (ULTRAVATE Equiv)	1	-
halobetasol propionate oint .05% (ULTRAVATE Equiv)	1	PA
hydrocortisone cream .5%, 1%, 2.5% (PROCTOCORT Equiv)	1	-
hydrocortisone lotion 1%, 2.5% (HYTONE Equiv)	1	-
hydrocortisone oint .5%, 1%, 2.5%	1	-
mometasone cream .1% (ELOCON Equiv)	1	-
mometasone oint .1% (ELOCON Equiv)	1	-
mometasone soln .1% (ELOCON Equiv)	1	-
NUCORT LOTION 2% ***(hydrocortisone acetate (topical))***	3	-
OLUX FOAM .05% ***(clobetasol propionate)***	3	PA
PREDNICARBATE CREAM .1% ***(prednicarbate)***	2	-
PREDNICARBATE OIN .1% ***(prednicarbate)***	2	-
PROCTOCORT CREAM 1% ***(hydrocortisone (topical))***	3	-
TEMOVATE CREAM .05% ***(clobetasol propionate)***	3	-
TEMOVATE GEL ***(clobetasol propionate)***	3	-
TEMOVATE OINT .05% ***(clobetasol propionate)***	3	-
TEMOVATE SOLN ***(clobetasol propionate)***	3	PA
TEMOVATE-E CREAM ***(clobetasol propionate emollient base)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TOPICORT CREAM .25% ***(desoximetasone)***	3	-
TOPICORT OINT .25% ***(desoximetasone)***	3	-
triamcinolone cream .025%, .1%, .5%	1	-
triamcinolone lotion .025%, .1%	1	-
triamcinolone oint .025%, .1%, .5%	1	-
U-CORT CREAM ***(hydrocortisone acetate-urea)***	2	-
ULTRAVATE CREAM .05% ***(halobetasol propionate)***	3	-
ULTRAVATE OINT .05% ***(halobetasol propionate)***	3	-
ECZEMA AGENTS - Drugs to treat eczema		
DUPIXENT INJ 200MG/1.14ML ***(dupilumab)***	4	LMSP-PA-QL QL= 2 inj/ 28 days
DUPIXENT INJ 100MG/0.67ML 100MG/0.67ML ***(dupilumab)***	4	LMSP-PA-QL QL= 2 inj/28 days
DUPIXENT PEN INJ 300MG/2ML ***(dupilumab)***	4	LMSP-PA-QL QL= 2 inj/28 days
EMOLLIENTS - Drugs to treat skin conditions		
ammonium lactate cream 12% (LAC-HYDRIN Equiv)	EXC	OTC
ammonium lactate lotion 10%, 12%, 5% (LAC-HYDRIN Equiv)	EXC	OTC
LAC-HYDRIN CREAM 12% ***(lactic acid (ammonium lactate))***	3	-
LAC-HYDRIN LOTION 12% ***(lactic acid (ammonium lactate))***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
LACTIC ACID LOTION 10%, 5% ***(lactic acid (ammonium lactate))***	1	-
ENZYMES - TOPICAL - Drugs to treat skin conditions		
SANTYL OINT 250UNIT/GM ***(collagenase)***	2	QL QL= 90gm/30 days
HAIR GROWTH AGENTS - drugs to grow hair		
finasteride tab 1MG (PROPECIA Equiv)	EXC	-
HAIR REDUCTION AGENTS - drugs to remove hair		
VANIQA CREAM 13.9% ***(eflornithine hcl)***	EXC	-
IMMUNOMODULATING AGENTS - TOPICAL - Drugs to treat disorders of the immune system		
ALDARA CREAM 5% ***(imiquimod)***	3	-
imiquimod cream 5% (ALDARA Equiv)	1	-
IMMUNOSUPPRESSIVE AGENTS - TOPICAL - Drugs to treat disorders of the immune system		
ELIDEL CREAM 1% ***(pimecrolimus)***	3	Covered for members 2 years or older
pimecrolimus cream 1% (ELIDEL Equiv)	1	Covered for members 2 years or older
PROTOPIC OINT .03%, .1% ***(tacrolimus (topical))***	3	-
tacrolimus oint .03%, .1% (PROTOPIC OINT Equiv)	1	-
KERATOLYTIC/ANTIMITOTIC AGENTS - Drugs to treat skin conditions		
CONDYLOX SOLN ***(podofilox)***	3	-
PODOCON SOLN 25% ***(podophyllum resin)***	2	-
podofilox soln (CONDYLOX Equiv)	1	-
SALEX SHAMPOO 2%, 3% ***(salicylic acid)***	3	-
SALEX SHAMPOO 6% ***(salicylic acid)***	3	-
LOCAL ANESTHETICS - TOPICAL - Drugs for numbing		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
EMLA CREAM ***(lidocaine-prilocaine)***	3	-
lidocaine cream 3% 3%, 4% (LIDAMANTLE Equiv)	1	-
lidocaine gel 2% (XYLOCAINE Equiv)	1	-
lidocaine oint	1	QL QL= 107gm/30 days
lidocaine patch 4%, 5% (LIDODERM Equiv)	1	QL QL= 3 patches/day
lidocaine soln 4% (XYLOCAINE Equiv)	1	-
lidocaine/prilocaine cream 2.5% (EMLA Equiv)	1	-
LIDODERM PATCH 4%, 5% ***(lidocaine)***	3	QL QL= 3 patches/day
SYNERA PATCH 70MG ***(lidocaine-tetracaine)***	3	-
XYLOCAINE SOLN ***(lidocaine hcl)***	3	-
MISC. TOPICAL - Miscellaneous topical products		
aluminum chloride soln (DRYSOL Equiv)	1	-
DRYSOL SOLN 20% ***(aluminum chloride)***	1	-
PIGMENTING-DEPIGMENTING AGENTS - drugs to treat skin discoloration		
hydroquinone cream 4% (LUSTRA Equiv)	EXC	-
TRI-LUMA CREAM .01%-.05%-4% ***(fluocinolone-hydroquinone-tretinoin)***	EXC	-
ROSACEA AGENTS - Drugs to treat skin conditions		
azelaic acid gel 15% (FINACEA Equiv)	1	-
FINACEA GEL 15% ***(azelaic acid)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FINACEA PLUS KIT ***(azelaic acid w/ cleanser & moisturizing lotion)***	2	-
METROCREAM .75% ***(metronidazole (topical))***	3	-
METROGEL 1% 1% ***(metronidazole (topical))***	3	-
METROLOTION .75% ***(metronidazole (topical))***	3	-
metronidazole cream .75% (METROCREAM Equiv)	1	-
metronidazole gel 1% (METROGEL Equiv)	1	-
metronidazole gel 0.75% .75% (METROGEL Equiv)	1	-
metronidazole lotion .75% (METROLOTION Equiv)	1	-
NORITATE CREAM 1% ***(metronidazole (topical))***	3	ST Step Therapy requires trial of FINACEA
SCABICIDES & PEDICULICIDES - Drugs to treat skin conditions		
CROTAN LOTION 10% ***(crotamiton)***	3	-
ELIMITE CREAM 5% ***(permethrin)***	3	-
EURAX LOTION 10% ***(crotamiton)***	3	-
IVERMECTIN LOTION .5% ***(ivermectin (pediculicide))***	3	PA-QL QL= 1 tube/fill
LINDANE LOTION ***(lindane)***	3	-
lindane lotion	1	-
LINDANE SHAMPOO 1% ***(lindane)***	1	-
lindane shampoo	1	-
malathion lotion .5% (OVIDE Equiv)	1	QL QL= 2 bottles/fill

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NATROBA SUSP .9% ***(spinosad)***	3	QL QL= 1 bottle/fill
OVIDE LOTION .5% ***(malathion)***	3	QL QL= 2 bottles/fill
permethrin cream 5% (ELIMITE CREAM Equiv)	1	-
SKLICE LOTION .5% ***(ivermectin (pediculicide))***	3	PA-QL QL= 1 tube/fill
SPINOSAD SUSP .9% ***(spinosad)***	2	QL QL= 1 bottle/fill
WOUND CARE PRODUCTS - Drugs to treat diabetic ulcers		
REGRANEX GEL .01% ***(becaplermin)***	2	QL QL= 30gm/fill
VENELEX OINT 87MG/GM-788MG/GM ***(balsam peru-castor oil)***	2	-
DIAGNOSTIC PRODUCTS - Miscellaneous diagnostic test products		
DIAGNOSTIC PRODUCTS, MISC. - drugs to diagnose or monitor conditions		
FREESTYLE LITE TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication
DIAGNOSTIC TESTS - Miscellaneous diagnostic test products		
ACCU-CHEK AVIVA PLUS TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ACCU-CHEK GUIDE TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication
ACCU-CHEK SMARTVIEW TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication
ACCU-CHEK TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication
FREESTYLE INSULINX TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication
FREESTYLE PRECISION NEO TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication
FREESTYLE TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication
KETO-DIASTIX TEST STRIP ***(urine glucose-ketones test)***	1	OTC
KETOSTIX ***(acetone (urine) test)***	1	OTC
PRECISION XTRA TEST STRIP ***(glucose blood)***	2	OTC Limited to 50 strips per month for members not on diabetes medication

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS - Drugs to treat nutrition condition		
INFANT FOODS		
INFANT FORMULA LIQUID ***(infant foods)***	2	OTC-PA
INFANT FORMULA POWDER ***(infant foods)***	2	OTC-PA
NUTRITIONAL SUPPLEMENTS - Drugs to treat nutrition deficiency		
NUTRITIONAL SUPPLEMENT LIQUID ***(nutritional supplements)***	2	OTC-PA
NUTRITIONAL SUPPLEMENT POWDER ***(nutritional supplements)***	2	OTC-PA
DIGESTIVE AIDS - Drugs to treat low digestive enzymes		
DIGESTIVE ENZYMES - Drugs to treat low digestive enzymes		
CREON CAP 12000UNIT-38000UNIT-60000UNIT, 24000UNIT-76000UNIT-120000UNIT, 3000UNIT-9500UNIT-15000UNIT, 36000UNIT-114000UNIT-180000UNIT, 6000UNIT-19000UNIT-30000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	-
DIURETICS - Drugs to treat heart, circulation conditions, and blood pressure		
CARBONIC ANHYDRASE INHIBITORS - Drugs to treat high blood pressure		
acetazolamide ER cap 500MG (DIAMOX SEQUEL Equiv)	1	-
acetazolamide tab 125MG, 250MG	1	-
DIAMOX SEQUEL CAP ***(acetazolamide)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
methazolamide tab 25MG, 50MG (NEPTAZANE Equiv)	1	-
NEPTAZANE TAB 25MG ***(methazolamide)***	3	-
DIURETIC COMBINATIONS - Drugs to treat heart, circulation conditions, and blood pressure		
ALDACTAZIDE TAB 25MG ***(spironolactone & hydrochlorothiazide)***	3	-
ALDACTAZIDE TAB 50-50MG 50MG ***(spironolactone & hydrochlorothiazide)***	3	-
amiloride/hydrochlorothiazide tab 5MG-50MG (MODURETIC Equiv)	1	-
DYAZIDE CAP 25MG-37.5MG ***(triamterene & hydrochlorothiazide)***	3	-
MAXZIDE TAB 25MG-37.5MG, 50MG-75MG ***(triamterene & hydrochlorothiazide)***	3	-
spironolactone/hydrochlorothiazide tab 25MG (ALDACTAZIDE Equiv)	1	-
triamterene/hydrochlorothiazide cap 25MG-37.5MG (DYAZIDE Equiv)	1	-
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg ***(triamterene & hydrochlorothiazide)***	2	-
triamterene/hydrochlorothiazide tab 25MG-37.5MG, 50MG-75MG (MAXZIDE Equiv)	1	-
LOOP DIURETICS - Drugs to treat heart, circulation conditions, and blood pressure		
bumetanide tab .5MG, 1MG, 2MG (BUMEX Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DEMADEX TAB 10MG, 20MG ***(torsemide)***	3	-
EDECRIN TAB 25MG ***(ethacrynic acid)***	3	-
ethacrynic tab 25MG (EDECRIN Equiv)	1	-
FUROSEMIDE SOLN 8MG/ML (LASIX Equiv) ***(furosemide)***	1	-
furosemide soln 10MG/ML (LASIX Equiv)	1	-
furosemide tab 20MG, 40MG, 80MG (LASIX Equiv)	1	-
LASIX TAB 20MG, 40MG, 80MG ***(furosemide)***	3	-
torsemide tab 100MG, 10MG, 20MG, 5MG (DEMADEX Equiv)	1	-
POTASSIUM SPARING DIURETICS - Drugs to treat heart, circulation conditions, and blood pressure		
ALDACTONE TAB 100MG, 25MG, 50MG ***(spironolactone)***	3	-
amiloride tab 5MG (MIDAMOR Equiv)	1	-
CAROSPIR SUSP 25MG/5ML ***(spironolactone)***	3	PA Prior Authorization required for members age 9 or older
MIDAMOR TAB ***(amiloride hcl)***	3	-
spironolactone tab 100MG, 25MG, 50MG (ALDACTONE Equiv)	1	-
THIAZIDES AND THIAZIDE-LIKE DIURETICS - Drugs to treat heart, circulation conditions, and blood pressure		
CHLOROTHIAZIDE TAB 250MG, 500MG (DIURIL Equiv) ***(chlorothiazide)***	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
chlorothiazide tab 500MG (DIURIL Equiv)	1	-
chlorthalidone tab 25MG, 50MG	1	-
DIURIL SUSP 250MG/5ML ***(chlorothiazide)***	2	-
hydrochlorothiazide cap 12.5MG (MICROZIDE Equiv)	1	-
hydrochlorothiazide tab 12.5MG, 25MG, 50MG (HYDRODIURIL Equiv)	1	-
indapamide tab 1.25MG, 2.5MG (LOZOL Equiv)	1	-
metolazone tab 10MG, 2.5MG, 5MG (ZAROXOLYN Equiv)	1	-
MICROZIDE CAP 12.5MG ***(hydrochlorothiazide)***	3	-
ZAROXOLYN TAB ***(metolazone)***	3	-
ENDOCRINE AND METABOLIC AGENTS - MISC. - Drugs to treat bone disease and regulate hormones		
BONE DENSITY REGULATORS - Drugs to treat bone disease		
ACTONEL TAB 150MG, 30MG, 35MG, 5MG ***(risedronate sodium)***	3	ST Step Therapy requires trial of alendronate
alendronate sodium oral soln 70MG/75ML (FOSAMAX Equiv)	1	-
alendronate tab 10MG, 35MG, 5MG, 70MG (FOSAMAX Equiv)	1	-
ALENDRONATE TAB 40MG 40MG, 5MG ***(alendronate sodium)***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ATELVIA TAB 35MG ***(risedronate sodium)***	3	ST Step Therapy requires trial of alendronate
BONIVA TAB 150MG 150MG ***(ibandronate sodium)***	3	QL-ST QL= 1 tab/30 days; Step Therapy requires trial of alendronate
calcitonin nasal spray 200UNIT/ACT (MIACALCIN Equiv)	1	-
FORTEO INJ 620MCG/2.48ML ***(teriparatide (recombinant))***	4	LMSP
FOSAMAX TAB 70MG ***(alendronate sodium)***	3	-
ibandronate tab 150mg 150MG (BONIVA Equiv)	1	QL-ST QL= 1 tab/30 days; Step Therapy requires trial of alendronate
NATPARA INJ 100MCG, 25MCG, 50MCG, 75MCG ***(parathyroid hormone (recombinant))***	4	LD-PA Only available through Walgreens 888-347-3416
PROLIA INJ 60MG/ML ***(denosumab)***	M	M
risedronate DR tab 35MG (ATELVIA Equiv)	1	ST Step Therapy requires trial of alendronate
risedronate tab 150MG, 30MG, 35MG, 5MG (ACTONEL Equiv)	1	ST Step Therapy requires trial of alendronate

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
SKELID TAB ***(tiludronate disodium)***	3	-
TYMLOS INJ 3120MCG/1.56ML ***(abaloparatide)***	4	LMSP
CORTICOTROPIN ***		
ACTHAR GEL INJ 80UNIT/ML ***(corticotropin)***	4	MSP-PA-QL QL= 4 vials/fill
GNRH/LHRH ANTAGONISTS - Drugs to treat endometriosis		
ORILISSA TAB 150MG 150MG ***(elagolix sodium)***	2	PA-QL QL= 1 tab/day
ORILISSA TAB 200MG 200MG ***(elagolix sodium)***	2	PA-QL QL= 2 tabs/day
GROWTH HORMONE RECEPTOR ANTAGONISTS - Drugs to regulate hormones		
SOMAVERT INJ 10MG, 15MG, 20MG, 25MG, 30MG ***(pegvisomant)***	4	LD-PA Only available through Walgreens 888-347-3416
GROWTH HORMONE RELEASING HORMONES (GHRH) - Drugs to treat abnormal fat distribution		
EGRIFTA INJ 1MG, 2MG ***(tesamorelin acetate)***	EXC	-
GROWTH HORMONES - Drugs to regulate hormones		
GENOTROPIN INJ .2MG, .4MG, .6MG, .8MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 12MG, 1MG, 2MG, 5MG ***(somatropin)***	4	LMSP-PA
HORMONE RECEPTOR MODULATORS - Drugs to regulate hormones		
EVISTA TAB 60MG ***(raloxifene hcl)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
raloxifene tab 60MG (EVISTA Equiv)	$0	Covered at $0 for women 35 years or older; All other members covered at generic copay
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS) - Drugs to regulate hormones		
INCRELEX INJ 40MG/4ML ***(mecasermin)***	4	MSP
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS - Drugs to regulate hormones		
LUPRON DEPOT PED INJ 11.25MG, 30MG ***(leuprolide acetate (cpp) (3 month))***	M	M
LUPRON DEPOT-PED INJ 11.25MG, 15MG, 7.5MG ***(leuprolide acetate (cpp))***	M	M
SYNAREL NASAL SOLN 2MG/ML ***(nafarelin acetate)***	4	LMSP
METABOLIC MODIFIERS - Drugs to regulate metabolism or hormones		
ALDURAZYME INJ 2.9MG/5ML ***(laronidase)***	M	M
calcitriol cap .25MCG, .5MCG (ROCALTROL Equiv)	1	-
calcitriol soln 1MCG/ML (ROCALTROL Equiv)	1	-
CARBAGLU TAB 200MG ***(carglumic acid)***	4	LD-PA Only available through Accredo 888-773-7376
carglumic acid tab 200MG (CARBAGLU Equiv)	4	LD-PA Only available through Accredo 888-773-7376
CARNITOR SOLN 1GM/10ML ***(levocarnitine (metabolic modifiers))***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CARNITOR TAB 330MG ***(levocarnitine (metabolic modifiers))***	3	-
cinacalcet tab 30MG, 60MG, 90MG (SENSIPAR Equiv)	4	LMSP
doxercalciferol cap .5MCG, 1MCG, 2.5MCG (HECTOROL Equiv)	1	-
FABRAZYME INJ 35MG, 5MG ***(agalsidase beta)***	M	M
HECTOROL CAP .5MCG, 1MCG, 2.5MCG ***(doxercalciferol)***	3	-
levocarnitine soln 1GM/10ML (CARNITOR Equiv)	1	-
levocarnitine tab 330MG (CARNITOR Equiv)	1	-
PALYNZIQ INJ 20MG/ML ***(pegvaliase-pqpz)***	4	LD-PA-QL-SF QL= 1 inj/day; Only available through Diplomat Pharmacy 877-977-9118
paricalcitol cap 1MCG, 2MCG, 4MCG (ZEMPLAR Equiv)	1	-
ROCALTROL CAP .25MCG, .5MCG ***(calcitriol)***	3	-
ROCALTROL SOLN 1MCG/ML ***(calcitriol)***	3	-
sapropterin dihydrochloride powder packet 100MG, 500MG (KUVAN Equiv)	4	LMSP-PA
sapropterin dihydrochloride soluble tab 100MG (KUVAN Equiv)	4	LMSP-PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
STRENSIQ INJ 18MG/0.45ML, 28MG/0.7ML, 40MG/ML, 80MG/0.8ML ***(asfotase alfa)***	4	LD-PA Only available through PantherRx Pharmacy 855-726-8479
ZEMPLAR CAP 1MCG, 2MCG ***(paricalcitol)***	3	-
POSTERIOR PITUITARY HORMONES - Drugs to regulate hormones		
DDAVP INJ 4MCG/ML ***(desmopressin acetate)***	3	-
DDAVP NASAL SOLN .01% ***(desmopressin acetate refrigerated)***	3	-
DDAVP NASAL SPRAY .01% ***(desmopressin acetate spray)***	3	-
DDAVP TAB .1MG, .2MG ***(desmopressin acetate)***	3	-
desmopressin acetate inj 4MCG/ML (DDAVP Equiv)	1	-
desmopressin acetate nasal spray .01%, .1MG/ML (DDAVP Equiv)	1	-
desmopressin acetate tab .1MG, .2MG (DDAVP Equiv)	1	-
desmopressin nasal soln (DDAVP Equiv)	1	-
STIMATE NASAL SOLN 1.5MG/ML ***(desmopressin acetate)***	2	LMSP
PROLACTIN INHIBITORS - Drugs to regulate hormones		
cabergoline tab .5MG (DOSTINEX Equiv)	1	-
SOMATOSTATIC AGENTS - Drugs to regulate hormones		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
octreotide inj 1000MCG/5ML, 1000MCG/ML, 100MCG/ML, 200MCG/ML, 500MCG/ML, 50MCG/ML (SANDOSTATIN Equiv)	4	LMSP
OCTREOTIDE INJ 100MCG 100MCG/ML, 500MCG/ML, 50MCG/ML ***(octreotide acetate)***	4	LMSP
SIGNIFOR INJ .3MG/ML, .6MG/ML, .9MG/ML ***(pasireotide diaspartate)***	4	LD-PA-QL QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007
VASOPRESSIN RECEPTOR ANTAGONISTS - Drugs to regulate hormones		
JYNARQUE PAK 15MG ***(tolvaptan)***	4	LD-PA-QL QL= 2 tabs/day; Only available through Walgreens 888-347-3416
JYNARQUE TAB 15MG, 30MG ***(tolvaptan)***	4	LD-PA-QL QL= 2 tabs/day; Only available through Walgreens 888-347-3416
ESTROGENS - Drugs to replace female hormones		
ESTROGEN COMBINATIONS - Drugs to replace female hormones		
ACTIVELLA TAB .1MG-.5MG, .5MG-1MG ***(estradiol & norethindrone acetate)***	3	-
ANGELIQ TAB .25MG-.5MG, .5MG-1MG ***(drospirenone-estradiol)***	3	-
CLIMARA PRO PATCH .015MG/DAY-.045MG/DAY ***(estradiol-levonorgestrel)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
COMBIPATCH .05MG/DAY-.14MG/DAY, .05MG/DAY-.25MG/DAY ***(estradiol & norethindrone acetate)***	3	-
estradiol/norethindrone tab .1MG-.5MG, .5MG-1MG (ACTIVELLA Equiv)	1	-
FEMHRT TAB .5MG-2.5MCG ***(norethindrone acetate-ethinyl estradiol)***	3	-
jinteli tab .5MG-2.5MCG, 1MG-5MCG (FEMHRT Equiv)	1	-
MYFEMBREE TAB .5MG-1MG-40MG ***(relugolix-estradiol-norethindrone acetate)***	2	PA-QL QL= 1 tab/day
ORIAHNN CAP .5MG-1MG-300MG ***(elagolix sodium-estradiol-norethindrone acetate)***	2	PA-QL QL= 2 caps/day
PREFEST TAB ***(estradiol-norgestimate)***	3	-
PREMPHASE TAB, PREMPRO TAB .3MG-1.5MG, .45MG-1.5MG, .625MG-2.5MG, .625MG-5MG ***(conjugated estrogens-medroxyprogesterone acetate)***	2	-
ESTROGENS - Drugs used for contraception		
ALORA PATCH .025MG/24HR, .05MG/24HR, .075MG/24HR, .1MG/24HR ***(estradiol)***	3	-
CENESTIN TAB ***(estrogens, conjugated synthetic a)***	3	-
CLIMARA PATCH .025MG/24HR, .05MG/24HR, .06MG/24HR, .075MG/24HR, .1MG/24HR, 37.5MCG/24HR ***(estradiol)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DIVIGEL GEL, ELESTRIN GEL .06%, .25MG/0.25GM, .5MG/0.5GM, .75MG/0.75GM, 1.25MG/1.25GM, 1MG/GM ***(estradiol)***	3	-
ENJUVIA TAB ***(estrogens, conjugated synthetic b)***	3	-
ESTRACE TAB ***(estradiol tab)***	3	-
estradiol patch .025MG/24HR, .0375MG/24HR, .05MG/24HR, .075MG/24HR, .1MG/24HR (CLIMARA Equiv)	1	-
estradiol tab .5MG, 1MG, 2MG (ESTRACE Equiv)	1	-
estradiol valerate inj 20MG/ML, 40MG/ML	1	-
ESTRASORB EMULSION ***(estradiol)***	3	-
EVAMIST SPRAY 1.53MG/SPRAY ***(estradiol)***	3	-
MENEST TAB .3MG, .625MG, 1.25MG, 2.5MG ***(esterified estrogens)***	3	-
MENOSTAR PATCH 14MCG/24HR ***(estradiol)***	3	-
PREMARIN TAB .3MG, .45MG, .625MG, .9MG, 1.25MG ***(estrogens, conjugated)***	2	-
VIVELLE-DOT PATCH .025MG/24HR, .0375MG/24HR, .05MG/24HR, .075MG/24HR, .1MG/24HR ***(estradiol)***	3	-
FLUOROQUINOLONES - Drugs to treat bacterial infections		
FLUOROQUINOLONES - Drugs to treat bacterial infections		
AVELOX TAB 400MG ***(moxifloxacin hcl)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CIPRO SUSP 5% 500MG/5ML, 5GM/100ML ***(ciprofloxacin)***	3	-
CIPRO TAB 250MG, 500MG ***(ciprofloxacin hcl)***	3	-
CIPRO XR TAB ***(ciprofloxacin-ciprofloxacin hcl)***	3	-
CIPROFLOXACIN 100MG TAB 100MG ***(ciprofloxacin hcl)***	3	-
CIPROFLOXACIN ER TAB 1000MG, 500MG ***(ciprofloxacin-ciprofloxacin hcl)***	3	-
ciprofloxacin susp 250MG/5ML, 500MG/5ML (CIPRO Equiv)	1	-
ciprofloxacin tab 250MG, 500MG, 750MG (CIPRO Equiv)	1	-
LEVAQUIN SOLN ***(levofloxacin)***	3	-
LEVAQUIN TAB 250MG, 500MG, 750MG ***(levofloxacin)***	3	-
levofloxacin soln 25MG/ML (LEVAQUIN Equiv)	1	-
levofloxacin tab 250MG, 500MG, 750MG (LEVAQUIN Equiv)	1	-
moxifloxacin tab 400MG (AVELOX Equiv)	1	-
NOROXIN TAB ***(norfloxacin)***	3	-
ofloxacin tab 400MG (FLOXIN Equiv)	1	-
GASTROINTESTINAL AGENTS - MISC. - Miscellaneous gastrointestinal drugs		
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC) - drugs to treat constipation		
TRULANCE TAB 3MG ***(plecanatide)***	2	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
BILE ACID SYNTHESIS DISORDER AGENTS - Drugs to treat bile acid disorders		
CHOLBAM CAP 250MG, 50MG ***(cholic acid)***	4	LD-PA Only available through Dohmen LSS 844-246-5226
FARNESOID X RECEPTOR (FXR) AGONISTS - Drugs to treat primary biliary cholangitis		
OCALIVA TAB 10MG, 5MG ***(obeticholic acid)***	4	LD-PA-QL-SF QL= 1 tab/day; Only available through Walgreens 888-347-3416
GALLSTONE SOLUBILIZING AGENTS - Drugs to treat bowel, intestine, and stomach conditions		
ACTIGALL CAP 300MG ***(ursodiol)***	3	-
URSO FORTE TAB 250MG, 500MG ***(ursodiol)***	3	-
ursodiol cap 300MG (ACTIGALL Equiv)	1	-
ursodiol tab 250MG, 500MG (URSO (FORTE) Equiv)	1	-
GASTROINTESTINAL ANTIALLERGY AGENTS - Drugs to treat bowel, intestine, and stomach conditions		
cromolyn conc 100MG/5ML (GASTROCROM Equiv)	1	-
GASTROCROM CONC 100MG/5ML ***(cromolyn sodium (mastocytosis))***	3	-
GASTROINTESTINAL STIMULANTS - Drugs to treat bowel, intestine, and stomach conditions		
metoclopramide soln 10MG/10ML, 5MG/5ML (REGLAN Equiv)	1	-
metoclopramide tab (REGLAN Equiv)	1	-
REGLAN TAB 10MG, 5MG ***(metoclopramide hcl)***	3	-
INFLAMMATORY BOWEL AGENTS - Drugs to treat disorders of the immune system		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
AZULFIDINE EN TAB 500MG ***(sulfasalazine)***	3	-
AZULFIDINE TAB 500MG ***(sulfasalazine)***	3	-
balsalazide cap 750MG (COLAZAL Equiv)	1	-
CIMZIA INJ 200MG, 200MG/ML ***(certolizumab pegol)***	4	LMSP-PA-QL QL= 2 inj/28 days
CIMZIA STARTER INJ KIT 200MG/ML ***(certolizumab pegol)***	4	LMSP-PA-QL QL= 1 kit/plan year
COLAZAL CAP 750MG ***(balsalazide disodium)***	3	-
DIPENTUM CAP 250MG ***(olsalazine sodium)***	3	-
mesalamine DR tab 1.2GM (LIALDA Equiv)	1	-
mesalamine enema 4GM (ROWASA Equiv)	1	-
mesalamine ER cap .375GM (APRISO Equiv)	1	-
mesalamine supp 1000MG (CANASA Equiv)	1	-
SFROWASA ENEMA 4GM/60ML ***(mesalamine)***	3	-
sulfasalazine EC tab 500MG (AZULFIDINE Equiv)	1	-
sulfasalazine tab 500MG (AZULFIDINE Equiv)	1	-
INTESTINAL ACIDIFIERS - Drugs to treat bowel, intestine, and stomach conditions		
lactulose soln 10GM/15ML	1	-
IRRITABLE BOWEL SYNDROME (IBS) AGENTS - Drugs to treat disorders of the immune system		
alosetron tab .5MG, 1MG (LOTRONEX Equiv)	1	-
LOTRONEX TAB .5MG, 1MG ***(alosetron hcl)***	3	-
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS - Drugs to treat overdose or toxicity		
MOVANTIK TAB 12.5MG, 25MG ***(naloxegol oxalate)***	2	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
SYMPROIC TAB .2MG ***(naldemedine tosylate)***	2	PA
SYMPROIC TAB .2MG ***(naldemedine tosylate)***	2	PA
PHOSPHATE BINDER AGENTS - Drugs to regulate calcium and phosphorus levels		
AURYXIA TAB 210MG ***(ferric citrate)***	3	-
calcium acetate cap 667MG (PHOSLO Equiv)	1	-
FOSRENOL CHEW TAB 1000MG, 500MG, 750MG ***(lanthanum carbonate)***	3	-
FOSRENOL POWDER PACK 1000MG, 750MG ***(lanthanum carbonate)***	2	-
lanthanum carbonate chew tab 1000MG, 500MG, 750MG (FOSRENOL Equiv)	1	-
PHOSLO CAP 667MG ***(calcium acetate (phosphate binder))***	3	-
PHOSLYRA SOLN 667MG/5ML ***(calcium acetate (phosphate binder))***	2	-
RENAGEL TAB 800MG 800MG ***(sevelamer hcl)***	3	-
RENVELA TAB 800MG ***(sevelamer carbonate)***	3	-
sevelamer hydrochloride tab 800MG (RENAGEL Equiv)	1	-
sevelamer powder pak .8GM, 2.4GM (RENVELA Equiv)	1	-
sevelamer tab 800MG (RENVELA TAB Equiv)	1	-
VELPHORO CHEW TAB 500MG ***(sucroferric oxyhydroxide)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
GENITOURINARY AGENTS - MISCELLANEOUS - Miscellaneous genitourinary drugs		
ALKALINIZERS - Drugs to treat low pH		
CYTRA K CRYSTALS 1002MG-3300MG ***(potassium citrate-citric acid)***	1	-
CYTRA-3 SYRUP 334MG/5ML-500MG/5ML-550MG/5ML ***(pot & sod citrates w/citric ac)***	1	-
ORACIT SOLN 490MG/5ML-640MG/5ML ***(sodium citrate & citric acid)***	1	-
POLYCITRA CRYSTAL PACK ***(potassium citrate-citric acid)***	3	-
POLYCITRA-LC SOLN ***(pot & sod citrates w/citric ac)***	3	-
potassium citrate CR tab 1080MG, 10MEQ, 15MEQ, 1620MG, 540MG (UROCIT-K TAB Equiv)	1	-
potassium citrate/citric acid powder pack 1002MG-3300MG (POLYCITRA Equiv)	1	-
potassium citrate/citric acid soln 334MG/5ML-1100MG/5ML (POLYCITRA-K Equiv)	1	-
sodium citrate/citric acid soln 334MG/5ML-500MG/5ML (BICITRA Equiv)	1	-
tricitrates soln 334MG/5ML-500MG/5ML-550MG/5ML (POLYCITRA-LC Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
UROCIT-K TAB 1080MG, 15MEQ, 540MG ***(potassium citrate (alkalinizer))***	3	-
CYSTINOSIS AGENTS - Drugs to treat enzyme deficiencies		
CYSTAGON CAP 150MG, 50MG ***(cysteamine bitartrate)***	4	LD-PA Only available through CVS Specialty 800-238-7828
GENITOURINARY IRRIGANTS - Drugs to treat the urinary system		
sodium chloride 0.9% irr soln .9%	1	-
INTERSTITIAL CYSTITIS AGENTS - Drugs to treat urinary incontinence		
ELMIRON CAP 100MG ***(pentosan polysulfate sodium)***	2	-
PROSTATIC HYPERTROPHY AGENTS - Drugs to treat enlarged prostate		
alfuzosin SR tab 10MG (UROXATRAL Equiv)	1	-
AVODART CAP .5MG ***(dutasteride)***	3	-
CARDURA XL TAB 4MG, 8MG ***(doxazosin mesylate (bph))***	3	-
dutasteride cap .5MG (AVODART Equiv)	1	-
finasteride tab 5MG (PROSCAR Equiv)	1	-
FLOMAX CAP .4MG ***(tamsulosin hcl)***	3	-
PROSCAR TAB 5MG ***(finasteride)***	3	-
tamsulosin cap .4MG (FLOMAX Equiv)	1	-
UROXATRAL TAB 10MG ***(alfuzosin hcl)***	3	-
URINARY ANALGESICS - Drugs to treat urinary pain		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
phenazopyridine tab 100MG, 200MG (PYRIDIUM Equiv)	1	-
URINARY STONE AGENTS - Drugs to prevent kidney stones		
LITHOSTAT TAB 250MG ***(acetohydroxamic acid)***	3	-
tiopronin tab 100MG (THIOLA Equiv)	4	LMSP-PA
GOUT AGENTS - Drugs to treat gout		
GOUT AGENT COMBINATIONS - Drugs to treat gout		
colchicine/probenecid tab .5MG-500MG (COL-BENEMID Equiv)	1	-
GOUT AGENTS - Drugs to treat gout		
allopurinol tab (ZYLOPRIM Equiv)	1	-
colchicine tab .6MG (COLCRYS Equiv)	2	-
febuxostat tab 40MG, 80MG (ULORIC Equiv)	1	ST Step Therapy requires trial of allopurinol
GLOPERBA SOLN .6MG/5ML ***(colchicine)***	3	PA Prior Authorization required for members age 9 or older
ULORIC TAB 40MG, 80MG ***(febuxostat)***	3	ST Step Therapy requires trial of allopurinol
ZYLOPRIM TAB 100MG, 300MG ***(allopurinol)***	3	-
URICOSURICS - Drugs to treat gout		
probenecid tab 500MG (BENEMID Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
HEMATOLOGICAL AGENTS - MISC. - Drugs to treat blood disorders		
ANTIHEMOPHILIC PRODUCTS - Drugs to treat hemophilia		
HEMLIBRA INJ 105MG/0.7ML, 150MG/ML, 30MG/ML, 60MG/0.4ML ***(emicizumab-kxwh)***	4	LMSP-PA
BRADYKININ B2 RECEPTOR ANTAGONISTS - Drugs to treat systemic swelling conditions		
icatibant inj 30MG/3ML (FIRAZYR Equiv)	M	M
COMPLEMENT INHIBITORS - Drugs to treat blood disorders		
CINRYZE INJ 500UNIT ***(c1 esterase inhibitor (human))***	M	M
EMPAVELI INJ 1080MG/20ML ***(pegcetacoplan)***	4	LD-PA-QL QL= 160ml/28 days; Only available through PantheRx 855-726-8479
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS - Drugs to treat blood disorders		
TAVALISSE TAB 100MG, 150MG ***(fostamatinib disodium)***	4	LD-PA-QL-SF QL= 2 tab/day; Only available through Biologics 800-850-4306
HEMATORHEOLOGIC AGENTS - Drugs to treat circulation disorders		
pentoxifylline ER tab 400MG (TRENTAL Equiv)	1	-
TRENTAL TAB ***(pentoxifylline)***	3	-
PLATELET AGGREGATION INHIBITORS - Drugs to thin the blood		
AGRYLIN CAP .5MG ***(anagrelide hcl)***	3	-
anagrelide cap .5MG, 1MG (AGRYLIN Equiv)	1	-
BRILINTA TAB 60MG, 90MG ***(ticagrelor)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CABLIVI INJ KIT 11MG ***(caplacizumab-yhdp)***	4	LD-PA-QL QL= 1 vial/day; Only available through Biologics 800-850-4306
cilostazol tab 100MG, 50MG (PLETAL Equiv)	1	-
clopidogrel tab 75mg 75MG (PLAVIX Equiv)	1	-
dipyridamole tab 25MG, 50MG, 75MG (PERSANTINE Equiv)	1	-
EFFIENT TAB 10MG, 5MG ***(prasugrel hcl)***	3	-
PERSANTINE TAB ***(dipyridamole)***	3	-
PLAVIX TAB 75MG 75MG ***(clopidogrel bisulfate)***	3	-
PLETAL TAB ***(cilostazol)***	3	-
prasugrel tab 10MG, 5MG (EFFIENT Equiv)	1	-
TICLOPIDINE TAB ***(ticlopidine hcl)***	1	-
ticlopidine tab	1	-
ZONTIVITY TAB 2.08MG ***(vorapaxar sulfate)***	3	RS Restricted to Cardiology Specialist
HEMATOPOIETIC AGENTS - Drugs to treat blood disorders		
AGENTS FOR GAUCHER DISEASE - Drugs to treat blood disorders		
CERDELGA CAP 84MG ***(eliglustat tartrate)***	4	MSP-PA
CEREZYME INJ 400UNIT ***(imiglucerase)***	M	M
miglustat cap 100MG (ZAVESCA Equiv)	4	LD-PA Only available through Accredo 800-803-2523
AGENTS FOR SICKLE CELL ANEMIA - Drugs to treat blood disorders		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DROXIA CAP 200MG, 300MG, 400MG ***(hydroxyurea (sickle cell anemia))***	2	-
AGENTS FOR SICKLE CELL DISEASE-Drugs to treat blood disorders		
ENDARI POWDER PACK 5GM ***(glutamine (sickle cell))***	4	LMSP-PA-QL QL= 6 packets/day
COBALAMINS - Drugs to treat vitamin deficiency		
cyanocobalamin inj 1000MCG/ML	1	-
NASCOBAL NASAL SPRAY 500MCG/0.1ML ***(cyanocobalamin)***	3	-
FOLIC ACID/FOLATES - Drugs to treat vitamin deficiency		
folic acid tab 1mg 1MG	$0	Covered at $0 for females only; All other members covered at generic copay
folic acid tab 400mcg 400MCG	$0	OTC Covered for females only
folic acid tab 800mcg 800MCG	$0	OTC Covered for females only
HEMATOPOIETIC GROWTH FACTORS - Drugs to treat blood disorders		
DOPTELET TAB 20MG ***(avatrombopag maleate)***	4	KMSP-PA-QL QL= 2 tabs/day
FULPHILA INJ 6MG/0.6ML ***(pegfilgrastim-jmdb)***	4	LMSP
NEUMEGA INJ ***(oprelvekin)***	4	LMSP
NIVESTYM INJ 300MCG/ML, 480MCG/1.6ML ***(filgrastim-aafi)***	4	LMSP

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PROMACTA TAB 12.5MG, 25MG, 50MG, 75MG ***(eltrombopag olamine)***	4	LMSP-PA
RETACRIT INJ 10000UNIT/ML, 20000UNIT/2ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML ***(epoetin alfa-epbx)***	4	LMSP
RETACRIT INJ 40000UNIT/ML ***(epoetin alfa-epbx)***	4	LMSP
ZARXIO INJ 300MCG/0.5ML, 480MCG/0.8ML ***(filgrastim-sndz)***	4	LMSP
ZIEXTENZO INJ 6MG/0.6ML ***(pegfilgrastim-bmez)***	4	LMSP
HEMATOPOIETIC MIXTURES - Drugs to treat blood disorders		
CHROMAGEN FA TAB ***(fe asparto gly-succinic acd-vit c-threonic acd-vit b12-fa)***	3	-
ferrex 150 forte cap (NIFEREX 150 FORTE Equiv)	1	-
FERREX 28 TAB .8MG-1MG-10MCG-60MG-70MG-81MG-140MG-150MG ***(fe asparto gly-fe fum-b12-folic acid-vit c-succinic acid)***	3	-
folbee tab 1MG-2.5MG-25MG	1	-
IRON POLYSACCH/THREONIC ACID/B12/FA CAP .8MG-1MG-25MCG-50MG-60MG-100MG ***(fe asp gly-fe polysaccharide-succ acd-c-threonic acid-b12-fa)***	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
MULTIGEN FOLIC TAB 1MG-2MG-10MCG-70MG-75MG-150MG ***(fe asparto gly-succinic acd-vit c-threonic acd-vit b12-fa)***	1	-
MULTIGEN PLUS TAB .8MG-1MG-10MCG-50MG-60MG-101MG ***(fe asparto gly-fe fumarate-succ acd-c-threonic acd-b12-fa)***	1	-
MULTIGEN TAB 2MG-10MCG-50MG-70MG-75MG-150MG ***(fe asparto gly-succin ac-c-threonic ac-b12-des stom subst)***	1	-
MULTIVITAMIN TAB 1MG-25MCG-100MG-250MG ***(iron-vitamin c-vitamin b12-folic acid)***	3	-
multivitamin tab 1MG-25MCG-100MG-250MG	1	-
NEPHRON FA TAB 1MG-1.5MG-1.7MG-6MCG-10MG-20MG-40MG-75 MG-200MG-300MCG ***(ferrous fumarate w/ fa-dss-b complex-vit c)***	2	-
tricon cap .5MG-15MCG-75MG-110MG-240MG (TRINSICON Equiv)	1	-
IRON - Drugs to treat iron deficiency		
ferrous sulfate elixir 220MG/5ML	$0	OTC Covered for members 1 year or younger

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FERROUS SULFATE LIQUID 220MG/5ML, 5MG/20ML ***(ferrous sulfate)***	$0	OTC Covered for members 1 year or younger
ferrous sulfate soln 15MG/ML	$0	OTC Covered for members 1 year or younger
ferrous sulfate syrup 300MG/5ML (FERROUS SULFATE Equiv)	$0	OTC
IRON SUSP ***(iron)***	$0	OTC Covered for members 1 year or younger
HEMOSTATICS - Drugs to stop bleeding/treat blood disorders		
HEMOSTATICS - SYSTEMIC - Drugs to thin the blood		
AMICAR SOLN .25GM/ML ***(aminocaproic acid)***	3	-
AMICAR SYRUP ***(aminocaproic acid)***	3	-
AMICAR TAB 1000MG, 500MG ***(aminocaproic acid)***	3	-
aminocaproic acid soln .25GM/ML (AMICAR Equiv)	1	-
aminocaproic acid syrup (AMICAR Equiv)	1	-
aminocaproic acid tab 1000MG, 500MG (AMICAR Equiv)	1	-
CYKLOKAPRON INJ 1000MG/10ML ***(tranexamic acid)***	M	M
LYSTEDA TAB 650MG ***(tranexamic acid)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
tranexamic acid inj 1000MG/10ML (CYKLOKAPRON Equiv)	M	M
tranexamic acid tab 650MG (LYSTEDA Equiv)	1	-
HYPNOTICS - Drugs to treat insomnia		
NON-BARBITURATE HYPNOTICS - Drugs to treat insomnia		
zolpidem tab 10MG, 5MG (AMBIEN Equiv)	1	QL QL= 1 tab/day
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - Drugs to treat insomnia		
ANTIHISTAMINE HYPNOTICS - Drugs to treat insomnia		
diphenhydramine cap 50mg 50MG (BENADRYL Equiv)	1	Only 50mg covered
BARBITURATE HYPNOTICS - Drugs to treat insomnia		
BUTISOL ELIXIR ***(butabarbital sodium)***	3	-
BUTISOL TAB 30MG ***(butabarbital sodium)***	3	-
phenobarbital elixir 20MG/5ML	1	-
phenobarbital tab 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG	1	-
NON-BARBITURATE HYPNOTICS - Drugs to treat insomnia		
AMBIEN TAB 10MG, 5MG ***(zolpidem tartrate)***	3	QL QL= 1 tab/day
estazolam tab 1MG, 2MG (PROSOM Equiv)	1	-
eszopiclone tab 1MG, 2MG, 3MG (LUNESTA Equiv)	1	QL QL= 1 tab/day
FLURAZEPAM CAP 15MG, 30MG ***(flurazepam hcl)***	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
HALCION TAB .25MG ***(triazolam)***	3	-
LUNESTA TAB 1MG, 2MG, 3MG ***(eszopiclone)***	3	QL QL= 1 tab/day
PROSOM TAB ***(estazolam)***	3	-
RESTORIL CAP 15MG 15MG ***(temazepam)***	3	-
RESTORIL CAP 22.5MG 22.5MG ***(temazepam)***	3	-
RESTORIL CAP 30MG 30MG ***(temazepam)***	3	-
RESTORIL CAP 7.5MG 7.5MG ***(temazepam)***	3	-
SONATA CAP 10MG, 5MG ***(zaleplon)***	3	-
temazepam cap 15mg 15MG (RESTORIL Equiv)	1	-
temazepam cap 22.5mg 22.5MG (RESTORIL Equiv)	1	-
temazepam cap 30mg 30MG (RESTORIL Equiv)	1	-
temazepam cap 7.5mg 7.5MG (RESTORIL Equiv)	1	-
triazolam tab .125MG, .25MG (HALCION Equiv)	1	-
zaleplon cap 10MG, 5MG (SONATA Equiv)	1	-
zolpidem ER tab 12.5MG, 6.25MG (AMBIEN CR Equiv)	1	QL QL= 1 tab/day
SELECTIVE MELATONIN RECEPTOR AGONISTS - Drugs to treat insomnia		
ramelteon tab 8MG (ROZEREM Equiv)	1	QL QL= 1 tab/day
ROZEREM TAB 8MG ***(ramelteon)***	3	QL QL= 1 tab/day
LAXATIVES - Drugs to treat constipation		
LAXATIVE COMBINATIONS - Drugs to treat constipation		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CLENPIQ SOLN 3.5GM/160ML-10MG/160ML-12GM/160ML ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)***	2	-
COLYTE SOLN ***(peg 3350-kcl-sod bicarb-sod chloride-sod sulfate)***	2	-
GAVILYTE-C SOLN 2.98GM-5.84GM-6.72GM-22.72GM-240GM ***(peg 3350-kcl-sod bicarb-sod chloride-sod sulfate)***	$0	Covered at $0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
GOLYTELY PACKET 2.82GM-5.53GM-6.36GM-21.5GM-227.1GM ***(peg 3350-kcl-sod bicarb-sod chloride-sod sulfate)***	1	-
GOLYTELY SOLN 2.97GM-5.86GM-6.74GM-22.74GM-236GM, 2.98GM-5.84GM-6.72GM-22.72GM-240GM ***(peg 3350-kcl-sod bicarb-sod chloride-sod sulfate)***	$0	QL Covered at $0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
MOVIPREP SOLN 1.015GM-2.691GM-4.7GM-5.9GM-7.5GM-100GM ***(peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid)***	3	ST Step Therapy requires trial of CLENPIQ

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NULYTELY SOLN 1.48GM-5.72GM-11.2GM-420GM ***(peg 3350-potassium chloride-sod bicarbonate-sod chloride)***	$0	QL Covered at $0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year
peg 3350 soln (100 gram Moviprep equiv) 1.015GM-2.691GM-4.7GM-5.9GM-7.5GM-100GM (MOVIPREP Equiv)	1	ST Step Therapy requires trial of CLENPIQ
peg 3350/electrolytes soln 2.97GM-5.86GM-6.74GM-22.74GM-236GM, 2.98GM-5.84GM-6.72GM-22.72GM-240GM (COLYTE Equiv)	$0	QL Covered at $0 for members 45-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
SUPREP SOLN 1.6GM/177ML-3.13GM/177ML-17.5GM/177ML ***(sodium sulfate-potassium sulfate-magnesium sulfate)***	3	ST Step Therapy requires trial of CLENPIQ
trilyte soln 1.48GM-5.72GM-11.2GM-420GM (NULYTELY Equiv)	$0	QL Covered at $0 for members 45-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year
LAXATIVES - MISCELLANEOUS - Drugs to treat constipation		
lactulose soln	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
MIRALAX 17GM/SCOOP ***(polyethylene glycol 3350)***	EXC	OTC
polyethylene glycol 3350 powder 17GM/SCOOP (MIRALAX Equiv)	EXC	OTC
SALINE LAXATIVES - Drugs to treat constipation		
OSMOPREP TAB .398GM-1.102GM ***(sodium phosphate monobasic-sodium phosphate dibasic)***	3	ST Step Therapy requires trial of CLENPIQ
VISICOL TAB ***(sodium phosphate monobasic-sodium phosphate dibasic-mcc)***	3	-
MACROLIDES - Drugs to treat bacterial infections		
AZITHROMYCIN - Drugs to treat bacterial infections		
azithromycin susp 100MG/5ML, 200MG/5ML (ZITHROMAX Equiv)	1	-
azithromycin tab 250MG, 500MG, 600MG (ZITHROMAX Equiv)	1	-
ZITHROMAX POWDER PACK 1GM ***(azithromycin)***	3	-
ZITHROMAX SUSP 100MG/5ML, 200MG/5ML ***(azithromycin)***	3	-
ZITHROMAX TAB 250MG, 500MG, 600MG ***(azithromycin)***	3	-
ZMAX SUSP 2GM ***(azithromycin)***	3	-
CLARITHROMYCIN - Drugs to treat bacterial infections		
BIAXIN SUSP ***(clarithromycin)***	3	-
BIAXIN TAB 500MG ***(clarithromycin)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
BIAXIN XL TAB ***(clarithromycin)***	3	-
clarithromycin ER tab 500MG (BIAXIN XL Equiv)	1	-
CLARITHROMYCIN SUSP 125MG/5ML, 250MG/5ML ***(clarithromycin)***	2	-
clarithromycin susp (BIAXIN Equiv)	1	-
clarithromycin tab 250MG, 500MG (BIAXIN Equiv)	1	-
ERYTHROMYCINS - Drugs to treat bacterial infections		
ERYTHROMYCIN EC CAP 250MG ***(erythromycin base)***	2	-
erythromycin ethylsuccinate susp 200MG/5ML, 400MG/5ML (ERYPED Equiv)	1	-
erythromycin stearate tab 250MG	1	-
erythromycin tab 250MG, 500MG (ERYTHROMYCIN Equiv)	1	all forms except PCE
PCE TAB 333MG, 500MG ***(erythromycin base (coated))***	3	-
FIDAXOMICIN - drugs to treat infections		
DIFICID SUSP 40MG/ML ***(fidaxomicin)***	2	QL-ST QL= 136 mL/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DIFICID TAB 200MG ***(fidaxomicin)***	2	QL-ST QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap, FIRST-VANCOMYCIN SOLN, or FIRVANQ SOLN
MEDICAL DEVICES AND SUPPLIES - Drugs for miscellaneous use		
CONTRACEPTIVES - Devices to prevent pregnancy		
CERVICAL CAP ***(cervical caps)***	$0	-
DIAPHRAGM ***(diaphragms)***	$0	-
FEMALE CONDOMS ***(condoms - female)***	$0	OTC
DIABETIC SUPPLIES - Devices to assist with diabetes		
ACCU-CHEK AVIVA PLUS METER ***(blood glucose monitoring supplies)***	$0	OTC
ACCU-CHEK GUIDE CARE METER ***(blood glucose monitoring supplies)***	$0	OTC
ACCU-CHEK GUIDE ME KIT ***(blood glucose monitoring supplies)***	$0	OTC
ACCU-CHEK NANO METER ***(blood glucose monitoring supplies)***	$0	OTC
CALIBRATION LIQUID ***(blood glucose calibration)***	1	OTC
DEXCOM G6 RECEIVER ***(continuous blood glucose system receiver)***	2	PA-QL QL= 1 receiver/year
DEXCOM G6 SENSOR ***(continuous blood glucose system sensor)***	2	PA-QL QL= 3 sensors/28 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DEXCOM G6 TRANSMITTER ***(continuous blood glucose system transmitter)***	2	PA-QL QL= 1 transmitter/90 days
FREESTLY LITE METER ***(blood glucose monitoring supplies)***	$0	OTC
FREESTYLE FREEDOM LITE METER ***(blood glucose monitoring supplies)***	$0	OTC
FREESTYLE INSULINX METER ***(blood glucose monitoring supplies)***	$0	OTC
FREESTYLE LIBRE 2 RECEIVER ***(continuous blood glucose system receiver)***	2	PA-QL QL= 1 receiver/year
FREESTYLE LIBRE 2 SENSOR ***(continuous blood glucose system sensor)***	2	PA-QL QL= 2 sensors/28 days
FREESTYLE LIBRE RECEIVER ***(continuous blood glucose system receiver)***	2	PA-QL QL= 1 receiver/year
FREESTYLE LIBRE SENSOR (10-DAY) ***(continuous blood glucose system sensor)***	2	PA-QL QL= 3 sensors/30 days
FREESTYLE LIBRE SENSOR (14-DAY) ***(continuous blood glucose system sensor)***	2	PA-QL QL= 2 sensors/28 days
FREESTYLE PRECISION NEO METER ***(blood glucose monitoring supplies)***	$0	OTC
LANCET DEVICE ***(lancet devices)***	1	OTC
LANCET KIT ***(lancets misc.)***	1	OTC
LANCETS ***(lancets)***	1	OTC

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PRECISION XTRA METER ***(blood glucose monitoring supplies)***	$0	OTC
V-GO INJ KIT ***(insulin infusion disposable pump)***	2	QL QL= 1 kit/day
MISC. DEVICES - Drugs for miscellaneous use		
ALCOHOL SWABS 70% ***(alcohol swabs)***	1	OTC
PARENTERAL THERAPY SUPPLIES - Miscellaneous supplies		
B-D AUTOSHIELD DUO PEN NEEDLE ***(insulin pen needle)***	1	OTC
B-D INSULIN SYRINGE U-500 ***(insulin syringe/needle u-500)***	1	-
TECHLITE INSULIN SYRINGE ***(insulin syringe/needle u-100)***	1	OTC
TECHLITE PEN NEEDLE ***(insulin pen needle)***	1	OTC
TRUEPLUS INSULIN SYRINGE ***(insulin syringe/needle u-100)***	1	OTC
TRUEPLUS PEN NEEDLE ***(insulin pen needle)***	1	OTC
RESPIRATORY THERAPY SUPPLIES - Devices to assist with lung disorders		
AEROCHAMBER ***(respiratory therapy supplies)***	2	OTC
AEROCHAMBER SUPPLIES ***(spacer/aerosol-holding chamber supplies - bags)***	2	-
PEAK FLOW METER ***(peak flow meter)***	1	OTC
MIGRAINE PRODUCTS - Drugs to treat migraine headaches		
MIGRAINE COMBINATIONS - Drugs to treat migraine headaches		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ergotamine tartrate/caffeine tab 1MG-100MG (CAFERGOT Equiv)	1	-
MIGRAINE PRODUCTS - Drugs to treat migraine headaches		
dihydroergotamine mesylate inj 1MG/ML (D.H.E. Equiv)	1	QL QL= 10 inj/14 days
ERGOMAR SL TAB ***(ergotamine tartrate sl tab)***	3	-
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES - Drugs to treat migraine headaches		
AIMOVIG INJ 140MG/ML, 70MG/ML ***(erenumab-aooe)***	2	PA-QL QL= 1 pack/28 days
EMGALITY INJ 120MG/ML ***(galcanezumab-gnlm)***	2	PA-QL QL= 1 inj/28 days
EMGALITY INJ 100MG/ML 100MG/ML ***(galcanezumab-gnlm)***	2	PA-QL QL= 3 inj/fill, 6 fills/year
NURTEC ODT 75MG ***(rimegepant sulfate)***	2	PA-QL QL= 8 tabs/30 days, 6 fills/year
UBRELVY TAB 100MG, 50MG ***(ubrogepant)***	2	PA-QL QL= 10 tabs/30 days, 6 fills/year
SEROTONIN AGONISTS - Drugs to treat migraine headaches		
IMITREX INJ 6MG/0.5ML ***(sumatriptan succinate)***	3	QL QL= 4 inj/fill, 2 fills/30 days
IMITREX INJ 4MG/0.5ML, 6MG/0.5ML ***(sumatriptan succinate)***	3	QL QL= 4 inj/fill, 2 fills/30 days
IMITREX TAB 100MG, 25MG, 50MG ***(sumatriptan succinate)***	3	QL QL= 9 tabs/fill, 2 fills/30 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
MAXALT MLT TAB 10MG, 5MG ***(rizatriptan benzoate)***	3	QL QL= 12 tabs/fill, 3 fills/60 days
MAXALT TAB 10MG, 5MG ***(rizatriptan benzoate)***	3	QL QL= 12 tabs/fill, 3 fills/60 days
REYVOW TAB 100MG, 50MG ***(lasmiditan succinate)***	2	PA-QL QL= 8 tabs/30 days, 6 fills/year
rizatriptan ODT 10MG, 5MG (MAXALT Equiv)	1	QL QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab 10MG, 5MG (MAXALT Equiv)	1	QL QL= 12 tabs/fill, 3 fills/60 days
SUMATRIPTAN INJ 4MG/0.5ML, 6MG/0.5ML (IMITREX Equiv) ***(sumatriptan succinate)***	1	QL QL= 4 inj/fill, 2 fills/30 days
sumatriptan inj 4MG/0.5ML, 6MG/0.5ML (IMITREX Equiv)	1	QL QL= 4 inj/fill, 2 fills/30 days
SUMATRIPTAN INJ 6MG/0.5ML 6MG/0.5ML ***(sumatriptan succinate)***	2	QL QL= 4 inj/fill, 2 fills/30 days
sumatriptan tab 100MG, 25MG, 50MG (IMITREX Equiv)	1	QL QL= 9 tabs/fill, 2 fills/30 days
zolmitriptan tab 2.5MG, 5MG (ZOMIG Equiv)	1	QL QL= 9 tabs/fill, 2 fills/30 days
MINERALS & ELECTROLYTES - Drugs to treat electrolyte disorders		
CHLORIDE - Drugs to treat electrolyte disorders		
AMMONIUM CHLORIDE INJ ***(ammonium chloride)***	M	M
FLUORIDE - Drugs to treat mineral deficiency		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FLUOR-A-DAY CHEW TAB ***(sodium fluoride-xylitol)***	1	-
LURIDE TAB ***(sodium fluoride)***	$0	Covered at $0 for members 5 years or younger; All other members covered at non-preferred brand copay
SODIUM FLUORIDE LOZENGE ***(sodium fluoride)***	$0	Covered at $0 for members 5 years or younger; All other members covered at generic copay
sodium fluoride soln .125MG/DROP, .5MG/ML (LURIDE Equiv)	$0	Covered at $0 for members 5 years or younger; All other members covered at generic copay
SODIUM FLUORIDE TAB .5MG, 1MG ***(sodium fluoride)***	$0	Covered at $0 for members 5 years or younger; All other members covered at generic copay
sodium fluoride tab .25MG, .5MG, 1MG, 2.2MG	$0	Covered at $0 for members 5 years or younger; All other members covered at generic copay
MAGNESIUM - Drugs to treat electrolyte disorders		
magnesium sulfate inj 20GM/500ML, 2GM/50ML, 40GM/1000ML, 4GM/100ML, 4GM/50ML, 50%	M	M
PHOSPHATE - Drugs to treat electrolyte deficiency		
K-PHOS NEUTRAL TAB 130MG-155MG-852MG ***(pot phosphate monobasic w/ sod phosphate dibasic & monobasic)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
K-PHOS TAB 500MG ***(potassium phosphate monobasic)***	2	-
phospha 250 neutral tab (K-PHOS NEUTRAL Equiv)	1	-
POTASSIUM - Drugs to treat electrolyte disorders		
KLOR-CON POWDER PACKET ***(potassium chloride)***	3	-
KLOR-CON POWDER PACKET 25MEQ ***(potassium chloride)***	3	-
K-TAB 20MEQ, 8MEQ ***(potassium chloride)***	3	-
K-TAB 10MEQ, 20MEQ ***(potassium chloride)***	3	-
MICRO-K CAP ***(potassium chloride)***	3	-
potassium bicarbonate effer tab 25MEQ, 2GM-2.5GM (K-LYTE Equiv)	1	-
potassium chloride ER cap 10MEQ, 8MEQ (MICRO-K Equiv)	1	-
potassium chloride ER tab 10MEQ, 20MEQ, 8MEQ (K-TAB Equiv)	1	-
potassium chloride micro tab 10MEQ, 15MEQ, 20MEQ (K-DUR Equiv)	1	-
potassium chloride powder packet 20MEQ (KLOR-CON Equiv)	1	-
potassium chloride soln 10%, 20%	1	-
SODIUM - Drugs to treat electrolyte disorders		
sodium chloride inj .45%, .9%, 2.5MEQ/ML, 3%, 4MEQ/ML, 5%	M	M

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ZINC - Drugs to treat mineral deficiency		
GALZIN CAP 25MG, 50MG ***(zinc acetate (oral))***	2	-
zinc sulfate cap 220MG	1	-
MISCELLANEOUS THERAPEUTIC CLASSES - Drugs to treat assorted conditions		
CHELATING AGENTS - Drugs to treat overdose or toxicity		
DEPEN TITRATAB 250MG ***(penicillamine)***	3	-
penicillamine tab 250MG (DEPEN TITRATAB Equiv)	1	-
trientine cap 250MG (SYPRINE Equiv)	4	LMSP-PA
IMMUNOSUPPRESSIVE AGENTS - Drugs to treat disorders of the immune system		
ENSPRYNG INJ 120MG/ML ***(satralizumab-mwge)***	4	LMSP-PA-QL
everolimus tab .25MG, .5MG, .75MG, 1MG (ZORTRESS Equiv)	4	LMSP-PA
LUPKYNIS CAP 7.9MG ***(voclosporin)***	4	LD-PA-QL QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479
sirolimus soln 1MG/ML (RAPAMUNE Equiv)	1	-
POTASSIUM REMOVING AGENTS - Drugs to manage potassium levels		
LOKELMA PAK 10GM, 5GM ***(sodium zirconium cyclosilicate)***	4	LMSP-PA
SPS SUSP 15GM/60ML ***(sodium polystyrene sulfonate)***	1	-
PROGERIA TREATMENT AGENTS ***		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ZOKINVY CAP 50MG, 75MG ***(lonafarnib)***	4	LD-PA-QL QL= 4 caps/day; Only available through US Bioservices 888-518-7246
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS - Drugs to treat disorders of the immune system		
BENLYSTA AUTO-INJECTOR 200MG/ML ***(belimumab)***	4	LMSP-PA-QL QL= 4 inj/28 day
BENLYSTA INJ 200MG/ML ***(belimumab)***	4	LMSP-PA-QL QL= 4 inj/28 day
MOUTH/THROAT/DENTAL AGENTS - Drugs to treat problems related to mouth/throat/teeth		
ANESTHETICS TOPICAL ORAL - Drugs for numbing		
FIRST MOUTHWASH BLM .1GM/119ML-.158GM/119ML-.8GM/119ML-1.58GM /119ML, .2GM/237ML-.315GM/237ML-1.6GM/237ML-3.15GM/237ML ***(diphenhydramine-lidocaine-alum hydroxide-mg hydroxide-simeth)***	3	-
lidocaine viscous soln 2%	1	-
LTA 360 KIT ***(lidocaine hcl (mouth-throat))***	3	-
ANTI-INFECTIVES - THROAT - Drugs to treat throat infections		
clotrimazole troches 10MG (MYCELEX TROCHES Equiv)	1	-
FIRST DUKES MOUTHWASH ***(diphenhydramine-hydrocortisone-nystatin)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FIRST MARYS MOUTHWASH ***(diphenhydramine-hydrocortisone-nystatin-tetracycline)***	3	-
MYCELEX TROCHES ***(clotrimazole)***	3	-
nystatin susp 100000UNIT/ML	1	-
ANTISEPTICS - MOUTH/THROAT - Drugs to treat bacterial infections in the mouth and throat		
chlorhexidine gluconate soln (PERIDEX Equiv)	1	-
PERIDEX SOLN .12% ***(chlorhexidine gluconate (mouth-throat))***	3	-
DENTAL PRODUCTS - Drugs to prevent cavities		
FLUORIDEX SENSITIVITY PASTE 1.1%-5% ***(sodium fluoride-potassium nitrate)***	1	-
sodium fluoride cream 1.1% (PREVIDENT Equiv)	$0	Covered at $0 for members 5 years or younger; All other members covered at generic copay
sodium fluoride gel 1.1% (PREVIDENT Equiv)	1	-
sodium fluoride paste 1.1% (PREVIDENT Equiv)	1	-
sodium fluoride rinse .02%, .022%, .05%, .2% (PREVIDENT Equiv)	1	-
sodium fluoride/potassium nitrate paste (PREVIDENT Equiv)	1	-
STEROIDS - MOUTH/THROAT - Drugs to treat throat swelling		
triamcinolone in orabase paste .1% (KENALOG/ORABASE Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
THROAT PRODUCTS - MISC. - Miscellaneous drugs to treat the throat		
cevimeline cap 30MG (EVOXAC Equiv)	1	-
EVOXAC CAP 30MG ***(cevimeline hcl)***	3	-
pilocarpine tab 5MG, 7.5MG (SALAGEN Equiv)	1	-
SALAGEN TAB 5MG, 7.5MG ***(pilocarpine hcl (oral))***	3	-
MULTIVITAMINS - Drugs to treat vitamin deficiency		
B-COMPLEX W/ FOLIC ACID - Drugs to treat vitamin deficiency		
DIALYVITE TAB ***(b-complex w/ c-biotin-e-minerals & folic acid)***	1	-
DIALYVITE/ZINC TAB ***(b-complex w/ c-zn & folic acid)***	1	-
DIATZ ZN TAB ***(b-complex w/ c-biotin-minerals & folic acid)***	3	-
FOLBEE PLUS CZ TAB ***(b-complex w/ c-biotin-minerals & folic acid)***	1	-
NEPHROCAP ***(b-complex w/ c & folic acid)***	3	-
renaphro cap (NEPHROCAP Equiv)	1	-
MULTIPLE VITAMINS W/ MINERALS - Drugs to treat vitamin and mineral deficiency		
multivitamin/minerals tab (STROVITE Equiv)	1	-
STROVITE TAB ***(multiple vitamins w/ minerals)***	3	-
V-C FORTE CAP ***(multiple vitamins w/ minerals)***	3	-
PED MULTI VITAMINS W/FL & FE - Drugs to treat vitamin deficiency		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ESCAVITE CHEW TAB ***(ped multivitamins w/fl & iron)***	3	-
pediatric multiple vitamins/fluoride/iron soln	1	-
PED MV W/ FLUORIDE - Drugs to treat vitamin deficiency		
FLORIVA PLUS DROPS ***(pediatric multivitamins w/fl)***	2	-
MULTIVITAMIN/FLOURIDE CHEW 0.25MG ***(pediatric multivitamins w/fl)***	1	-
MULTIVITAMIN/FLOURIDE CHEW 1MG ***(pediatric multivitamins w/fl)***	1	-
MULTIVITAMIN/FLUORIDE CHEW TAB ***(pediatric multivitamins w/fl)***	1	-
pediatric multiple vitamins/fluoride chew tab	1	-
pediatric multiple vitamins/fluoride soln	1	-
QUFLORA PEDIATRIC CHEW TAB ***(pediatric multivitamins w/fl)***	3	-
PRENATAL VITAMINS - Drugs to treat and prevent vitamin deficiency		
CONCEPT DHA CAP ***(prenatal vit w/ fe fum-iron polysacch complex -fa-omega 3)***	3	-
MYNATAL-Z TAB ***(prenatal vit w/ ferrous fumarate-folic acid)***	3	-
NEONATAL 19 TAB ***(prenatal vitamin-folic acid)***	3	-
NEONATAL FE TAB ***(prenatal multivitamins w/ iron-folic acid)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PRENATABS RX TAB ***(prenatal vit w/ iron carbonyl-folic acid)***	3	-
PRENATAL 19 CHEW TAB ***(prenatal vit w/ ferrous fumarate-folic acid)***	3	-
PRENATAL 19 TAB ***(prenatal vit w/ docusate-fe fumarate-folic acid)***	3	-
PRENATAL VITAMINS (NON-PREFERRED) ***(prenatal w/o vit a w/ fe fumarate-fe carbonyl-dss-fa-dha)***	3	-
VITAFOL STRIPS ***(prenatal w/ vit b6-b12-cholecalciferol-folic acid)***	3	-
VP-PNV-DHA CAP ***(prenatal vit w/ ferrous fumarate-fa-omega 3 fatty acids)***	3	-
MUSCULOSKELETAL THERAPY AGENTS - Drugs to treat spasms		
CENTRAL MUSCLE RELAXANTS - Drugs to treat muscle spasms		
baclofen tab 10MG, 20MG, 5MG (BACLOFEN Equiv)	1	-
carisoprodol tab 350MG (SOMA Equiv)	1	QL QL=120 tabs/30 days
chlorzoxazone tab 500mg 500MG	1	-
cyclobenzaprine tab 10mg 10MG (FLEXERIL Equiv)	1	-
cyclobenzaprine tab 5mg 5MG (FLEXERIL Equiv)	1	-
FEXMID TAB 7.5MG ***(cyclobenzaprine hcl)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FIRST BACLOFEN SUSP KIT 1MG/ML, 5MG/ML ***(baclofen)***	3	PA Prior Authorization required for members age 9 or older
FLEXERIL TAB ***(cyclobenzaprine hcl)***	3	-
metaxalone tab 400MG, 800MG (SKELAXIN Equiv)	1	-
METAXALONE TAB 400MG 400MG ***(metaxalone)***	3	-
methocarbamol tab (ROBAXIN Equiv)	1	-
PARAFON FORTE TAB ***(chlorzoxazone)***	3	-
ROBAXIN TAB 500MG, 750MG ***(methocarbamol)***	3	-
SKELAXIN TAB 800MG ***(metaxalone)***	3	-
SOMA TAB 350MG ***(carisoprodol)***	3	QL QL=120 tabs/30 days
tizanidine tab 2MG, 4MG (ZANAFLEX Equiv)	1	-
ZANAFLEX TAB 4MG ***(tizanidine hcl)***	3	-
DIRECT MUSCLE RELAXANTS - Drugs to treat muscle spasms		
DANTRIUM CAP 25MG, 50MG ***(dantrolene sodium)***	3	-
dantrolene cap 100MG, 25MG, 50MG (DANTRIUM Equiv)	1	-
NASAL AGENTS - SYSTEMIC AND TOPICAL - Drugs to treat the nose or sinus		
NASAL AGENTS - MISC. - Miscellaneous nasal agents		
ALCOHOL SWABS 62% ***(alcohol (nasal))***	1	OTC
NASAL ANTIALLERGY - Drugs to treat cough, cold, and allergy symptoms		
azelastine nasal spray 0.1% .1%, 137MCG/SPRAY (ASTELIN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
NASAL ANTICHOLINERGICS - Drugs to treat cough, cold, and allergy symptoms		
ATROVENT NASAL SPRAY ***(ipratropium bromide (nasal))***	3	-
ipratropium nasal spray .03%, .06% (ATROVENT Equiv)	1	-
NASAL STEROIDS - Drugs to treat cough, cold, and allergy symptoms		
BECONASE AQ NASAL SPRAY 42MCG/SPRAY ***(beclomethasone diprop monohyd)***	3	QL-ST QL= 2 bottles/fill; Step Therapy requires trial of fluticasone or triamcinolone
fluticasone nasal spray 50MCG/ACT (FLONASE Equiv)	1	QL QL= 2 bottles/fill
NASACORT OTC NASAL SPRAY 55MCG/ACT ***(triamcinolone acetonide (nasal))***	3	OTC-QL QL= 2 bottles/fill
triamcinolone OTC nasal spray 55MCG/ACT (NASACORT Equiv)	1	OTC-QL QL= 2 bottles/fill
ZETONNA NASAL SPRAY 37MCG/ACT ***(ciclesonide (nasal))***	3	QL-ST QL= 2 bottles/fill; Step Therapy requires trial of fluticasone or triamcinolone
SYMPATHOMIMETIC DECONGESTANTS - Drugs to treat sinus congestion		
TYZINE NASAL SOLN ***(tetrahydrozoline hcl)***	3	-
NEUROMUSCULAR AGENTS - Drugs to relax/paralyze muscles		
ALS AGENTS - Drugs to treat ALS		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
riluzole tab 50MG (RILUTEK Equiv)	1	-
SPINAL MUSCULAR ATROPHY AGENTS (SMA) - Drugs to treat spinal muscular atrophy		
EVRYSDI SOLN .75MG/ML ***(risdiplam)***	4	LD-PA-QL QL= 6.67ml/day; Only available through Accredo 800-803-2523
NUTRIENTS - Drugs to treat nutrient disorders		
LIPIDS - Drugs to treat nutrient disorders		
LIQUIGEN ***(medium chain triglycerides)***	2	OTC-PA
MCT OIL ***(medium chain triglycerides)***	2	OTC-PA
MISC. NUTRITIONAL SUBSTANCES - Miscellaneous nutritional substances		
CREATINE PACKET 5000MG ***(creatine)***	2	OTC-PA
PROTEINS - Drugs to treat nutrient disorders		
CITRULLINE PACKET ***(citrulline)***	2	OTC-PA
phlexy-10 tab	1	OTC-PA
pro-stat liquid	1	OTC-PA
OPHTHALMIC AGENTS - Drugs to treat eye conditions		
BETA-BLOCKERS - OPHTHALMIC - Drugs to treat glaucoma		
BETAGAN OPHTH SOLN .5% ***(levobunolol hcl)***	3	-
COMBIGAN OPHTH SOLN .2%-.5% ***(brimonidine tartrate-timolol maleate)***	2	-
COSOPT OPHTH SOLN 6.8MG/ML-22.3MG/ML ***(dorzolamide hcl-timolol maleate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
dorzolamide/timolol ophth soln .5%-2%, 5MG/ML-20MG/ML, 6.8MG/ML-22.3MG/ML (COSOPT Equiv)	1	-
LEVOBUNOLOL OPHTH SOLN .5% ***(levobunolol hcl)***	1	-
levobunolol ophth soln .5%	1	-
timolol maleate ophth gel .25%, .5% (TIMOPTIC-XE Equiv)	1	-
timolol maleate ophth soln .25%, .5% (TIMOPTIC Equiv)	1	-
TIMOLOL OPHTH GEL SOLN .25%, .5% ***(timolol maleate (ophth))***	2	-
TIMOPTIC OPHTH SOLN .25%, .5% ***(timolol maleate (ophth))***	3	-
TIMOPTIC-XE OPHTH GEL .25%, .5% ***(timolol maleate (ophth))***	3	-
CYCLOPLEGIC MYDRIATICS - Drugs to treat eye conditions		
atropine ophth oint 1%	1	-
atropine ophth soln 1% (ISOPTO ATROPINE Equiv)	1	-
CYCLOGYL OPHTH SOLN .5%, 1%, 2% ***(cyclopentolate hcl)***	3	-
CYCLOMYDRIL OPHTH SOLN .2%-1% ***(cyclopentolate w/ phenylephrine)***	2	-
cyclopentolate ophth soln .5%, 1%, 2% (CYCLOGYL Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
HOMATROPINE OPHTH SOLN 5% ***(homatropine hbr)***	2	-
homatropine ophth soln 5% (ISOPTO HOMATROPINE Equiv)	1	-
ISOPTO ATROPINE OPHTH SOLN 1% ***(atropine sulfate (ophthalmic))***	3	-
ISOPTO HYOSCINE OPHTH SOLN ***(scopolamine hbr (ophth))***	2	-
MYDRIACYL OPHTH SOLN ***(tropicamide ophth soln)***	3	-
phenylephrine ophth soln 10%, 2.5% (MYDFRIN Equiv)	1	-
tropicamide ophth soln .5%, 1% (MYDRIACYL Equiv)	1	-
MIOTICS - Drugs to treat eye conditions		
ISOPTO CARBACHOL OPHTH SOLN ***(carbachol (ophth))***	2	-
ISOPTO CARPINE OPHTH SOLN 1%, 2%, 4% ***(pilocarpine hcl)***	3	-
PHOSPHOLINE OPHTH SOLN .125% ***(echothiophate iodide)***	2	-
pilocarpine ophth soln 1%, 2%, 4% (ISOPTO CARPINE Equiv)	1	-
PILOPINE HS OPHTH GEL ***(pilocarpine hcl)***	3	-
OPHTHALMIC ADRENERGIC AGENTS - Drugs to treat eye conditions		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ALPHAGAN P OPHTH SOLN 0.15% .15% ***(brimonidine tartrate)***	3	-
apraclonidine ophth soln .5% (IOPIDINE Equiv)	1	-
brimonidine ophth soln 0.15% .15% (ALPHAGAN P 0.15% Equiv)	1	-
brimonidine ophth soln 0.2% .2%	1	-
IOPIDINE OPHTH SOLN .5% ***(apraclonidine hcl)***	3	-
IOPIDINE OPHTH SOLN 1% 1% ***(apraclonidine hcl)***	2	-
SIMBRINZA OPHTH SUSP .2%-1% ***(brinzolamide-brimonidine tartrate)***	2	-
OPHTHALMIC ANTI-INFECTIVES - Drugs to treat eye infections		
AZASITE SOLN 1% ***(azithromycin (ophth))***	2	-
BACITRACIN OPHTH OINT 500UNIT/GM ***(bacitracin (ophthalmic))***	2	-
bacitracin/neomycin/polymyxin b ophth oint 3.5MG/GM-400UNIT/GM-10000UNIT/GM, 5MG/GM-400UNIT/GM-10000UNIT/GM (NEOSPORIN Equiv)	1	-
bacitracin/polymyxin b ophth oint 500UNIT/GM-10000UNIT/GM (POLYSPORIN Equiv)	1	-
BLEPH-10 OPHTH SOLN 10% ***(sulfacetamide sodium (ophth))***	3	-
CILOXAN OPHTH OINT .3% ***(ciprofloxacin hcl (ophth))***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CILOXAN OPHTH SOLN .3% ***(ciprofloxacin hcl (ophth))***	3	-
ciprofloxacin ophth soln .3% (CILOXAN Equiv)	1	-
erythromycin ophth oint 5MG/GM	1	-
gatifloxacin ophth soln .5% (ZYMAXID Equiv)	1	ST Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA
GENTAK OPHTH OINT .3% ***(gentamicin sulfate (ophth))***	1	-
gentamicin ophth oint (GARAMYCIN Equiv)	1	-
gentamicin ophth soln .3% (GARAMYCIN Equiv)	1	-
levofloxacin ophth soln .5% (QUIXIN Equiv)	1	-
moxifloxacin ophth soln .5% (VIGAMOX OPHTH SOLN Equiv)	1	-
NATACYN OPHTH SUSP 5% ***(natamycin)***	2	QL QL= 15ml/fill
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN .025MG/ML-1.75MG/ML-10000UNIT/ML ***(neomycin-polymyxin-gramicidin)***	1	-
NEOSPORIN OPHTH SOLN .025MG/ML-1.75MG/ML-10000UNIT/ML ***(neomycin-polymyxin-gramicidin)***	3	-
OCUFLOX OPHTH SOLN .3% ***(ofloxacin (ophth))***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ofloxacin ophth soln .3% (OCUFLOX Equiv)	1	-
polymyxin b/trimethoprim ophth soln .1% -10000UNIT/ML (POLYTRIM Equiv)	1	-
POLYTRIM OPHTH SOLN .1%-10000UNIT/ML ***(polymyxin b-trimethoprim)***	3	-
sulfacetamide sodium ophth soln 10% (BLEPH-10 Equiv)	1	-
tobramycin ophth soln (TOBREX Equiv)	1	-
TOBREX OPHTH OINT ***(tobramycin sulfate (ophth))***	3	-
TOBREX OPHTH SOLN ***(tobramycin sulfate (ophth))***	3	-
TRIFLURIDINE OPHTH SOLN 1% ***(trifluridine)***	1	-
trifluridine ophth soln	1	-
VIGAMOX OPHTH SOLN .5% ***(moxifloxacin hcl (ophth))***	3	-
VIROPTIC OPHTH SOLN 1% ***(trifluridine)***	3	-
ZIRGAN OPHTH GEL .15% ***(ganciclovir ophthalmic)***	2	-
ZYMAXID OPHTH SOLN .5% ***(gatifloxacin (ophth))***	3	ST Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA
OPHTHALMIC DECONGESTANTS - Drugs to treat eye conditions		
MYDFRIN OPHTH SOLN ***(phenylephrine hcl (ophth))***	3	-
naphazoline ophth soln	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
OPHTHALMIC IMMUNOMODULATORS - Drugs to treat dry eyes		
RESTASIS OPHTH EMULSION .05% ***(cyclosporine (ophth))***	2	RS Restricted to Ophthalmology or Optometry Specialist
OPHTHALMIC LOCAL ANESTHETICS - Drugs for numbing		
ALCAINE OPHTH SOLN .5% ***(proparacaine hcl)***	3	-
proparacaine ophth soln .5% (ALCAINE Equiv)	1	-
OPHTHALMIC STEROIDS - Drugs to treat inflammation		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint .5%-1%-400UNIT/GM-10000UNIT/GM, 1% -3.5MG/GM-400UNIT/GM-10000UNIT/GM (CORTISPORIN Equiv)	1	-
BLEPHAMIDE S.O.P. OPHTH OINT .2%-10% ***(sulfacetamide sod-prednisolone)***	3	-
CORTISPORIN OPHTH SOLN ***(neomycin-polymyxin-hc (ophth))***	3	-
DEXAMETHASONE OPHTH SOLN .1% ***(dexamethasone sodium phosphate (ophth))***	2	-
dexamethasone ophth soln	1	-
difluprednate ophth emulsion .05% (DUREZOL Equiv)	1	-
DUREZOL OPHTH EMULSION .05% ***(difluprednate)***	3	-
FLAREX OPHTH SUSP .1% ***(fluorometholone acetate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
fluorometholone ophth soln .1% (FML LIQUIFILM Equiv)	1	-
FML FORTE OPHTH SUSP .25% ***(fluorometholone (ophth))***	3	-
FML LIQUIFLIM OPHTH SUSP .1% ***(fluorometholone (ophth))***	3	-
FML S.O.P. OPHTH OINT .1% ***(fluorometholone (ophth))***	3	-
LOTEMAX OPHTH GEL .5% ***(loteprednol etabonate)***	3	-
LOTEMAX OPHTH OINT .5% ***(loteprednol etabonate)***	2	-
LOTEMAX OPHTH SUSP .5% ***(loteprednol etabonate)***	3	-
loteprednol etabonate ophth gel .5% (LOTEMAX Equiv)	1	-
loteprednol ophth susp .5% (LOTEMAX Equiv)	1	-
MAXIDEX OPHTH SOLN .1%, 9% ***(dexamethasone (ophth))***	2	-
MAXITROL OPHTH OINT .1% -3.5MG/GM-10000UNIT/GM ***(neomycin-polymy-dexameth)***	3	-
MAXITROL OPHTH SUSP .1% -3.5MG/ML-10000UNIT/ML ***(neomycin-polymy-dexameth)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
neomycin/polymyxin/dexamethasone ophth oint .1% -3.5MG/GM-10000UNIT/GM (MAXITROL Equiv)	1	-
neomycin/polymyxin/dexamethasone ophth soln .1% -3.5MG/ML-10000UNIT/ML (MAXITROL Equiv)	1	-
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN 1%-3.5MG/ML-10000UNIT/ML ***(neomycin-polymyxin-hc (ophth))***	1	-
PRED FORTE OPHTH SUSP 1% ***(prednisolone acetate (ophth))***	3	-
PRED FORTE OPHTH SUSP 1% ***(prednisolone acetate (ophth))***	3	-
PRED MILD OPHTH SOLN .12% ***(prednisolone acetate (ophth))***	2	-
PRED-G OPHTH SOLN .3%-1% ***(gentamicin-prednisolone acetate)***	2	-
PREDNISOLONE OPHTH SUSP 1% ***(prednisolone acetate (ophth))***	1	-
PREDNISOLONE OPHTH SUSP 1% ***(prednisolone acetate (ophth))***	1	-
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN 1% ***(prednisolone sodium phosphate (ophth))***	2	-
sulfacetamide sodium/prednisolone ophth soln .23% -10% (VASOCIDIN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
SULFACETAMIDE/PREDNISOLONE OPHTH SOLN .23%-10% ***(sulfacetamide sod-prednisolone)***	1	-
TOBRADEX OPHTH OINT .1%-.3% ***(tobramycin-dexamethasone)***	2	-
TOBRADEX OPHTH SOLN .1%-.3% ***(tobramycin-dexamethasone)***	3	-
TOBRADEX ST OPHTH SUSP ***(tobramycin-dexamethasone ophth susp)***	3	-
tobramycin/dexamethasone ophth soln .1%-.3% (TOBRADEX Equiv)	1	-
VEXOL OPHTH SUSP ***(rimexolone)***	2	-
ZYLET OPHTH SUSP .3%-.5% ***(loteprednol etabonate-tobramycin)***	2	QL QL= 5ml/fill (10ml bottle is Not Covered)
OPHTHALMICS - MISC. - Miscellaneous eye agents		
ACULAR (LS) OPHTH SOLN .4%, .5% ***(ketorolac tromethamine (ophth))***	3	-
ACUVAIL OPHTH SOLN .45% ***(ketorolac tromethamine (ophth))***	3	-
ALAMAST OPHTH SOLN ***(pemirolast potassium)***	2	-
ALOCRIL OPHTH SOLN 2% ***(nedocromil sodium (ophth))***	2	-
ALOMIDE OPHTH SOLN .1% ***(lodoxamide tromethamine)***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

L.A. Care Covered Formulary and L.A. Care Covered Direct Formulary
Last Updated 1/3/2022

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
azelastine ophth soln .05% (OPTIVAR Equiv)	1	-
AZOPT OPHTH SUSP 1% ***(brinzolamide)***	3	-
bepotastine ophth soln 1.5% (BEPREVE Equiv)	1	-
BEPREVE OPHTH SOLN 1.5% ***(bepotastine besilate)***	3	-
brinzolamide ophth susp 1% (AZOPT Equiv)	1	-
bromfenac ophth soln .09% (BROMDAY Equiv)	1	-
BROMFENAC OPHTH SOLN 0.09% (TWICE DAILY) ***(bromfenac sodium (ophth))***	1	-
CROLOM OPHTH SOLN ***(cromolyn sodium (ophth))***	3	-
cromolyn ophth soln 4% (CROLOM Equiv)	1	-
CYSTADROPS SOLN .37% ***(cysteamine hcl)***	4	LD-QL-RS QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007
CYSTARAN OPHTH SOLN .44% ***(cysteamine hcl)***	4	LD-QL-RS QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416
diclofenac sodium ophth soln .1% (VOLTAREN Equiv)	1	-
dorzolamide ophth soln 2% (TRUSOPT Equiv)	1	-
ELESTAT OPHTH SOLN .05% ***(epinastine hcl (ophth))***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
EMADINE OPHTH SOLN .05% ***(emedastine difumarate)***	3	-
epinastine opthth soln .05% (ELESTAT Equiv)	1	-
FLURBIPROFEN OPHTH SOLN .03% ***(flurbiprofen sodium)***	2	-
flurbiprofen ophth soln .03% (OCUFEN Equiv)	1	-
ILEVRO OPHTH SUSP .3% ***(nepafenac)***	2	-
ketorolac ophth soln .4%, .5% (ACULAR (LS) Equiv)	1	-
ketotifen ophth soln .025% (ZADITOR Equiv)	1	OTC OTC covered only
LASTACAFT OPHTH SOLN .25% ***(alcaftadine)***	3	QL QL= 3ml/30 days
NEVANAC OPHTH SUSP .1% ***(nepafenac)***	2	-
OCUFEN OPHTH SOLN ***(flurbiprofen sodium)***	3	-
olopatadine ophth soln 0.1% .1% (PATANOL Equiv)	1	-
olopatadine ophth soln 0.2% .2% (PATADAY Equiv)	1	QL QL= 2.5ml/30 days
OPTIVAR OPHTH SOLN ***(azelastine hcl (ophth))***	3	-
PATANOL OPHTH SOLN .1% ***(olopatadine hcl)***	3	-
PROLENSA OPHTH SOLN .07% ***(bromfenac sodium (ophth))***	2	-
TRUSOPT OPHTH SOLN 2% ***(dorzolamide hcl)***	3	-
UPNEEQ SOLN .1% ***(oxymetazoline hcl (blepharoptosis))***	EXC	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
VOLTAREN OPTH SOLN ***(diclofenac sodium (ophth))***	3	-
PROSTAGLANDINS - OPHTHALMIC - Drugs to treat glaucoma		
bimatoprost ophth soln .03%	1	QL QL= 2.5ml/30 days
latanoprost ophth soln .005% (XALATAN Equiv)	1	QL QL= 2.5ml/30 days
LUMIGAN OPHTH SOLN .01% ***(bimatoprost)***	2	QL QL= 2.5ml/30 days
TRAVATAN Z DROPS .004% ***(travoprost)***	3	QL QL= 2.5ml/30 days
travoprost ophth soln .004% (TRAVATAN Z Equiv)	1	QL QL= 2.5ml/30 days
XALATAN OPHTH SOLN .005% ***(latanoprost)***	3	QL QL= 2.5ml/30 days
OTIC AGENTS - Drugs to treat ear infection		
OTIC AGENTS - MISCELLANEOUS - Miscellaneous ear agents		
acetic acid otic soln 2% (VOSOL Equiv)	1	-
CRESYLATE OTIC SOLN ***(cresyl acetate)***	3	-
VOSOL OTIC SOLN ***(acetic acid (otic))***	3	-
OTIC ANTI-INFECTIVES - Drugs to treat ear infections		
CIPROFLOXACIN OTIC SOLN .2% ***(ciprofloxacin hcl (otic))***	2	-
ofloxacin otic soln .3% (FLOXIN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
OTIC COMBINATIONS - Drugs to treat ear conditions		
CIPRO HC OTIC SUSP .2%-1% ***(ciprofloxacin-hydrocortisone)***	3	-
CIPRODEX OTIC SUSP .1%-.3% ***(ciprofloxacin-dexamethasone)***	3	-
ciprofloxacin/dexamethasone otic susp .1%-.3% (CIPRODEX Equiv)	1	-
COLY-MYCIN S OTIC SUSP .5MG/ML-3MG/ML-3.3MG/ML-10MG/ML ***(neomycin-colistin-hc-thonzonium)***	2	-
CORTISPORIN OTIC SOLN ***(neomycin-polymyxin-hc (otic))***	3	-
neomycin/polymixin/hydrocoritisone otic soln 1% -3.5MG/ML-10000UNIT/ML (CORTISPORIN Equiv)	1	-
neomycin/polymixin/hydrocoritisone otic susp 1% -3.5MG/ML-10000UNIT/ML (CORTISPORIN Equiv)	1	-
OTOZIN OTIC DROPS ***(antipyrine-benzocaine-glycerin-zinc acetate)***	3	-
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS Equiv)	1	-
OTIC STEROIDS - Drugs to treat ear swelling		
ACETASOL HC OTIC SOLN ***(hydrocortisone w/acetic acid)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
acetic acid/hydrocortisone otic soln 1%-2% (VOSOL HC Equiv)	1	-
DERMOTIC OIL .01% ***(fluocinolone acetonide (otic))***	3	-
fluocinolone otic oil .01% (DERMOTIC Equiv)	1	-
VOSOL HC OTIC SOLN ***(hydrocortisone w/acetic acid)***	3	-
OXYTOCICS - Drugs to prevent/control uterine bleeding		
OXYTOCICS - Drugs to prevent/control uterine bleeding		
methylergonovine tab .2MG (METHERGINE Equiv)	1	QL QL= 28 tabs/fill, 1 fill/365 days
PASSIVE IMMUNIZING AGENTS - Antibody drugs to treat low immune system		
IMMUNE SERUMS - Antibody drugs to treat low immune system		
GAMASTAN INJ ***(immune globulin (human) im)***	M	M
GAMMAGARD INJ 10GM, 12GM, 5GM, 6GM ***(immune globulin (human) iv)***	M	M
HIZENTRA INJ 10GM/50ML, 1GM/5ML, 2GM/10ML, 4GM/20ML ***(immune globulin (human) subcutaneous)***	2	KMSP-PA
PASSIVE IMMUNIZING AGENTS - COMBINATIONS - Drugs to treat immune deficiency		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
HYQVIA INJ 10GM/100ML-800UNIT/5ML, 2.5GM/25ML-200UNT/1.25ML, 20GM/200ML-1600UNIT/10ML, 30GM/300ML-2400UNIT/15ML, 5GM/50ML-400UNIT/2.5ML ***(immune globulin (human)-hyaluronidase (human recombinant))***	4	KMSP-PA
PASSIVE IMMUNIZING AND TREATMENT AGENTS - Antibody drugs to treat low immune system		
IMMUNE SERUMS - Antibody drugs to treat low immune system		
HIZENTRA INJ 1GM/5ML, 2GM/10ML, 4GM/20ML ***(immune globulin (human) subcutaneous)***	2	KMSP-PA
XEMBIFY INJ 10GM/50ML, 1GM/5ML, 2GM/10ML, 4GM/20ML ***(immune globulin (human)-klhw)***	4	LD-PA Only available through CVS Specialty 800-237-2767
PENICILLINS - Drugs to treat bacterial infections		
AMINOPENICILLINS - Drugs to treat infections		
amoxicillin cap 250MG, 500MG (TRIMOX Equiv)	1	-
AMOXICILLIN CHEW TAB 125MG, 250MG ***(amoxicillin)***	1	-
amoxicillin susp 125MG/5ML, 200MG/5ML, 250MG/5ML, 400MG/5ML (TRIMOX Equiv)	1	-
amoxicillin tab 500MG, 875MG (AMOXIL Equiv)	1	-
AMPICILLIN CAP 500MG (PRINCIPEN Equiv) ***(ampicillin)***	1	-
ampicillin cap (PRINCIPEN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ampicillin susp (PRINCIPEN Equiv)	1	-
NATURAL PENICILLINS - Drugs to treat bacterial infections		
PENICILLIN G PROCAINE INJ 600000UNIT/ML ***(penicillin g procaine)***	M	M
PENICILLIN G SODIUM INJ 5000000UNIT ***(penicillin g sodium)***	M	M
PENICILLIN VK SOLN 125MG/5ML, 250MG/5ML ***(penicillin v potassium)***	1	-
penicillin vk soln	1	-
penicillin vk tab 250MG, 500MG (VEETIDS Equiv)	1	-
PFIZERPEN G INJ 20000000UNIT, 20MU, 5000000UNIT ***(penicillin g potassium)***	M	M
pfizerpen g inj 20000000UNIT, 5000000UNIT	M	M
PENICILLIN COMBINATIONS - Drugs to treat bacterial infections		
amoxicillin/clavulanate chew tab (AUGMENTIN Equiv)	1	-
AMOXICILLIN/CLAVULANATE ER TAB 62.5MG-1000MG ***(amoxicillin & pot clavulanate)***	3	-
amoxicillin/clavulanate ER tab 62.5MG-1000MG (AUGMENTIN XR Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
amoxicillin/clavulanate susp 28.5MG/5ML-200MG/5ML, 42.9MG/5ML-600MG/5ML, 57MG/5ML-400MG/5ML, 62.5MG/5ML-250MG/5ML (AUGMENTIN ES Equiv)	1	-
amoxicillin/clavulanate tab 500-125mg, 875-125mg 125MG-500MG, 125MG-875MG (AUGMENTIN Equiv)	1	-
ampicillin/sulbactam inj .5GM-1GM, 1GM-2GM, 5GM-10GM	M	M
AUGMENTIN ES-600 SUSP 42.9MG/5ML-600MG/5ML, 62.5MG/5ML-250MG/5ML ***(amoxicillin & pot clavulanate)***	3	-
AUGMENTIN SUSP 31.25MG/5ML-125MG/5ML ***(amoxicillin & pot clavulanate)***	3	-
AUGMENTIN TAB 125MG-500MG, 125MG-875MG ***(amoxicillin & pot clavulanate)***	3	-
AUGMENTIN XR TAB 62.5MG-1000MG ***(amoxicillin & pot clavulanate)***	3	-
piperacillin/tazobactam inj .25GM-2GM, .375GM-3GM, .5GM-4GM, 1.5GM-12GM, 4.5GM-36GM	M	M
TIMENTIN INJ ***(ticarcillin & pot clavulanate)***	M	M

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PENICILLINASE-RESISTANT PENICILLINS - Drugs to treat bacterial infections		
dicloxacillin cap 250MG, 500MG (DYNAPEN Equiv)	1	-
nafcillin inj 10GM, 1GM, 2GM	M	M
oxacillin inj 10GM, 1GM, 2GM	M	M
PHARMACEUTICAL ADJUVANTS - Drugs to enhance primary drug effects		
SEMI SOLID VEHICLES - Miscellaneous compounding ingredients		
POLYETHYLENE GLYCOL 8000 GRANULES ***(polyethylene glycol 8000)***	2	-
PROGESTINS - Drugs to replace female hormones		
PROGESTINS - Drugs used for contraception		
AYGESTIN TAB 5MG ***(norethindrone acetate)***	3	-
hydroxyprogesterone inj 250MG/ML (MAKENA Equiv)	4	LMSP-PA
medroxyprogesterone tab 10MG, 2.5MG, 5MG (PROVERA Equiv)	1	-
norethindrone tab 5MG (AYGESTIN Equiv)	1	-
progesterone cap 100MG, 200MG (PROMETRIUM Equiv)	1	-
PROMETRIUM CAP 100MG, 200MG ***(progesterone)***	3	-
PROVERA TAB 10MG, 2.5MG, 5MG ***(medroxyprogesterone acetate)***	3	-
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - Drugs to treat mental and emotional conditions		
AGENTS FOR CHEMICAL DEPENDENCY - Drugs to treat chemical dependency		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
acamprosate calcium DR tab 333MG (CAMPRAL Equiv)	1	-
ANTABUSE TAB 250MG, 500MG ***(disulfiram)***	3	-
CAMPRAL TAB ***(acamprosate calcium)***	3	-
DISULFIRAM TAB (ANTABUSE Equiv) ***(disulfiram tab)***	1	-
disulfiram tab 250MG, 500MG (ANTABUSE Equiv)	1	-
ANTI-CATAPLECTIC AGENTS - Drugs to treat sleep disorders		
XYREM SOLN 500MG/ML ***(sodium oxybate)***	4	LD-PA-QL QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 314-587-4050
ANTIDEMENTIA AGENTS - Drugs to treat dementia and memory loss		
ARICEPT ODT ***(donepezil hydrochloride)***	3	QL QL= 1 tab/day
ARICEPT TAB 10MG, 5MG ***(donepezil hydrochloride)***	3	QL QL= 2 tabs/day
ARICEPT TAB 23MG 23MG ***(donepezil hydrochloride)***	3	QL-ST QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
donepezil ODT 10MG, 5MG (ARICEPT Equiv)	1	QL QL= 1 tab/day
donepezil tab 10MG, 5MG (ARICEPT Equiv)	1	QL QL= 2 tabs/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
donepezil tab 23mg 23MG (ARICEPT Equiv)	1	QL-ST QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
EXELON CAP ***(rivastigmine tartrate)***	3	-
EXELON PATCH 13.3MG/24HR, 4.6MG/24HR, 9.5MG/24HR ***(rivastigmine)***	3	ST Step Therapy requires trial of rivastigmine cap
galantamine ER cap 16MG, 24MG, 8MG (RAZADYNE ER Equiv)	1	-
galantamine tab 12MG, 4MG, 8MG (RAZADYNE Equiv)	1	-
memantine ER cap 14MG, 21MG, 28MG, 7MG (NAMENDA XR Equiv)	1	ST Step Therapy requires trial of memantine tab
memantine sol 10MG/5ML, 2MG/ML (NAMENDA Equiv)	1	-
memantine tab 10MG, 5MG (NAMENDA Equiv)	1	-
NAMENDA SOL ***(memantine hcl)***	3	-
NAMENDA TAB 10MG, 5MG ***(memantine hcl)***	3	-
RAZADYNE ER CAP 16MG, 24MG, 8MG ***(galantamine hydrobromide)***	3	-
RAZADYNE TAB 12MG, 4MG, 8MG ***(galantamine hydrobromide)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
rivastigmine cap 1.5MG, 3MG, 4.5MG, 6MG (EXELON Equiv)	1	-
rivastigmine patch 13.3MG/24HR, 4.6MG/24HR, 9.5MG/24HR (EXELON Equiv)	1	ST Step Therapy requires trial of rivastigmine cap
COMBINATION PSYCHOTHERAPEUTICS - Drugs to treat psychoses		
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB 10MG-25MG, 5MG-12.5MG ***(chlordiazepoxide-amitriptyline)***	1	-
LIMBITROL TAB ***(chlordiazepoxide-amitriptyline)***	3	-
olanzapine/fluoxetine cap 12MG-25MG, 12MG-50MG, 3MG-25MG, 6MG-25MG, 6MG-50MG (SYMBYAX Equiv)	1	-
PERPHENAZINE/ AMITRIPTYLINE TAB 2MG-10MG, 2MG-25MG, 4MG-10MG, 4MG-25MG, 4MG-50MG ***(perphenazine-amitriptyline)***	1	-
SYMBYAX CAP 12MG-25MG, 12MG-50MG, 3MG-25MG, 6MG-25MG, 6MG-50MG ***(olanzapine-fluoxetine hcl)***	3	-
FIBROMYALGIA AGENTS - Drugs to treat widespread muscle pain		
SAVELLA PAK ***(milnacipran hcl)***	2	-
SAVELLA TAB 100MG, 12.5MG, 25MG, 50MG ***(milnacipran hcl)***	2	QL QL= 2 tabs/day
MOVEMENT DISORDER DRUG THERAPY - Drugs to treat movement disorders		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
INGREZZA CAP 40MG, 60MG, 80MG ***(valbenazine tosylate)***	4	LD-PA-QL QL= 1 cap/day; Only available through Garfield Pharmacy 323-295-5585
tetrabenazine tab 12.5MG, 25MG (XENAZINE Equiv)	4	LMSP-PA
MULTIPLE SCLEROSIS AGENTS - Drugs to treat multiple sclerosis (MS)		
AUBAGIO TAB 14MG, 7MG ***(teriflunomide)***	4	LMSP
AVONEX INJ 30MCG/0.5ML ***(interferon beta-1a)***	4	LMSP
dalfampridine ER tab 10MG (AMPYRA Equiv)	1	LMSP-PA-QL QL= 2 tabs/day
dimethyl fumarate DR cap 120MG, 240MG (TECFIDERA Equiv)	4	LMSP
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK Equiv)	4	LMSP
EXTAVIA INJ .3MG ***(interferon beta-1b)***	4	MSP
GILENYA CAP .25MG, .5MG ***(fingolimod hcl)***	4	LMSP-QL QL= 1 cap/day
glatiramer inj 20MG/ML, 40MG/ML (COPAXONE Equiv)	4	LMSP
KESIMPTA INJ 20MG/0.4ML ***(ofatumumab (ms))***	4	LMSP
MAYZENT TAB .25MG, 2MG ***(siponimod fumarate)***	4	LMSP
MAYZENT TAB STARTER PACK .25MG ***(siponimod fumarate)***	4	LMSP
PLEGRIDY INJ 125MCG/0.5ML ***(peginterferon beta-1a)***	4	LMSP

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PLEGRIDY PEN INJ 125MCG/0.5ML ***(peginterferon beta-1a)***	4	LMSP
ZEPOSIA CAP .92MG ***(ozanimod hcl)***	4	LMSP-PA-QL QL= 1 cap/day
ZEPOSIA STARTER PACK ***(ozanimod hcl)***	4	LMSP-PA-QL QL= 1 cap/day
PSEUDOBULBAR AFFECT (PBA) AGENTS - Drugs to treat nervous system disorders		
NUEDEXTA CAP 10MG-20MG ***(dextromethorphan hbr-quinidine sulfate)***	2	PA-QL QL= 2 caps/day
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - Miscellaneous psyotherapeutic and neurological drugs		
ERGOLOID MESYLATES TAB 1MG ***(ergoloid mesylates)***	3	-
ergoloid mesylates tab (HYDERGINE Equiv)	1	-
ORAP TAB 1MG, 2MG ***(pimozide)***	3	-
PIMOZIDE TAB 1MG, 2MG ***(pimozide)***	2	-
SMOKING DETERRENTS - Drugs to treat smoking urges		
bupropion SR tab (ZYBAN Equiv)	$0	SMKG
CHANTIX PAK ***(varenicline tartrate)***	$0	SMKG
CHANTIX TAB .5MG, 1MG ***(varenicline tartrate)***	$0	SMKG
nicotine gum 2MG, 4MG (NICORETTE Equiv)	$0	OTC-SMKG
NICOTINE KIT ***(nicotine)***	$0	OTC-SMKG
nicotine lozenge 2MG, 4MG (COMMIT Equiv)	$0	OTC-SMKG

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
nicotine patch 14MG/24HR, 21MG/24HR, 7MG/24HR (NICODERM Equiv)	$0	OTC-SMKG
NICOTROL INHALER 10MG ***(nicotine)***	$0	SMKG
NICOTROL NASAL SPRAY 10MG/ML ***(nicotine)***	$0	SMKG
TRANSTHYRETIN AMYLOIDOSIS AGENTS - Drugs to treat nerve problems associated with transthyretin amyloidosis		
TEGSEDI INJ 284MG/1.5ML ***(inotersen sodium)***	4	LD-PA-QL QL= 4 inj/28 days; Only available through Accredo 800-803-2523
RESPIRATORY AGENTS - MISC. - Drugs to treat lung conditions		
CYSTIC FIBROSIS AGENTS - Drugs to treat cystic fibrosis conditions		
KALYDECO PAK 25MG, 50MG, 75MG ***(ivacaftor)***	4	KMSP-PA-QL-SF QL= 2 packets/day
KALYDECO TAB 150MG ***(ivacaftor)***	4	KMSP-PA-QL-SF QL= 2 tabs/day
ORKAMBI GRANULES PACKET 100MG-125MG, 150MG-188MG ***(lumacaftor-ivacaftor)***	4	KMSP-PA-QL-SF QL= 2 packets/day
ORKAMBI TAB 100MG-125MG, 125MG-200MG ***(lumacaftor-ivacaftor)***	4	KMSP-PA-QL-SF QL= 4 tabs/day
PULMOZYME INH SOLN 2.5MG/2.5ML ***(dornase alfa)***	4	LMSP
SYMDEKO TAB 100MG-150MG, 50MG-75MG ***(tezacaftor-ivacaftor)***	4	KMSP-PA-QL-SF QL= 2 tabs/day

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TRIKAFTA TAB 25MG-50MG, 50MG-100MG ***(elexacaftor-tezacaftor-ivacaftor)***	4	KMSP-PA-QL QL= 84 tabs/28 days
PULMONARY FIBROSIS AGENTS - Drugs to treat pulmonary fibrosis		
ESBRIET CAP 267MG ***(pirfenidone)***	4	LMSP-PA-QL-SF QL= 9 caps/day
ESBRIET TAB 267MG 267MG ***(pirfenidone)***	4	LMSP-PA-QL-SF QL= 9 tabs/day
ESBRIET TAB 801MG 801MG ***(pirfenidone)***	4	LMSP-PA-QL-SF QL= 3 tabs/day
OFEV CAP 100MG, 150MG ***(nintedanib esylate)***	4	LD-PA-QL-SF QL= 2 caps/day; Only available through Walgreens 888-347-3416
SULFONAMIDES - Drugs to treat bacterial infections		
SULFONAMIDES - Drugs to treat infection		
SULFADIAZINE TAB ***(sulfadiazine tab)***	1	-
SULFADIAZINE TAB 500MG	1	-
TETRACYCLINES - Drugs to treat bacterial infections		
TETRACYCLINES - Drugs to treat infections		
ADOXA TAB ***(doxycycline (monohydrate))***	3	-
demeclocycline tab 150MG, 300MG (DECLOMYCIN Equiv)	1	-
doxycycline hyclate cap 100MG, 50MG (VIBRAMYCIN Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DOXYCYCLINE HYCLATE DR CAP ***(doxycycline hyclate)***	3	-
doxycycline hyclate tab 100MG, 20MG (VIBRATAB Equiv)	1	-
doxycycline monohydrate cap 100mg 100MG (MONODOX Equiv)	1	-
doxycycline monohydrate cap 50mg 50MG (MONODOX Equiv)	1	-
doxycycline monohydrate tab 100MG, 50MG, 75MG (ADOXA Equiv)	1	-
doxycycline susp 25MG/5ML (VIBRAMYCIN Equiv)	1	-
MINOCIN CAP 100MG, 50MG ***(minocycline hcl)***	3	-
minocycline cap 100MG, 50MG, 75MG (MINOCIN Equiv)	1	-
MONODOX CAP 100MG, 75MG ***(doxycycline (monohydrate))***	3	-
ORAXYL CAP ***(doxycycline hyclate)***	3	-
tetracycline cap 250MG, 500MG	1	-
VIBRAMYCIN CAP 100MG ***(doxycycline hyclate)***	3	-
VIBRAMYCIN SUSP 25MG/5ML ***(doxycycline (monohydrate))***	3	-
VIBRAMYCIN SYRUP 50MG/5ML ***(doxycycline calcium)***	3	-
THYROID AGENTS - Drugs to regulate thyroid hormones		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ANTITHYROID AGENTS - Drugs to treat high thyroid level		
methimazole tab (TAPAZOLE Equiv)	1	-
propylthiouracil tab 50MG	1	-
TAPAZOLE TAB 10MG, 5MG ***(methimazole)***	3	-
THYROID HORMONES - Drugs to regulate thyroid hormones		
ARMOUR THYROID TAB, NATURE THROID TAB 113.75MG, 130MG, 146.25MG, 16.25MG, 162.5MG, 180MG, 195MG, 240MG, 260MG, 300MG, 32.5MG, 325MG, 48.75MG, 65MG, 81.25MG, 97.5MG ***(thyroid)***	1	-
ARMOUR THYROID TAB, NATURE THROID TAB 120MG, 15MG, 30MG, 60MG, 90MG ***(thyroid)***	1	-
CYTOMEL TAB 25MCG, 50MCG, 5MCG ***(liothyronine sodium)***	3	-
liothyronine tab 25MCG, 50MCG, 5MCG (CYTOMEL Equiv)	1	-
np thyroid tab 120MG, 15MG, 30MG, 60MG, 90MG (ARMOUR THYROID, NATURE THROID Equiv)	1	-
SYNTHROID TAB 100MCG, 112MCG, 125MCG, 137MCG, 150MCG, 175MCG, 200MCG, 25MCG, 300MCG, 50MCG, 75MCG, 88MCG ***(levothyroxine sodium)***	1	-
THYROLAR TAB 120MG, 15MG, 180MG, 30MG, 60MG ***(liotrix (t3-t4))***	2	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TIROSINT-SOL 100MCG/ML, 112MCG/ML, 125MCG/ML, 137MCG/ML, 13MCG/ML, 150MCG/ML, 175MCG/ML, 200MCG/ML, 25MCG/ML, 37.5MCG/ML, 44MCG/ML, 50MCG/ML, 62.5MCG/ML, 75MCG/ML, 88MCG/ML ***(levothyroxine sodium)***	3	PA-QL QL=1 ml/day; Prior Authorization required for members age 9 or older
TOXOIDS - Drugs to prevent infection		
TOXOID COMBINATIONS - Drugs to prevent infection		
ADACEL/BOOSTRIX INJ 2.5LF/0.5ML-5LF/0.5ML-18.5MCG/0.5ML, 2LF/0.5ML-5LF/0.5ML-15.5MCG/0.5ML ***(tetanus toxoid-diphtheria-acellular pertussis adsorb (tdap))***	$0	VAC Covered for members age 19 years or older
TETANUS/DIPHTHERIA TOXOID INJ 2LF/0.5ML ***(tetanus-diphtheria toxoids (td))***	$0	VAC Covered for members age 19 years or older
ULCER DRUGS - Drugs to treat bowel, intestine, and stomach conditions		
ANTISPASMODICS - Drugs to treat diarrhea		
ANASPAZ ODT .125MG ***(hyoscyamine sulfate)***	3	-
BENTYL CAP 10MG ***(dicyclomine hcl)***	3	-
BENTYL SYRUP ***(dicyclomine hcl)***	3	-
BENTYL TAB ***(dicyclomine hcl)***	3	-
CANTIL TAB ***(mepenzolate bromide)***	3	-
CUVPOSA SOLN 1MG/5ML ***(glycopyrrolate)***	4	MSP
dicyclomine cap 10MG (BENTYL Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
dicyclomine soln 10MG/5ML (BENTYL Equiv)	1	-
dicyclomine tab 20MG (BENTYL Equiv)	1	-
DONNATAL EXTENTABS ***(phenobarbital-hyoscyamine-atropine-scopolamine)***	2	-
glycopyrrolate tab 1MG, 2MG (ROBINUL Equiv)	1	-
hyoscyamine sulfate CR tab .375MG (LEVBID Equiv)	1	-
hyoscyamine sulfate elixir .125MG/5ML (LEVSIN Equiv)	1	-
hyoscyamine sulfate ODT .125MG (ANASPAZ Equiv)	1	-
hyoscyamine sulfate SL tab .125MG (LEVSIN Equiv)	1	-
hyoscyamine sulfate SR cap (LEVSINEX Equiv)	1	-
hyoscyamine tab .125MG (LEVSIN Equiv)	1	-
LEVBID TAB .375MG ***(hyoscyamine sulfate)***	3	-
LEVSIN SL TAB .125MG ***(hyoscyamine sulfate)***	3	-
LEVSIN TAB .125MG ***(hyoscyamine sulfate)***	3	-
LEVSINEX CAP ***(hyoscyamine sulfate)***	3	-
methscopolamine tab 2.5MG, 5MG (PAMINE Equiv)	1	-
PAMINE TAB ***(methscopolamine bromide)***	3	-
ROBINUL TAB 1MG, 2MG ***(glycopyrrolate)***	3	-
SYMAX DUOTAB .375MG ***(hyoscyamine sulfate)***	3	-
H-2 ANTAGONISTS - Drugs to treat bowel, intestine, and stomach conditions		
cimetidine tab 200MG, 300MG, 400MG, 800MG (TAGAMET Equiv)	1	-
famotidine susp 40MG/5ML (PEPCID Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
famotidine tab 10MG, 20MG, 40MG (PEPCID Equiv)	1	-
nizatidine cap 150MG, 300MG (AXID Equiv)	1	-
NIZATIDINE SOLN 15MG/ML ***(nizatidine)***	3	PA Members age 9 or older require Prior Authorization
PEPCID SUSP 40MG/5ML ***(famotidine)***	3	-
PEPCID TAB 10MG, 20MG, 40MG ***(famotidine)***	3	-
ZANTAC GRANULE PACKET ***(ranitidine hcl)***	3	-
MISC. ANTI-ULCER - Miscellaneous anti-ulcer drugs		
CARAFATE TAB 1GM ***(sucralfate)***	3	-
sucralfate tab 1GM (CARAFATE Equiv)	1	-
PROTON PUMP INHIBITORS - Drugs to treat acid reflux		
lansoprazole cap 15MG, 30MG (PREVACID Equiv)	1	Rx Only
omeprazole DR cap 10MG, 20MG, 40MG (PRILOSEC Equiv)	1	-
pantoprazole EC tab 20MG, 40MG (PROTONIX Equiv)	1	-
ULCER DRUGS - PROSTAGLANDINS - Drugs to treat bowel, intestine, and stomach conditions		
CYTOTEC TAB 100MCG, 200MCG ***(misoprostol)***	3	-
misoprostol tab 100MCG, 200MCG (CYTOTEC Equiv)	1	-
ULCER THERAPY COMBINATIONS - Drugs to treat bowel, intestine, and stomach conditions		
lansoprazole/amoxicillin/clarithromycin kit 30MG-500MG (PREVPAC Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
PREVPAC KIT 30MG-500MG ***(amoxicillin-clarithromycin w/ lansoprazole)***	3	-
PYLERA CAP 125MG-140MG ***(bismuth subcitrate potassium-metronidazole-tetracycline)***	3	-
ZEGERID CAP OTC 20MG-1100MG ***(omeprazole-sodium bicarbonate)***	1	OTC
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - Drugs to treat ulcers		
H-2 ANTAGONISTS - Drugs to treat bowel, intestine, and stomach conditions		
NIZATIDINE CAP 150MG, 300MG ***(nizatidine)***	1	-
MISC. ANTI-ULCER - Miscellaneous anti-ulcer drugs		
CARAFATE SUSP 1GM/10ML ***(sucralfate)***	3	-
sucralfate susp 1GM/10ML (CARAFATE Equiv)	1	-
URINARY ANTI-INFECTIVES - Drugs to treat bladder/kidney infections		
URINARY ANTI-INFECTIVE COMBINATIONS - Drugs to treat bladder/kidney infections		
UROQID #2 TAB ***(methenamine mandelate-sodium phosphate monobasic)***	3	-
URINARY ANTISPASMODICS - Drugs to treat miscellaneous bladder spasms		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC) - Drugs to treat miscellaneous bladder spasms		
darifenacin SR tab 15MG, 7.5MG (ENABLEX Equiv)	1	PA
DETROL LA CAP 2MG, 4MG ***(tolterodine tartrate)***	3	-
DETROL TAB 1MG, 2MG ***(tolterodine tartrate)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
DITROPAN XL TAB 10MG, 15MG, 5MG ***(oxybutynin chloride)***	3	-
ENABLEX TAB 15MG, 7.5MG ***(darifenacin hydrobromide)***	3	PA
oxybutynin ER tab 10MG, 15MG, 5MG (DITROPAN XL Equiv)	1	-
oxybutynin syrup 5MG/5ML	1	-
oxybutynin tab 5MG (DITROPAN Equiv)	1	-
OXYTROL PATCH (OTC) 3.9MG/24HR ***(oxybutynin)***	1	OTC
SANCTURA TAB ***(trospium chloride)***	3	-
solifenacin tab 10MG, 5MG (VESICARE Equiv)	1	-
tolterodine SR cap 2MG, 4MG (DETROL LA Equiv)	1	-
tolterodine tab 1MG, 2MG (DETROL Equiv)	1	-
trospium chloride SR cap 60MG (SANCTURA XR Equiv)	1	PA
trospium tab 20MG (SANCTURA Equiv)	1	-
VESICARE TAB 10MG, 5MG ***(solifenacin succinate)***	3	-
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS - Drugs to treat miscellaneous bladder spasms		
MYRBETRIQ TAB 25MG, 50MG ***(mirabegron)***	2	-
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS - Drugs to treat urinary retention		
bethanechol tab 10MG, 25MG, 50MG, 5MG (URECHOLINE Equiv)	1	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
URECHOLINE TAB 10MG, 25MG, 50MG, 5MG ***(bethanechol chloride)***	3	-
VACCINES - Drugs to prevent infection		
BACTERIAL VACCINES - Drugs to prevent infection		
BEXSERO INJ ***(meningococcal vac group b (recombant omv adjuvanted))***	$0	VAC Covered for members age 19 years or older
MENACTRA INJ ***(meningococcal (a,c,y&w-135) polysacch diphth conj vaccine)***	EXC	VAC
MENQUADFI INJ ***(meningococcal (a,c,y&w-135) polysacch tetanus conj vaccine)***	EXC	VAC
PNEUMOVAX INJ 25MCG/0.5ML ***(pneumococcal vac polyvalent)***	$0	VAC
PREVNAR 13 INJ ***(pneumococcal 13-valent conjugate vaccine)***	$0	PA-QL-VAC QL=1 vaccine/lifetime; Covered for members age 19 years or older, Prior authorization required if member less than 19 years.
PREVNAR 20 INJ ***(pneumococcal 20-valent conjugate vaccine)***	$0	QL-VAC QL=1 vaccine/lifetime; Covered for members age 19 years or older
TRUMENBA INJ ***(meningococcal group b vaccine (recombinant))***	$0	VAC Covered for members age 19 years or older

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
VAXNEUVANCE INJ ***(pneumococcal 15-valent conjugate vaccine)***	$0	QL-VAC QL= 1 vaccine/lifetime; Covered for members age 19 years or older
VIVOTIF CAP ***(typhoid vaccine)***	2	QL-VAC QL= 4 caps/fill
VIRAL VACCINES - Drugs to prevent infection		
AFLURIA INJ ***(influenza virus vaccine split preservative free)***	$0	QL-VAC QL= 1 inj/28 days
AFLURIA INJ, FLUZONE INJ ***(influenza virus vaccine split)***	$0	QL-VAC QL= 1 inj/28 days
COVID-19 VACCINE INJ (JANSSEN) .5ML ***(covid-19 (sars-cov-2) adenovirus vaccine)***	$0	QL QL= 1 dose/45 days; limit 2 fills/12 months
COVID-19 VACCINE INJ (MODERNA) 100MCG/0.5ML ***(covid-19 (sars-cov-2) mrna virus vaccine)***	$0	QL QL= 1 dose/24 days; limit 3 fills/12 months
COVID-19 VACCINE INJ (PFIZER) 30MCG/0.3ML ***(covid-19 (sars-cov-2) mrna virus vaccine)***	$0	QL QL= 1 dose/17 days; limit 3 fills/12 months
COVID-19 VACCINE INJ 5-11Y (PFIZER) 10MCG/0.2ML ***(covid-19 (sars-cov-2) mrna virus vaccine)***	$0	QL QL= 1 dose/17 days; limit 2 fills/12 months

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ENGERIX-B INJ 10MCG/0.5ML, 20MCG/ML ***(hepatitis b vaccine (recomb))***	$0	VAC Covered for members age 19 years or older
ENGERIX-B INJ, RECOMBIVAX-HB INJ 10MCG/0.5ML, 10MCG/ML, 20MCG/ML, 40MCG/ML, 5MCG/0.5ML ***(hepatitis b vaccine (recomb))***	$0	VAC Covered for members age 19 years or older
FLUAD INJ ***(influenza virus vaccine types a & b surface antigen adjuvant)***	$0	QL-VAC QL= 1 inj/28 days
FLUAD QUAD INJ .5ML ***(influenza virus vacc types a & b surf antigen adjuvant quad)***	$0	QL-VAC QL= 1 inj/28 days
FLUBLOK INJ ***(influenza virus vaccine recombinant hemagglutinin (ha))***	$0	QL-VAC QL= 1 inj/28 days
FLUBLOK QUAD PF INJ ***(influenza virus vac recomb hemagglutinin (ha) quadrivalent)***	$0	QL-VAC QL= 1 inj/28 days
FLUCELVAX INJ ***(influenza virus vaccine tissue-cultured subunit)***	$0	QL-VAC QL= 1 inj/28 days
FLUCELVAX QUAD INJ ***(influenza virus vaccine tissue-cultured subunit quadrivalent)***	$0	QL-VAC QL= 1 inj/28 days
FLULAVAL QUAD INJ, FLUZONE QUAD INJ ***(influenza virus vaccine split quadrivalent)***	$0	QL-VAC QL= 1 inj/28 days
FLUMIST QUADRIVALENT NASAL SUSP ***(influenza virus vaccine live quadrivalent)***	$0	QL-VAC QL= 1 inj/28 days

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
FLUVIRIN INJ ***(influenza virus vaccine types a & b surface antigen)***	$0	QL-VAC QL= 1 inj/28 days
FLUVIRIN PF INJ ***(influenza virus vaccine types a & b preservative free)***	$0	QL-VAC QL= 1 inj/28 days
FLUZONE HD PF INJ ***(influenza virus vac split high-dose quad preservative free)***	$0	QL-VAC QL= 1 inj/28 days
FLUZONE HIGH DOSE PF INJ ***(influenza virus vaccine split high-dose preservative free)***	$0	QL-VAC QL= 1 inj/28 days
FLUZONE INTRADERMAL INJ ***(influenza virus vaccine split)***	$0	QL-VAC QL= 1 inj/28 days
FLUZONE QUADRIVALENT INJ ***(influenza virus vaccine split quadrivalent)***	$0	QL-VAC QL= 1 inj/28 days
FLUZONE/FLUARIX QUAD INJ ***(influenza virus vaccine split quadrivalent)***	$0	QL-VAC QL= 1 inj/28 days
HEPLISAV-B INJ 20MCG/0.5ML ***(hepatitis b vaccine recombinant adjuvanted)***	$0	VAC Covered for members age 19 years or older
IMOVAX RABIES INJ 2.5UNIT/ML ***(rabies virus vaccine, hdc)***	$0	VAC Covered for members age 19 years or older
SHINGRIX INJ 50MCG/0.5ML ***(zoster vaccine recombinant adjuvanted)***	$0	VAC Covered for members age 19 years or older

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
TICOVAC INJ 2.4MCG/0.5ML ***(tick-borne encephalitis virus vaccine, inactivated)***	EXC	VAC
VARIVAX INJ 1350PFU/0.5ML ***(varicella virus vaccine live)***	$0	VAC Covered for members age 19 years or older
ZOSTAVAX INJ 19400UNT/0.65ML ***(zoster vaccine live)***	$0	VAC Covered for members age 50 or older
VAGINAL PRODUCTS - Drugs to treat vaginal infections and low hormones		
MISCELLANEOUS VAGINAL PRODUCTS - Drugs to treat miscellaneous vaginal disorders		
ACIDIC VAGINAL JELLY ***(acetic acid vaginal)***	2	-
FEM PH GEL .025%-.9% ***(acetic acid-oxyquinoline vaginal)***	3	-
FEM PH GEL .025%-.9% ***(acetic acid-oxyquinoline vaginal)***	3	-
SPERMICIDES - Drugs to prevent pregnancy		
CONCEPTROL GEL 4% ***(nonoxynol-9)***	$0	OTC
CONTRACEPTIVE FILM 28% ***(nonoxynol-9)***	$0	OTC
CONTRACEPTIVE FOAM 12.5% ***(nonoxynol-9)***	$0	OTC
CONTRACEPTIVE GEL 2%, 3%, 4% ***(nonoxynol-9)***	$0	OTC
CONTRACEPTIVE SUPP 100MG ***(nonoxynol-9)***	$0	OTC
TODAY SPONGE 1000MG ***(nonoxynol-9)***	$0	OTC
VAGINAL ANTI-INFECTIVES - Drugs to treat vaginal infections		
CLEOCIN VAGINAL CREAM 2% ***(clindamycin phosphate vaginal)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
CLEOCIN VAGINAL SUPP 100MG ***(clindamycin phosphate vaginal)***	3	-
clindamycin vaginal cream 2% (CLEOCIN Equiv)	1	-
CLINDESSE VAGINAL CREAM 2% ***(clindamycin phosphate (one dose))***	3	-
METROGEL VAGINAL GEL .75% ***(metronidazole vaginal)***	3	-
metronidazole vaginal gel .75% (METROGEL Equiv)	1	-
MICONAZOLE 3 SUPP 200MG 200MG ***(miconazole nitrate vaginal)***	3	-
NYSTATIN VAGINAL TAB ***(nystatin vaginal)***	1	-
TERAZOL CREAM .4% ***(terconazole vaginal)***	3	-
TERAZOL SUPP ***(terconazole vaginal)***	3	-
terconazole cream .4%, .8% (TERAZOL Equiv)	1	-
TERCONAZOLE CREAM 0.8% .8% ***(terconazole vaginal)***	1	-
terconazole supp 80MG (TERAZOL Equiv)	1	-
VAGINAL ESTROGENS - Drugs to treat low hormones		
ESTRACE VAGINAL CREAM .1MG/GM ***(estradiol vaginal)***	3	-
estradiol cream .1MG/GM (ESTRACE Equiv)	1	-
estradiol vaginal tab, yuvafem vaginal tab 10MCG (VAGIFEM Equiv)	1	QL QL= 8 tabs/28 days (18 tabs on first fill)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
ESTRING 2MG ***(estradiol vaginal)***	2	-
FEMRING .05MG/24HR, .1MG/24HR ***(estradiol acetate vaginal)***	3	3 copays per Rx
PREMARIN VAGINAL CREAM .625MG/GM ***(estrogens, conjugated vaginal)***	2	-
VAGIFEM TAB 10MCG ***(estradiol vaginal)***	3	QL QL= 8 tabs/28 days (18 tabs on first fill)
VAGINAL PROGESTINS - Drugs to treat low hormones		
CRINONE GEL 4%, 8% ***(progesterone (vaginal))***	2	PA
ENDOMETRIN INSERT 100MG ***(progesterone (vaginal))***	2	PA
PROGESTERONE SUPP 100MG, 200MG ***(progesterone (vaginal))***	3	PA
VASOPRESSORS - Drugs to treat heart and circulation conditions		
ANAPHYLAXIS THERAPY AGENTS - Drugs to treat systemic swelling conditions		
epinephrine pen inj 0.15mg, 0.3mg .15MG/0.3ML, .3MG/0.3ML (EPIPEN (JR) Equiv)	1	QL QL= 2 inj/fill
SYMJEPI INJ .15MG/0.3ML, .3MG/0.3ML ***(epinephrine (anaphylaxis))***	1	QL QL= 2 inj/fill
VIRAL VACCINES - Drugs to prevent infection		
midodrine tab 10MG, 2.5MG, 5MG (PROAMATINE Equiv)	1	-
PROAMATINE TAB ***(midodrine hcl)***	3	-

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
VITAMINS - Drugs to treat vitamin deficiency		
MISC. NUTRITIONAL FACTORS - Drugs to treat vitamin deficiency		
PRENATAL VITAMINS (NON-PREFERRED) ***(prenatal vit w/ fe polysacch cmplx-fe asp-fe glyc-fa & dha)***	3	-
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS) ***(prenatal vit w/ ferrous fumarate-folic acid)***	1	-
OIL SOLUBLE VITAMINS - Drugs to treat vitamin deficiency		
cholecalciferol cap 50000 unit 1.25MG, 50000UNIT	1	OTC
DRISDOL CAP 50000UNIT ***(ergocalciferol)***	3	-
MEPHYTON TAB 5MG ***(phytonadione)***	3	-
phytonadione tab 100MCG, 5MG (MEPHYTON Equiv)	1	-
vitamin D cap 1.25MG, 50000UNIT	1	Rx covered Only
vitamin D cap 1000unit 1000UNIT, 25MCG	$0	OTC
vitamin D cap 400unit 400UNIT	$0	OTC
VITAMIN D TAB 400UNIT 400UNIT ***(ergocalciferol)***	$0	OTC Covered for members 65 years or older
WATER SOLUBLE VITAMINS - Drugs to treat vitamin deficiency		
niacin cap	1	OTC
niacin CR tab 250MG, 500MG, 750MG (SLO-NIACIN Equiv)	1	OTC
niacin tab 100MG, 250MG, 500MG, 50MG	1	OTC
NIACIN TR TAB 1000MG ***(niacin)***	1	OTC

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DRUG NAME Name of drug	DRUG TIER What the drug will cost you (tier level)	REQUIREMENTS/LIMITS Necessary actions, restrictions, or limits on use
niacinamide tab 100MG, 500MG	1	OTC
POTABA CAP 500MG ***(potassium aminobenzoate)***	3	-
POTABA POWDER PACKET 2GM ***(potassium aminobenzoate)***	2	-
POTABA TAB ***(potassium aminobenzoate)***	2	-
SLO-NIACIN TAB 250MG, 500MG, 750MG ***(niacin)***	3	OTC

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

Other
8-MOP CAP 141

A
abacavir soln 106
abacavir tab 106
abacavir/lamivudine tab 106
abacavir/lamivudine/zidovudine tab 106
ABILIFY TAB 105
abiraterone tab 250mg 87
ABSTRAL SL TAB 12
acamprosate calcium DR tab 219
acarbose tab 48
ACCOLATE TAB 27
ACCU-CHEK AVIVA PLUS METER 185
ACCU-CHEK AVIVA PLUS TEST STRIP 152
ACCU-CHEK GUIDE CARE METER 185
ACCU-CHEK GUIDE ME KIT 185
ACCU-CHEK GUIDE TEST STRIP 153
ACCU-CHEK NANO METER 185
ACCU-CHEK SMARTVIEW TEST STRIP 153
ACCU-CHEK TEST STRIP 153
ACCUNEB NEB SOLN 28
ACCUPRIL TAB 68
ACCURETIC TAB 72
acebutolol cap 116
acetaminophen/codeine soln 16
acetaminophen/codeine tab 16
ACETASOL HC OTIC SOLN 213
acetazolamide ER cap 154
acetazolamide tab 154
acetic acid otic soln 212
acetic acid/hydrocortisone otic soln 214
acetylcysteine soln 135
ACIDIC VAGINAL JELLY 237
acitretin cap 141
ACLOVATE CREAM 144
ACLOVATE OINT 144
ACTEMRA ACTPEN INJ 7
ACTEMRA SC INJ 7
ACTHAR GEL INJ 159
ACTIGALL CAP 167
ACTIMMUNE INJ 98
ACTIQ LOZENGE 12
ACTIVELLA TAB 163
ACTONEL TAB 157
ACTOPLUS MET XR TAB 48
ACTOS TAB 55
ACULAR (LS) OPHTH SOLN 209
ACUVAIL OPHTH SOLN 209
acyclovir cap 112
acyclovir oint 143
acyclovir susp 112
acyclovir tab 112
ADACEL/BOOSTRIX INJ 228
ADAGEN INJ 117
ADALAT CC TAB 118
adapalene cream 135
adapalene gel 135
adapalene/benzoyl peroxide gel 0.1-2.5% 135
ADDERALL TAB 1
adefovir dipivoxil tab 111
ADEMPAS TAB 123
ADIPEX-P CAP 2
ADIPEX-P TAB 2
ADMELOG INJ, INSULIN LISPRO INJ 52

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

ADMELOG SOLOSTAR INJ, INSULIN LISPRO KWIKPEN INJ (JUNIOR) 52
ADOXA TAB 225
ADVAIR DISKUS INHALER 28
ADVAIR HFA INHALER 29
AEROCHAMBER 187
AEROCHAMBER SUPPLIES 187
AFLURIA INJ 234
AFLURIA INJ, FLUZONE INJ 234
AGRYLIN CAP 173
AIMOVIG INJ 188
AKNE-MYCIN OINT 135
AKYNZEO CAP 60
ALAMAST OPHTH SOLN 209
ALBATUSSIN LIQUID 132
albendazole tab 21
ALBENZA TAB 21
albuterol neb soln 29
albuterol sulfate ER tab 29
albuterol sulfate syrup 29
albuterol sulfate tab 29
albuterol/ipratropium neb soln 29
ALCAINE OPHTH SOLN 206
alclometasone cream 144
alclometasone oint 144
ALCOHOL SWABS 187
ALDACTAZIDE TAB 155
ALDACTAZIDE TAB 50-50MG 155
ALDACTONE TAB 156
ALDARA CREAM 149
ALDURAZYME INJ 160
ALECENSA CAP 90
alendronate sodium oral soln 157
alendronate tab 157
ALENDRONATE TAB 40MG 157
ALFERON-N INJ 98
alfuzosin SR tab 171
ALINIA SUSP 78
ALINIA TAB 78
aliskiren tab 76
ALKERAN TAB 84
ALLEGRA ODT 63
allopurinol tab 172
ALOCRIL OPHTH SOLN 209
ALOGLIPTIN TAB 51
ALOGLIPTIN-METFORMIN TAB 48
ALOGLIPTIN-PIOGLITAZONE TAB 48
ALOMIDE OPHTH SOLN 209
ALORA PATCH 164
alosetron tab 168
ALPHAGAN P OPHTH SOLN 0.15% 203
alprazolam tab 24
ALTACE CAP 68
ALTACE TAB 68
ALTOPREV TAB 66
aluminum chloride soln 150
ALUNBRIG TAB 30MG 90
ALUNBRIG TAB 90MG, 180MG 90
amantadine cap 99
amantadine syrup 99
amantadine tab 99
AMARYL TAB 56
AMBIEN TAB 179
ambrisentan tab 122
amethyst tab 125
AMICAR SOLN 178
AMICAR SYRUP 178
AMICAR TAB 178
amikacin inj 5
amiloride tab 156

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

amiloride/hydrochlorothiazide tab	155	amoxicillin/clavulanate chew tab	216	ANDROGEL 1.62% 2.5GM	19
aminocaproic acid soln	178	amoxicillin/clavulanate ER tab	216	ANDROGEL PUMP 1%	19
aminocaproic acid syrup	178	amoxicillin/clavulanate susp	217	ANDROGEL PUMP 1.62%	19
aminocaproic acid tab	178	amoxicillin/clavulanate tab 500-125mg, 875-125mg	217	ANDROID CAP, TESTRED CAP	19
aminophylline tab	31	amphetamine/dextroamphetamine ER cap	1	ANGELIQ TAB	163
amiodarone tab	25	amphetamine/dextroamphetamine tab	1	ANORO ELLIPTA INHALER	29
amitriptyline tab	46	ampicillin cap	215	ANTABUSE TAB	219
amlodipine tab	118	ampicillin susp	216	ANUSOL-HC CREAM	21
amlodipine/atorvastatin tab	120	ampicillin/sulbactam inj	217	ANZEMET TAB	59
amlodipine/benazepril cap	72	AMTURNIDE TAB	72	APIDRA INJ	52
amlodipine/olmesartan tab	72	ANADROL TAB	18	APIDRA SOLOSTAR INJ	52
amlodipine/valsartan tab	72	ANAFRANIL CAP	46	apraclonidine ophth soln	203
amlodipine/valsartan/hydrochlorothiazide tab	72	anagrelide cap	173	aprepitant pak	60
AMMONIUM CHLORIDE INJ	189	ANASPAZ ODT	228	APTIVUS CAP	106
ammonium lactate cream	148	anastrozole tab	87	APTIVUS SOLN	106
ammonium lactate lotion	148	ANCOBON CAP	61	ARALEN TAB	81
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap	136	ANDRODERM PATCH	19	aranelle tab	125
AMOXAPINE TAB	46	ANDROGEL 1% 25MG	19	ARAVA TAB	10
amoxicillin cap	215	ANDROGEL 1% 50MG, TESTIM GEL 1%	19	arformoterol tartrate neb soln	29
AMOXICILLIN CHEW TAB	215	ANDROGEL 1.62% 1.25GM	19	ARICEPT ODT	219
amoxicillin susp	215			ARICEPT TAB	219
amoxicillin tab	215			ARICEPT TAB 23MG	219
				ARIMIDEX TAB	87

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

aripiprazole soln 105
aripiprazole tab 105
ARIXTRA INJ 33
armodafinil tab 3
ARMOUR THYROID TAB, NATURE THROID TAB 227
ARNUITY ELLIPTA INHALER 27
AROMASIN TAB 87
ARTHROTEC TAB 8
asenapine maleate SL tab 103
ASMANEX HFA INHALER 28
ASMANEX INHALER 28
aspirin chew tab 81mg 11
aspirin ec tab 325mg 11
aspirin ec tab 81mg 11
aspirin tab 325mg 11
aspirin tab 81mg 11
atazanavir cap 106
ATELVIA TAB 158
atenolol tab 116
atenolol/chlorthalidone tab 72
atomoxetine cap 2
atorvastatin tab 10mg 66
atorvastatin tab 20mg 66
atorvastatin tab 40mg 66
atorvastatin tab 80mg 66
atovaquone susp 78
atovaquone/proguanil tab 81
ATRALIN GEL, RETIN-A GEL 136
atropine ophth oint 201
atropine ophth soln 201
ATROVENT HFA INHALER 26
ATROVENT NASAL SPRAY 199
AUBAGIO TAB 222
AUGMENTIN ES-600 SUSP 217
AUGMENTIN SUSP 217
AUGMENTIN TAB 217
AUGMENTIN XR TAB 217
AURYXIA TAB 169
AVALIDE TAB 72
AVANDAMET TAB 48
AVANDARYL TAB 48
AVANDIA TAB 55
AVAPRO TAB 70
AVELOX TAB 165
aviane tab 125
AVINZA CAP 12
AVODART CAP 171
AVONEX INJ 222
AXIRON SOLN 19
AYGESTIN TAB 218
AYVAKIT TAB 89
AZASITE SOLN 203
azathioprine tab 114
azelaic acid gel 150
azelastine nasal spray 0.1% 198
azelastine ophth soln 210
AZILECT TAB 100
azithromycin susp 183
azithromycin tab 183
AZOPT OPHTH SUSP 210
AZOR TAB 72
AZULFIDINE EN TAB 168
AZULFIDINE TAB 168

B

BACITRACIN OPHTH OINT 203
bacitracin/neomycin/polymyxin b ophth oint 203
bacitracin/polymyxin b ophth oint 203
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint 206
baclofen tab 197
BACTRIM DS TAB 78
BACTROBAN OINT 138

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

balsalazide cap	168	BENZNIDAZOLE TAB	21	BETAPACE TAB	116
BALVERSA TAB 3MG	90	benzonatate cap 100mg, 200mg	132	bethanechol tab	232
BALVERSA TAB 4MG	90			bexarotene cap	98
BALVERSA TAB 5MG	90	benztropine tab	99	BEXSERO INJ	233
BANZEL SUSP	34	bepotastine ophth soln	210	BIAXIN SUSP	183
BAQSIMI NASAL POWDER	50	BEPREVE OPHTH SOLN	210	BIAXIN TAB	183
		BETAGAN OPHTH SOLN	200	BIAXIN XL TAB	184
BARACLUDE SOLN	111	betamethasone augmented cream	144	bicalutamide tab	87
BASAGLAR INJ	52			BIKTARVY TAB	106
B-D AUTOSHIELD DUO PEN NEEDLE	187	BETAMETHASONE AUGMENTED GEL	144	BILTRICIDE TAB	21
				bimatoprost ophth soln	212
B-D INSULIN SYRINGE U-500	187	betamethasone augmented lotion	144	bisoprolol tab	116
				bisoprolol/hydrochlorothiazide tab	73
BECONASE AQ NASAL SPRAY	199	betamethasone augmented oint	144		
				BLEPH-10 OPHTH SOLN	203
benazepril tab	68	betamethasone diproprionate cream	144	BLEPHAMIDE S.O.P. OPHTH OINT	206
BENAZEPRIL/HCT TAB	73				
benazepril/hydrochlorothiazide tab	73	betamethasone diproprionate lotion	144	BONIVA TAB 150MG	158
				bosentan tab	122
BENICAR HCT TAB	73	betamethasone diproprionate oint	144	BOSULIF TAB	91
				BRAFTOVI CAP 75MG	91
BENLYSTA AUTO-INJECTOR	193	betamethasone valerate cream	144	BREO ELLIPTA INHALER	29
BENLYSTA INJ	193				
BENTYL CAP	228	betamethasone valerate lotion	144	BREZTRI AEROSPHERE INHALER	29
BENTYL SYRUP	228				
BENTYL TAB	228	betamethasone valerate oint	144	BRILINTA TAB	173
BENZACLIN GEL	136			brimonidine ophth soln 0.15%	203
BENZAMYCIN GEL	136	BETAPACE AF TAB	116		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

brimonidine ophth soln 0.2% 203
brinzolamide ophth susp 210
bromfenac ophth soln 210
BROMFENAC OPHTH SOLN 0.09% (TWICE DAILY) 210
bromocriptine cap 99
bromocriptine tab 99
BRONCOPECTOL SYRUP 132
BROVANA NEB SOLN 29
BROVEX PEB LIQUID 132
BRUKINSA CAP 91
budesonide ER tab 130
budesonide inh susp 28
budesonide SR cap 130
bumetanide tab 155
buprenorphine patch 18
buprenorphine SL tab 18
buprenorphine/naloxone sl film 18
buprenorphine/naloxone SL tab 18
bupropion ER tab 42
bupropion SR tab 223
bupropion tab 42
bupropion XL tab 42
BUSPAR TAB 23
buspirone tab 23
busulfan inj 84
BUSULFEX INJ 84
BUTISOL ELIXIR 179
BUTISOL TAB 179
butorphanol nasal spray 18
BUTRANS PATCH 18
BYDUREON BCISE AUTO INJ 51
BYDUREON INJ 51
BYDUREON PEN INJ 51
BYETTA INJ 51

C

cabergoline tab 162
CABLIVI INJ KIT 174
CABOMETYX TAB 91
CADUET TAB 120
CALAN SR TAB 118
CALAN TAB 118
calcipotriene cream 142
calcipotriene oint 142
calcipotriene soln 142
calcitonin nasal spray 158
calcitriol cap 160
CALCITRIOL OINT 142
calcitriol soln 160
calcium acetate cap 169
CALIBRATION LIQUID 185
CALQUENCE CAP 91
CAMPRAL TAB 219
CANTIL TAB 228
capecitabine tab 85
CAPITAL/CODEINE SUSP 16
CAPRELSA TAB 91
captopril tab 68
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB 73
CARAFATE SUSP 231
CARAFATE TAB 230
CARBAGLU TAB 160
carbamazepine chew tab 34
carbamazepine ER cap 34
carbamazepine ER tab 34
carbamazepine susp 35
carbamazepine tab 35
CARBATROL CAP 35
carbidopa tab 99
carbidopa/levodopa ER tab 99
CARBIDOPA/LEVODOPA ODT 99
carbidopa/levodopa tab 99
CARBIDOPA/LEVODOPA/ENTACAPONE TAB 100
CARBINOXAMINE SOLN 63

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

carbinoxamine tab	63	CEFDITOREN TAB	124	chlordiazepoxide cap	24
CARDENE SR CAP	118	cefixime cap	124	CHLORDIAZEPOXIDE/A MITRIPTYLINE TAB	221
CARDIZEM CD CAP	118	cefixime susp	124		
CARDIZEM TAB	118	CEFOTAXIME INJ	124	chlorhexidine gluconate soln	194
CARDURA TAB	70	cefoxitin inj	124		
CARDURA XL TAB	171	cefpodoxime proxetil susp	125	CHLOROQUINE TAB	81
carglumic acid tab	160	cefpodoxime proxetil tab	125	chlorothiazide tab	156
carisoprodol tab	197	CEFTIN TAB	124	chlorpheniramine ER cap	63
CARMOL-HC CREAM	144	ceftriaxone inj	125	chlorpromazine tab	104
CARNITOR SOLN	160	cefuroxime tab	124	chlorthalidone tab	157
CARNITOR TAB	161	CELEBREX CAP	8	chlorzoxazone tab 500mg	197
CAROSPIR SUSP	156	celecoxib cap	8	CHOLBAM CAP	167
carvedilol tab	115	CELEXA SOLN	43	cholecalciferol cap 50000 unit	240
CASODEX TAB	87	CELEXA TAB	43		
CATAFLAM TAB	8	CELONTIN CAP	41	cholestyramine lite powder	64
CATAPRES TAB	71	CENESTIN TAB	164		
CATAPRES-TTS PATCH	71	CENTANY OINT	138	cholestyramine lite powder pack	65
CAVERJECT INJ	120	cephalexin cap	123		
CAYSTON INH SOLN	79	cephalexin susp	123	cholestyramine powder	65
CEDAX CAP	124	CERDELGA CAP	174	cholestyramine powder pack	65
CEDAX SUSP	124	CEREZYME INJ	174		
CEFACLOR CAP	124	CERVICAL CAP	185	choline magnesium trisalicylate tab	12
CEFACLOR ER TAB	124	CESAMET CAP	60		
CEFACLOR SUSP	124	cesia tab	125	CHROMAGEN FA TAB	176
cefazolin inj	123	cevimeline cap	195	ciclopirox cream	138
CEFAZOLIN INJ	123	CHANTIX PAK	223	ciclopirox gel	138
cefdinir cap	124	CHANTIX TAB	223	ciclopirox nail soln	139
cefdinir susp	124	CHEMET CAP	57	ciclopirox shampoo	139

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

ciclopirox topical susp	139	citalopram tab	43	clindamycin vaginal cream	238
cilostazol tab	174	CITRULLINE PACKET	200	clindamycin/benzoyl peroxide gel	136
CILOXAN OPHTH OINT	203	CLARINEX REDITAB	63	clindamycin/tretinoin gel	136
CILOXAN OPHTH SOLN	204	CLARINEX SYRUP	63	CLINDESSE VAGINAL CREAM	238
CIMDUO TAB	106	CLARINEX TAB	63	CLINORIL TAB	8
cimetidine tab	229	CLARINEX-D TAB	132	clobazam tab	34
CIMZIA INJ	168	clarithromycin ER tab	184	clobetasol foam	144
CIMZIA STARTER INJ KIT	168	clarithromycin susp	184	clobetasol lotion	145
cinacalcet tab	161	clarithromycin tab	184	clobetasol propionate cream	145
CINRYZE INJ	173	clemastine syrup	63	clobetasol propionate emollient cream	145
CIPRO HC OTIC SUSP	213	CLENPIQ SOLN	181	clobetasol propionate gel	145
CIPRO SUSP 5%	166	CLEOCIN CAP	79	clobetasol propionate oint	145
CIPRO TAB	166	CLEOCIN SOLN	79	clobetasol propionate soln	145
CIPRO XR TAB	166	CLEOCIN VAGINAL CREAM	237	clobetasol shampoo	145
CIPRODEX OTIC SUSP	213	CLEOCIN VAGINAL SUPP	238	clobetasol spray	145
CIPROFLOXACIN 100MG TAB	166	CLEOCIN-T LOTION	136	CLOBEX LOTION	145
CIPROFLOXACIN ER TAB	166	CLEOCIN-T PAD	136	CLOBEX SHAMPOO	145
ciprofloxacin ophth soln	204	CLEOCIN-T SOLN	136	CLOBEX SPRAY	145
CIPROFLOXACIN OTIC SOLN	212	CLIMARA PATCH	164	clomipramine cap	46
ciprofloxacin susp	166	CLIMARA PRO PATCH	163	clonazepam ODT	34
ciprofloxacin tab	166	clindamycin cap	79	clonazepam tab	34
ciprofloxacin/dexamethasone otic susp	213	clindamycin gel	136	clonidine ER tab	2
citalopram soln	43	clindamycin lotion	136	clonidine patch	71
		clindamycin pad	136	clonidine tab	71
		clindamycin soln	79		
		clindamycin topical soln	136		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

clopidogrel tab 75mg 174
clotrimazole troches 193
clotrimazole/betamethasone cream 139
clotrimazole/betamethasone lotion 139
clozapine tab 103
CLOZARIL TAB 103
COARTEM TAB 81
CODEINE SULFATE TAB 15MG 12
CODEINE SULFATE TAB 60MG 12
codeine sulfate tablet 15mg, 30mg 13
COLAZAL CAP 168
colchicine tab 172
colchicine/probenecid tab 172
colesevelam pack 65
colesevelam tab 65
COLESTID GRANULE 65
COLESTID POWDER PACK 65
COLESTID TAB 65
colestipol granule 65
colestipol powder packet 65
colestipol tab 65
COLY-MYCIN S OTIC SUSP 213
COLYTE SOLN 181
COMBIGAN OPHTH SOLN 200
COMBIPATCH 164
COMBIVENT INHALER 30
COMBIVENT RESPIMAT INHALER 30
COMETRIQ KIT 91
COMPLERA TAB 106
COMTAN TAB 99
CONCEPT DHA CAP 196
CONCEPTROL GEL 237
CONCERTA TAB, RITALIN SR TAB 3
CONDYLOX SOLN 149
CONTRACEPTIVE FILM 237
CONTRACEPTIVE FOAM 237
CONTRACEPTIVE GEL 237
CONTRACEPTIVE SUPP 237
CONTRAVE TAB 2
COPIKTRA CAP 91
CORDARONE TAB 26
COREG TAB 115
CORGARD TAB 116
CORLANOR TAB 123
CORTEF TAB 130
CORTENEMA 21
CORTISPORIN CREAM 138
CORTISPORIN OINT 138
CORTISPORIN OPHTH SOLN 206
CORTISPORIN OTIC SOLN 213
CORZIDE TAB 73
CORZIDE TAB 80-5MG 73
COSOPT OPHTH SOLN 200
COTELLIC TAB 91
COUMADIN TAB 32
COVERA-HS TAB 118
COVID-19 VACCINE INJ (JANSSEN) 234
COVID-19 VACCINE INJ (MODERNA) 234
COVID-19 VACCINE INJ (PFIZER) 234
COVID-19 VACCINE INJ 5-11Y (PFIZER) 234
COZAAR TAB 70
CPM CAP 63
CREATINE PACKET 5000MG 200
CREON CAP 154
CRESTOR TAB 66
CRESTOR TAB 20MG 66

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

CRESYLATE OTIC SOLN 212
CRINONE GEL 239
CRIXIVAN CAP 106
CROLOM OPHTH SOLN 210
cromolyn conc 167
cromolyn neb soln 26
cromolyn ophth soln 210
CROTAN LOTION 151
cryselle tab 125
CUTIVATE CREAM 145
CUTIVATE OINT 145
CUVPOSA SOLN 228
cyanocobalamin inj 175
CYCLESSA TAB 126
cyclobenzaprine tab 10mg 197
cyclobenzaprine tab 5mg 197
CYCLOGYL OPHTH SOLN 201
CYCLOMYDRIL OPHTH SOLN 201
cyclopentolate ophth soln 201
cyclophosphamide cap 84
CYCLOPHOSPHAMIDE TAB 84
CYCLOSET TAB 51
cyclosporine cap 114
cyclosporine modified cap 114
cyclosporine modified soln 114
CYKLOKAPRON INJ 178
cyproheptadine syrup 64
cyproheptadine tab 64
CYSTADROPS SOLN 210
CYSTAGON CAP 171
CYSTARAN OPHTH SOLN 210
CYTOMEL TAB 227
CYTOTEC TAB 230
CYTRA K CRYSTALS 170
CYTRA-3 SYRUP 170

D

dalfampridine ER tab 222
danazol cap 19
DANTRIUM CAP 198
dantrolene cap 198
dapsone tab 79
darifenacin SR tab 231
DAYTRANA PATCH 3
DAZIDOX TAB 13
DDAVP INJ 162
DDAVP NASAL SOLN 162
DDAVP NASAL SPRAY 162
DDAVP TAB 162
DECON-A LIQUID 132
deferasirox granules packet 58
deferasirox tab 58
deferasirox tab 180mg 58
deferasirox tab 90mg, 360mg 58
deferiprone tab 58
DELSTRIGO TAB 106
DEMADEX TAB 156
demeclocycline tab 225
DENAVIR CREAM 143
DEPAKENE CAP 41
DEPAKENE SYRUP 41
DEPAKOTE ER TAB 41
DEPAKOTE SPRINKLE CAP 41
DEPAKOTE TAB 42
DEPEN TITRATAB 192
DEPO-PROVERA INJ 129
DEPO-PROVERA SC INJ 104MG 129
DEPO-TESTOSTERONE INJ 19
DERMA-SMOOTH/FS OIL 145
DERMATOP CREAM 145
DERMATOP OINT 145
DERMOTIC OIL 214

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered		**generic** =small letters		**BRANDS** =CAPITAL LETTERS	
EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DESCOVY TAB 106
desipramine tab 46
DESLORATADINE ODT 63
desloratadine tab 63
desmopressin acetate inj 162
desmopressin acetate nasal spray 162
desmopressin acetate tab 162
desmopressin nasal soln 162
DESOGEN TAB 126
desoximetasone cream 145
desoximetasone oint 145
desvenlafaxine ER tab 45
DETROL LA CAP 231
DETROL TAB 231
DEXAMETHASONE CONC 130
dexamethasone elixir 130
DEXAMETHASONE OPHTH SOLN 206
DEXAMETHASONE SOLN 130
DEXAMETHASONE TAB 130
DEXCOM G6 RECEIVER 185
DEXCOM G6 SENSOR 185
DEXCOM G6 TRANSMITTER 186
DEXEDRINE CAP 1
dexmethylphenidate ER cap 3
dexmethylphenidate tab 3
dextroamphetamine ER cap 1
dextroamphetamine soln 1
dextroamphetamine tab 1
DIABETA TAB 56
DIACOMIT CAP 35
DIACOMIT POWDER PACK 35
DIALYVITE TAB 195
DIALYVITE/ZINC TAB 195
DIAMOX SEQUEL CAP 154
DIAPHRAGM 185
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL 34
DIATZ ZN TAB 195
diazepam conc 24
diazepam oral soln 5mg/5ml 24
diazepam tab 2mg, 10mg 24
diazepam tab 5mg 24
diazoxide susp 50
DIBENZYLINE CAP 70
diclofenac gel 140
diclofenac gel 1% 140
DICLOFENAC PATCH, FLECTOR PATCH 140
diclofenac potassium tab 8
diclofenac sodium EC tab 8
diclofenac sodium ophth soln 210
diclofenac sodium XR tab 8
diclofenac/misoprostol DR tab 8
dicloxacillin cap 218
dicyclomine cap 228
dicyclomine soln 229
dicyclomine tab 229
didanosine DR cap 107
DIFFERIN CREAM 136
DIFFERIN GEL 136
DIFICID SUSP 184
DIFICID TAB 185
DIFLUCAN SUSP 61
DIFLUCAN TAB 61
difluprednate ophth emulsion 206
DIGOXIN SOLN 120
digoxin tab 120
dihydroergotamine mesylate inj 188
DILANTIN CAP 100MG 41
DILANTIN CAP 30MG 41

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DILANTIN INFATABS	41	divalproex ER tab	42	doxycycline hyclate cap	225
DILANTIN SUSP	41	divalproex sodium DR tab	42	DOXYCYCLINE	226
DILATRATE SR CAP	22	divalproex sprinkle cap	42	HYCLATE DR CAP	
DILAUDID TAB 2MG	13	DIVIGEL GEL, ELESTRIN GEL	165	doxycycline hyclate tab	226
DILAUDID TAB 4MG	13			doxycycline monohydrate cap 100mg	226
DILAUDID TAB 8MG	13	dofetilide cap	26		
diltiazem ER cap	118	DOLOPHINE TAB	13	doxycycline monohydrate cap 50mg	226
diltiazem tab	118	donepezil ODT	219		
dimethyl fumarate DR cap	222	donepezil tab	219	doxycycline monohydrate tab	226
dimethyl fumarate DR starter pack	222	donepezil tab 23mg	220		
		DONNATAL EXTENTABS	229	doxycycline susp	226
DIOVAN HCT TAB	73			D-PENAMINE TAB	114
DIOVAN TAB	70	DOPTELET TAB	175	DRISDOL CAP	240
DIPENTUM CAP	168	DORIBAX INJ	78	DRITHO-SCALP CREAM	142
diphenhydramine cap 50mg	63	DORIPENEM INJ	78	dronabinol cap	60
		dorzolamide ophth soln	210	DROXIA CAP	175
diphenhydramine inj	63	dorzolamide/timolol ophth soln	201	DRYSOL SOLN	150
DIPHENOXYLATE/ATROPINE LIQUID	57			DUAC CS KIT	137
		DOVATO TAB	107	DUAC GEL	137
diphenoxylate/atropine tab	57	DOVONEX CREAM	142	DULERA INHALER	30
DIPROLENE AF CREAM	146	DOVONEX SOLN	142	duloxetine EC cap	45
DIPROLENE LOTION	146	doxazosin tab	71	DUONEB NEB SOLN	30
DIPROLENE OINT	146	doxepin cap	46	DUPIXENT INJ	148
dipyridamole tab	174	doxepin conc	47	DUPIXENT INJ 100MG/0.67ML	148
disopyramide cap	25	DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	141		
DISULFIRAM TAB	219			DUPIXENT PEN INJ	148
DITROPAN XL TAB	232			DURAGESIC PATCH	13
DIURIL SUSP	157	doxercalciferol cap	161		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

DUREZOL OPHTH EMULSION 206
dutasteride cap 171
DYAZIDE CAP 155
DYNACIRC CR TAB 118

E

econazole cream 139
EDARBI TAB 70
EDARBYCLOR TAB 73
EDECRIN TAB 156
EDEX INJ 120
EDURANT TAB 107
efavirenz cap 107
efavirenz tab 107
efavirenz/emtricitabine/tenofovir df tab 107
efavirenz/lamivudine/tenofovir df (lo) tab 107
EFFEXOR TAB 46
EFFEXOR XR CAP 46
EFFIENT TAB 174
EFUDEX CREAM 140
EGRIFTA INJ 159
ELDEPYRL CAP 101
ELESTAT OPHTH SOLN 210
ELIDEL CREAM 149
ELIMITE CREAM 151
ELIQUIS TAB, ELIQUIS STARTER PACK 32
ELIXOPHYLLIN ELIXIR 32
ELLA TAB 129
ELMIRON CAP 171
ELOCON CREAM 146
ELOCON OINT 146
ELOCON SOLN 146
EMADINE OPHTH SOLN 211
EMCYT CAP 88
EMEND CAP 60
EMGALITY INJ 188
EMGALITY INJ 100MG/ML 188
EMLA CREAM 150
EMPAVELI INJ 173
EMSAM PATCH 43
emtricitabine cap 107
emtricitabine/tenofovir disoproxil fumarate tab 107
EMTRIVA SOLN 107
EMVERM TAB 21
ENABLEX TAB 232
enalapril maleate oral soln 69
enalapril tab 69
enalapril/hydrochlorothiazide tab 73
ENBREL INJ 25MG 10
ENBREL INJ 50MG 11
ENBREL MINI INJ 11
ENBREL SURECLICK INJ 50MG 11
ENDARI POWDER PACK 175
ENDOMETRIN INSERT 239
ENGERIX-B INJ 235
ENGERIX-B INJ, RECOMBIVAX-HB INJ 235
ENJUVIA TAB 165
enoxaparin inj 33
enpresse tab 126
ENSPRYNG INJ 192
entacapone tab 99
entecavir tab 111
EPANED SOLN 69
EPIDIOLEX SOLN 35
EPIDUO FORTE GEL 0.3-2.5% 137
EPIDUO GEL 0.1-2.5% 137
EPIFOAM AEROSOL 146
epinastine opthth soln 211
epinephrine pen inj 0.15mg, 0.3mg 239
EPIVIR HBV SOLN 111
eplerenone tab 76
EPROSARTAN TAB 70
EQUETRO CAP 102

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

ERGOLOID MESYLATES TAB 223
ERGOMAR SL TAB 188
ergotamine tartrate/caffeine tab 188
ERIVEDGE CAP 87
ERLEADA TAB 88
erlotinib tab 86
ertapenem inj 78
ERY PAD 137
ERYTHROMYCIN EC CAP 184
erythromycin ethylsuccinate susp 184
erythromycin gel 137
erythromycin ophth oint 204
erythromycin pad 137
erythromycin soln 137
erythromycin stearate tab 184
erythromycin tab 184
erythromycin/benzoyl peroxide gel 137
erythromycin/sulfisoxazole susp 78
ESBRIET CAP 225
ESBRIET TAB 267MG 225
ESBRIET TAB 801MG 225
ESCAVITE CHEW TAB 196
escitalopram soln 43
escitalopram tab 43
estazolam tab 179
ESTRACE TAB 165
ESTRACE VAGINAL CREAM 238
estradiol cream 238
estradiol patch 165
estradiol tab 165
estradiol vaginal tab, yuvafem vaginal tab 238
estradiol valerate inj 165
estradiol/norethindrone tab 164
ESTRASORB EMULSION 165
ESTRING 239
ESTROSTEP FE TAB 126
eszopiclone tab 179
ethacrynic tab 156
ethambutol tab 83
ethosuximide cap 41
ethosuximide soln 41
etodolac cap 8
etodolac ER tab 8
etodolac tab 8
ETOPOSIDE CAP 98
etravirine tab 107
EURAX LOTION 151
EVAMIST SPRAY 165
everolimus tab 91
everolimus tab 5mg 92
everolimus tab for oral susp 92
EVISTA TAB 159
EVOTAZ TAB 107
EVOXAC CAP 195
EVRYSDI SOLN 200
EXELDERM SOLN 139
EXELON CAP 220
EXELON PATCH 220
exemestane tab 88
EXFORGE HCT TAB 74
EXFORGE TAB 74
EXTAVIA INJ 222
ezetimibe tab 68
ezetimibe/simvastatin tab 64

F

FABRAZYME INJ 161
famciclovir tab 113
famotidine susp 229
famotidine tab 230
FAMVIR TAB 113
FANAPT TAB 102
FANAPT TITRATION PACK 102
FANSIDAR TAB 81
FARESTON TAB 88

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

FARYDAK CAP	92	FERREX 28 TAB	176	FIRST MOUTHWASH BLM	193
FASENRA PEN INJ	26	FERRIPROX SOLN	57		
febuxostat tab	172	FERRIPROX TAB	57	FIRST-VANCOMYCIN SOLN	79
felbamate susp	39	ferrous sulfate elixir	177		
felbamate tab	39	FERROUS SULFATE LIQUID	178	FIRVANQ SOLN	79
FELBATOL SUSP	39			FLAGYL ER TAB	77
FELBATOL TAB	39	ferrous sulfate soln	178	FLAGYL TAB	77
FELDENE CAP	8	ferrous sulfate syrup	178	FLAREX OPHTH SUSP	206
felodipine ER tab	118	FETZIMA CAP	46	flecainide tab	25
FEM PH GEL	237	FETZIMA TITRATION PACK	46	FLEXERIL TAB	198
FEMALE CONDOMS	185			FLOMAX CAP	171
FEMARA TAB	88	FEXMID TAB	197	FLORIVA PLUS DROPS	196
FEMCON FE CHEW TAB	126	FIASP FLEXTOUCH INJ	53	FLOVENT DISKUS INHALER	28
FEMHRT TAB	164	FIASP INJ	53		
FEMRING	239	FIASP PENFILL INJ	53	FLOVENT HFA INHALER	28
fenofibrate cap 67mg, 134mg, 200mg	65	FINACEA GEL	150	FLUAD INJ	235
		FINACEA PLUS KIT	151	FLUAD QUAD INJ	235
fenofibrate tab 48mg, 54mg, 145mg, 160mg	66	finasteride tab	149	FLUBLOK INJ	235
		FINTEPLA SOLN	35	FLUBLOK QUAD PF INJ	235
fenofibric acid DR cap	66	FIRST BACLOFEN SUSP KIT	198	FLUCELVAX INJ	235
FENOFIBRIC TAB, FIBRICOR TAB	66			FLUCELVAX QUAD INJ	235
		FIRST DUKES MOUTHWASH	193	fluconazole susp	61
fentanyl citrate lollipop	13			fluconazole tab	62
fentanyl patch	13	FIRST MARYS MOUTHWASH	194	flucytosine cap	61
FENTORA TAB, FENTANYL BUCCAL TAB	13			fludrocortisone tab	131
		FIRST METRONIDAZOLE SUSP	77	FLULAVAL QUAD INJ, FLUZONE QUAD INJ	235
ferrex 150 forte cap	176			FLUMADINE TAB	113

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

FLUMIST QUADRIVALENT NASAL SUSP	235	fluoxetine cap	43	FML FORTE OPHTH SUSP	207
		fluoxetine soln	44		
fluocinolone acetonide cream	146	fluphenazine tab	104	FML LIQUIFLIM OPHTH SUSP	207
		FLURAZEPAM CAP	179		
fluocinolone acetonide oil	146	FLURBIPROFEN OPHTH SOLN	211	FML S.O.P. OPHTH OINT	207
				FOCALIN TAB	4
fluocinolone acetonide oint	146	FLURBIPROFEN TAB	9	FOCALIN XR CAP	4
		FLUTAMIDE CAP	88	FOLBEE PLUS CZ TAB	195
fluocinolone acetonide soln	146	fluticasone nasal spray	199	folbee tab	176
		fluticasone propionate cream	146	folic acid tab 1mg	175
fluocinolone otic oil	214			folic acid tab 400mcg	175
fluocinonide cream 0.05%	146	fluticasone propionate oint	146	folic acid tab 800mcg	175
fluocinonide cream 0.1%	146	FLUTICASONE/SALMET EROL INHALER	30	fondaparinux inj	33
fluocinonide emollient cream	146			formoterol fumarate neb soln	30
fluocinonide gel	146	fluvastatin ER tab	66	FORTEO INJ	158
fluocinonide oint	146	FLUVIRIN INJ	236	FOSAMAX TAB	158
fluocinonide soln	146	FLUVIRIN PF INJ	236	fosamprenavir tab	107
FLUOR-A-DAY CHEW TAB	190	fluvoxamine ER cap	44	foscarnet sodium inj	111
		fluvoxamine tab	44	FOSCAVIR INJ	111
FLUORIDEX SENSITIVITY PASTE	194	FLUZONE HD PF INJ	236	fosinopril tab	69
		FLUZONE HIGH DOSE PF INJ	236		
fluorometholone ophth soln	207			fosinopril/hydrochlorothiazide tab	74
fluorouracil cream	141	FLUZONE INTRADERMAL INJ	236	FOSRENOL CHEW TAB	169
FLUOROURACIL CREAM 0.5%	141	FLUZONE QUADRIVALENT INJ	236	FOSRENOL POWDER PACK	169
FLUOROURACIL SOLN	141	FLUZONE/FLUARIX QUAD INJ	236	FOTIVDA CAP	92
				FRAGMIN INJ	33

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

FREESTLY LITE METER 186
FREESTYLE FREEDOM LITE METER 186
FREESTYLE INSULINX METER 186
FREESTYLE INSULINX TEST STRIP 153
FREESTYLE LIBRE 2 RECEIVER 186
FREESTYLE LIBRE 2 SENSOR 186
FREESTYLE LIBRE RECEIVER 186
FREESTYLE LIBRE SENSOR (10-DAY) 186
FREESTYLE LIBRE SENSOR (14-DAY) 186
FREESTYLE LITE TEST STRIP 152
FREESTYLE PRECISION NEO METER 186
FREESTYLE PRECISION NEO TEST STRIP 153
FREESTYLE TEST STRIP 153
FULPHILA INJ 175
furosemide soln 156
furosemide tab 156
FUZEON INJ 107

G

gabapentin cap 35
gabapentin cap 100mg 35
gabapentin soln 35
gabapentin tab 600mg 36
gabapentin tab 800mg 36
GABITRIL TAB 40
galantamine ER cap 220
galantamine tab 220
GALZIN CAP 192
GAMASTAN INJ 214
GAMMAGARD INJ 214
GANCICLOVIR CAP 111
GASTROCROM CONC 167
gatifloxacin ophth soln 204
GAVILYTE-C SOLN 181
GAVRETO CAP 92
gemfibrozil tab 66
GENOTROPIN INJ 159
GENTAK OPHTH OINT 204
gentamicin ophth oint 204
gentamicin ophth soln 204
gentamicin sulfate cream 138
gentamicin sulfate oint 138
GENVOYA TAB 107
GEODON CAP 102
gianvi tab, ocella tab 126
GILENYA CAP 222
GILOTRIF TAB 86
GILTUSS LIQUID 132
GILTUSS TR TAB 132
glatiramer inj 222
GLEOSTINE/LOMUSTINE CAP 84
glimepiride tab 56
glipizide ER tab 56
glipizide tab 56
glipizide/metformin tab 48
GLOPERBA SOLN 172
GLUCAGEN HYPOKIT INJ 50
glucagon (rdna) for inj kit 50
GLUCAGON EMR INJ 50
GLUCAGON INJ KIT 50
GLUCOPHAGE TAB 49
GLUCOPHAGE XR TAB 49
GLUCOTROL TAB 56
GLUCOTROL XL TAB 56
GLUCOVANCE TAB 48
glyburide micronized tab 56
glyburide tab 56
glyburide/metformin tab 48
glycopyrrolate tab 229
GLYNASE TAB 56
GLYSET TAB 48
GOLYTELY PACKET 181

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

GOLYTELY SOLN 181
granisetron tab 59
GRANISOL SOLN 59
GRIFULVIN V TAB 61
griseofulvin micro tab 61
griseofulvin susp 61
griseofulvin tab 61
GRIS-PEG TAB 61
guaifenesin/codeine soln 133
GUAIFENESIN/CODEINE SYRUP 133
GUANABENZ TAB 71
guanfacine ER tab 2
guanfacine IR tab 71
GUANIDINE TAB 82
GVOKE INJ 50
GVOKE INJ KIT 50
GVOKE PFS INJ 50

H

HALCION TAB 180
halobetasol propionate cream 147
halobetasol propionate oint 147
haloperidol lactate conc 103
haloperidol tab 103
HECTOROL CAP 161
HEMLIBRA INJ 173
heparin porcine inj 33
HEPLISAV-B INJ 236
HEXALEN CAP 84
HIPREX TAB 80
HIZENTRA INJ 214
homatropine ophth soln 202
HUMALOG MIX INJ 53
HUMALOG MIX 53
KWIKPEN INJ, INSULIN LISPRO PROTAMINE INJ 53
HUMIRA INJ 10MG 6
HUMIRA INJ 20MG 6
HUMIRA INJ 40MG 6
HUMIRA INJ 80MG 6
HUMIRA INJ 6
CROHNS/UC/HIDRADENITIS STARTER PACK 6
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK 7
HUMIRA INJ PEDIATRIC UC STARTER PACK 7
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK 7
HUMIRA PEN INJ 40MG 7
HUMULIN MIX INJ 53
HUMULIN MIX PEN INJ 53
HUMULIN N INJ 53
HUMULIN N PEN INJ 53
HUMULIN R INJ 54
HUMULIN R INJ U-500 54
HUMULIN R U-500 54
KWIKPEN INJ 54
HYCAMTIN CAP 84
HYCET SOLN 16
HYCODAN SYRUP 132
hydralazine tab 77
HYDREA CAP 98
hydrochlorothiazide cap 157
hydrochlorothiazide tab 157
hydrocodone/acetaminophen soln 16
hydrocodone/acetaminophen soln 10-325 mg/15ml 16
hydrocodone/acetaminophen tab 17
hydrocodone/acetaminophen tab 2.5-325mg 17
hydrocodone/chlorpheniramine CR susp 133
hydrocodone/chlorpheniramine/pseudoephedrine liquid 133
hydrocodone/homatropine syrup 132

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

hydrocortisone cream 147
hydrocortisone enema 21
hydrocortisone lotion 147
hydrocortisone oint 147
hydrocortisone tab 130
hydromorphone tab 2mg 14
hydromorphone tab 4mg 14
hydromorphone tab 8mg 14
hydroquinone cream 150
hydroxychloroquine tab 81
HYDROXYCHLOROQUINE TAB 100MG 81
hydroxyprogesterone inj 218
hydroxyurea cap 98
hydroxyzine pamoate cap 23
HYDROXYZINE PAMOATE CAP 100MG 23
hydroxyzine syrup 23
hydroxyzine tab 24
hyoscyamine sulfate CR tab 229
hyoscyamine sulfate elixir 229
hyoscyamine sulfate ODT 229
hyoscyamine sulfate SL tab 229
hyoscyamine sulfate SR cap 229
hyoscyamine tab 229
HYPER-SAL NEB SOLN 135
HYQVIA INJ 215
HYTRIN CAP 71
HYZAAR TAB 74

I

ibandronate tab 150mg 158
IBRANCE CAP 92
IBRANCE TAB 92
ibuprofen susp (Rx ONLY) 9
ibuprofen tab 9
icatibant inj 173
ICLUSIG TAB 92
IDHIFA TAB 92
ILEVRO OPHTH SUSP 211
imatinib tab 92
IMBRUVICA CAP 140MG 93
IMBRUVICA CAP 70MG 93
IMBRUVICA TAB 420MG, 560MG 93
IMCIVREE INJ 2
IMDUR TAB 22
imipramine pamoate cap 47
imipramine tab 47
imiquimod cream 149
IMITREX INJ 188
IMITREX TAB 188
IMOVAX RABIES INJ 236
IMPAVIDO CAP 77
IMURAN TAB 114
INBRIJA INH POWDER 101
INCRELEX INJ 160
INCRUSE ELLIPTA INHALER 26
indapamide tab 157
INDERAL LA CAP 117
indomethacin cap 9
indomethacin CR cap 9
INFANT FORMULA LIQUID 154
INFANT FORMULA POWDER 154
INGREZZA CAP 222
INLYTA TAB 85
INQOVI TAB 90
INSPRA TAB 76
INSULIN ASPART FLEXPEN INJ 54
INSULIN ASPART INJ 54
INSULIN ASPART MIX FLEXPEN INJ 54
INSULIN ASPART MIX INJ 54
INSULIN ASPART PENFILL INJ 54
INTELENCE TAB 25MG 108

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

INTRON-A INJ 98
INTUNIV TAB 3
INVANZ INJ 78
INVEGA TAB 102
INVIRASE CAP 108
INVIRASE TAB 108
IOPIDINE OPHTH SOLN 203
IOPIDINE OPHTH SOLN 1% 203
ipratropium nasal spray 199
ipratropium neb soln 26
irbesartan tab 70
irbesartan/hydrochlorothiazide tab 74
IRESSA TAB 86
IRON POLYSACCH/THREONIC ACID/B12/FA CAP 176
IRON SUSP 178
ISENTRESS (HD) TAB 108
ISENTRESS CHEW TAB 108
ISENTRESS POWDER PACK 108
isibloom tab, enskyce tab, apri tab 126
ISONIAZID SYRUP 83
ISONIAZID TAB 83
ISOPTO ATROPINE OPHTH SOLN 202
ISOPTO CARBACHOL OPHTH SOLN 202
ISOPTO CARPINE OPHTH SOLN 202
ISOPTO HYOSCINE OPHTH SOLN 202
ISORDIL TITRADOSE TAB 22
isosorbide dinitrate ER tab 22
isosorbide dinitrate SL tab 22
isosorbide dinitrate tab 22
isosorbide dinitrate tab 40mg 22
isosorbide mononitrate ER tab 22
isosorbide mononitrate tab 22
ISOXSUPRINE TAB 121
itraconazole cap 62
itraconazole soln 62
IVERMECTIN LOTION 151
ivermectin tab 22

J

JAKAFI TAB 93
JANUMET TAB 49
JANUMET XR TAB 49
JANUVIA TAB 51
JARDIANCE TAB 56
jinteli tab 164
jolessa tab, amethia tab 126
JULUCA TAB 108
junel FE tab 126
junel tab 126
JYNARQUE PAK 163
JYNARQUE TAB 163

K

KALYDECO PAK 224
KALYDECO TAB 224
KANAMYCIN INJ 5
KAPVAY TAB 3
KATERZIA SUSP 118
KAYEXALATE POWDER 115
KEFLEX CAP 123
kelnor tab 126
KEPPRA SOLN 36
KEPPRA TAB 36
KEPPRA XR TAB 36
KESIMPTA INJ 222
ketoconazole cream 139
ketoconazole shampoo 139
ketoconazole tab 62
KETO-DIASTIX TEST STRIP 153
ketorolac ophth soln 211
ketorolac tab 9

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

KETOSTIX 153
ketotifen ophth soln 211
KEVZARA INJ 8
KINERET INJ 7
KLARON LOTION 137
KLONOPIN TAB 34
KLOR-CON POWDER PACKET 191
KLOR-CON POWDER PACKET 25MEQ 191
KLOXXADO NASAL SPRAY 58
KORLYM TAB 51
KOSELUGO CAP 93
K-PHOS NEUTRAL TAB 190
K-PHOS TAB 191
KRINTAFEL TAB 82
K-TAB 191

L

labetalol tab 115
LAC-HYDRIN CREAM 148
LAC-HYDRIN LOTION 148
LACTIC ACID LOTION 149
lactulose soln 168
LAMICTAL CHEW TAB 36
LAMICTAL CHEW TAB 2MG 36
LAMICTAL ODT 36
LAMICTAL ODT KIT 36
LAMICTAL ODT KIT, LAMICTAL XR KIT 36
LAMICTAL STARTER KIT 36
LAMICTAL TAB 36
LAMICTAL XR TAB 36
LAMISIL TAB 61
lamivudine soln 108
lamivudine tab 108
lamivudine tab 100mg 111
lamivudine/zidovudine tab 108
lamotrigine chew tab 36
lamotrigine ER tab 36
lamotrigine ODT 37
lamotrigine ODT kit 37
lamotrigine tab 37
LAMPIT TAB 78
LANCET DEVICE 186
LANCET KIT 186
LANCETS 186
LANOXIN TAB 120
lansoprazole cap 230
lansoprazole/amoxicillin/clarithromycin kit 230
lanthanum carbonate chew tab 169
lapatinib ditosylate tab 93
LARIAM TAB 82
LASIX TAB 156
LASTACAFT OPHTH SOLN 211
latanoprost ophth soln 212
LAZANDA NASAL SPRAY 14
LEDIPASVIR/SOFOSBUV IR TAB 112
leflunomide tab 10
LENVIMA CAP 85
LESCOL XL TAB 66
letrozole tab 88
leucovorin tab 98
LEUKERAN TAB 84
leuprolide inj 88
LEVALBUTEROL INHALER, XOPENEX HFA INHALER 30
levalbuterol neb soln 30
LEVAQUIN SOLN 166
LEVAQUIN TAB 166
LEVATOL TAB 117
LEVBID TAB 229
levetiracetam ER tab 37
levetiracetam soln 37
levetiracetam tab 37

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

LEVOBUNOLOL OPHTH SOLN 201
levocarnitine soln 161
levocarnitine tab 161
levofloxacin ophth soln 204
levofloxacin soln 166
levofloxacin tab 166
levonorgestrel tab 129
LEVONORGESTREL TAB 0.75MG 129
LEVSIN SL TAB 229
LEVSIN TAB 229
LEVSINEX CAP 229
LEXAPRO SOLN 44
LEXAPRO TAB 44
LEXIVA SUSP 108
LIBRIUM CAP 24
lidocaine cream 3% 150
lidocaine gel 150
lidocaine oint 150
lidocaine patch 150
lidocaine soln 150
lidocaine viscous soln 193
lidocaine/hydrocortisone cream 21
lidocaine/prilocaine cream 150
LIDODERM PATCH 150
LIMBITROL TAB 221
lindane lotion 151
LINDANE SHAMPOO 151
linezolid susp 80
linezolid tab 80
liothyronine tab 227
LIPITOR TAB 66
LIPTRUZET TAB 64
LIQUIGEN 200
lisinopril tab 69
lisinopril/hydrochlorothiazide tab 74
lithium carbonate cap 101
lithium carbonate ER tab 102
lithium carbonate tab 102
lithium citrate soln 102
LITHOBID TAB 102
LITHOSTAT TAB 172
LIVALO TAB 67
LO LOESTRIN TAB 126
LODOSYN TAB 99
LOESTRIN 24 FE TAB 126
LOESTRIN FE TAB 127
LOESTRIN TAB 127
lohist liquid 133
LOKELMA PAK 192
LOMOTIL LIQUID 57
LOMOTIL TAB 57
LONSURF TAB 90
LOPID TAB 66
lopinavir/ritonavir soln 108
lopinavir/ritonavir tab 108
LOPRESSOR HCT TAB 74
LOPRESSOR TAB 116
LOPROX CREAM 139
LOPROX GEL 139
LOPROX SHAMPOO 139
loratadine cap 63
lorazepam conc 24
lorazepam tab 24
LORBRENA TAB 100MG 93
LORBRENA TAB 25MG 93
LORTAB 17
LORTAB ELIXIR 17
losartan tab 70
losartan/hydrochlorothiazide tab 74
LOTEMAX OPHTH GEL 207
LOTEMAX OPHTH OINT 207
LOTEMAX OPHTH SUSP 207
LOTENSIN HCT TAB 74
LOTENSIN TAB 69
loteprednol etabonate ophth gel 207
loteprednol ophth susp 207
LOTREL CAP 75
LOTRISONE CREAM 139

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

LOTRISONE LOTION	139
LOTRONEX TAB	168
lovastatin tab	67
LOVAZA CAP	64
LOVENOX INJ	33
loxapine cap	103
LOXITANE CAP	104
LTA 360 KIT	193
LUFYLLIN TAB	32
LUMAKRAS TAB	93
LUMIGAN OPHTH SOLN	212
LUNESTA TAB	180
LUPKYNIS CAP	192
LUPRON DEPOT INJ	88
LUPRON DEPOT PED INJ	160
LUPRON DEPOT-PED INJ	160
LURIDE TAB	190
LUVOX CR CAP	44
LYNPARZA CAP	93
LYNPARZA TAB	94
LYSODREN TAB	88
LYSTEDA TAB	178

M

MACROBID CAP	80
MACRODANTIN CAP	81
magnesium sulfate inj	190
MALARONE TAB	81
malathion lotion	151
maldemar tab	59
MAPROTILINE TAB	43
MARINOL CAP	60
MARPLAN TAB	43
MATULANE CAP	98
MAVYRET PAK	112
MAVYRET TAB	112
MAXALT MLT TAB	189
MAXALT TAB	189
MAXIDEX OPHTH SOLN	207
MAXITROL OPHTH OINT	207
MAXITROL OPHTH SUSP	207
MAXZIDE TAB	155
MAYZENT TAB	222
MAYZENT TAB STARTER PACK	222
MCT OIL	200
mebendazole chew tab	22
meclizine chew tab	59
meclizine tab	59
MEDROL DOSE PACK	130
MEDROL TAB	130
medroxyprogesterone inj	129
medroxyprogesterone tab	218
mefloquine tab	82
MEGACE SUSP	88
megestrol susp	88
megestrol tab	88
MEKINIST TAB 0.5MG	94
MEKINIST TAB 2MG	94
MEKTOVI TAB	94
MELOXICAM SUSP	9
meloxicam tab	9
melphalan inj	84
melphalan tab	85
memantine ER cap	220
memantine sol	220
memantine tab	220
MENACTRA INJ	233
MENEST TAB	165
MENOSTAR PATCH	165
MENQUADFI INJ	233
MENTAX CREAM	139
MEPHYTON TAB	240
MEPRON SUSP	78
mercaptopurine tab	85
meropenem inj	79
mesalamine DR tab	168
mesalamine enema	168
mesalamine ER cap	168
mesalamine supp	168
MESNEX TAB	98

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

MESTINON TAB	82	methscopolamine tab	229	METROGEL VAGINAL GEL	238
MESTINON TIMESPAN TAB	82	METHYLDOPA TAB	71	METROLOTION	151
METADATE CD CAP	4	METHYLDOPA/HYDRO CHLOROTHIAZIDE TAB	75	metronidazole cream	151
METAGLIP TAB	49	methylergonovine tab	214	metronidazole gel	151
METAPROTERENOL SYRUP	30	METHYLIN CHEW TAB	4	metronidazole gel 0.75%	151
metaxalone tab	198	METHYLIN SOLN	4	metronidazole lotion	151
METAXALONE TAB 400MG	198	methylphenidate CD cap	4	metronidazole tab	77
metformin ER tab	49	methylphenidate chew tab	4	metronidazole vaginal gel	238
metformin soln	49	methylphenidate ER cap	4	MEVACOR TAB	67
metformin tab	50	methylphenidate ER tab	4	mexiletine hcl cap	25
methadone conc	14	methylphenidate soln	4	mibelas chew tab	127
METHADONE SOLN 10MG/5ML	14	methylphenidate tab	4	MICARDIS TAB	70
methadone soln 5mg/5ml	14	methylprednisolone dose pack	130	MICONAZOLE 3 SUPP 200MG	238
methadone tab	14	methylprednisolone tab	130	MICRO-K CAP	191
methadone tab 10mg	14	METHYLTESTOSTERONE CAP	20	MICROZIDE CAP	157
METHADOSE CONC	14	metoclopramide soln	167	MIDAMOR TAB	156
methazolamide tab	155	metoclopramide tab	167	midodrine tab	239
methenamine hippurate tab	81	metolazone tab	157	miglitol tab	48
methimazole tab	227	metoprolol ER tab	116	miglustat cap	174
METHITEST TAB	20	metoprolol tab	116	MINASTRIN CHEW TAB	127
methocarbamol tab	198	METOPROLOL/HYDROCHLOROTHIAZIDE TAB	75	MINIPRESS CAP	71
methotrexate inj	85	METROCREAM	151	MINOCIN CAP	226
methotrexate tab	85	METROGEL 1%	151	minocycline cap	226
METHOXSALEN CAP	142			minoxidil tab	77
				MIRALAX	183
				MIRAPEX TAB	100

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

MIRCETTE TAB	127
MIRENA IUD	129
mirtazapine ODT	42
mirtazapine tab	42
misoprostol tab	230
MOBIC TAB	9
modafinil tab	4
MOLNUPIRAVIR CAP	114
mometasone cream	147
mometasone oint	147
mometasone soln	147
MONODOX CAP	226
MONOPRIL HCT TAB	75
MONOPRIL TAB	69
montelukast chew tab	27
montelukast granule pack	27
montelukast tab	27
MORPHINE SULFATE ER BEAD CAP	15
morphine sulfate ER tab	15
morphine sulfate soln	15
MORPHINE SULFATE TAB	15
MOTOFEN TAB	57
MOTRIN SUSP	9
MOVANTIK TAB	168
MOVIPREP SOLN	181
moxifloxacin ophth soln	204
moxifloxacin tab	166
MULTAQ TAB	26
MULTIGEN FOLIC TAB	177
MULTIGEN PLUS TAB	177
MULTIGEN TAB	177
MULTIVITAMIN TAB	177
MULTIVITAMIN/FLOURIDE CHEW 0.25MG	196
MULTIVITAMIN/FLOURIDE CHEW 1MG	196
MULTIVITAMIN/FLUORIDE CHEW TAB	196
multivitamin/minerals tab	195
mupirocin oint	138
MUSE SUPP	121
MYAMBUTOL TAB	83
MYCELEX TROCHES	194
MYCOBUTIN CAP	83
mycophenolate DR tab	114
mycophenolate mofetil cap	115
mycophenolate mofetil susp	115
mycophenolate mofetil tab	115
MYDFRIN OPHTH SOLN	205
MYDRIACYL OPHTH SOLN	202
MYFEMBREE TAB	164
MYLERAN TAB	85
MYNATAL-Z TAB	196
MYRBETRIQ TAB	232
MYSOLINE TAB	37
MYTELASE TAB	82

N

nabumetone tab	9
nadolol tab	117
nadolol/bendroflumethiazide tab	75
nafcillin inj	218
naftifine cream	139
naftifine gel	139
NAFTIN CREAM	139
NAFTIN GEL	140
naloxone hcl nasal spray	58
naloxone inj	58
NALOXONE PREFILLED INJ	58
naltrexone tab	58
NAMENDA SOL	220
NAMENDA TAB	220
naphazoline ophth soln	205
NAPROSYN EC TAB	9
NAPROSYN TAB	9
naproxen EC tab	9
naproxen tab	9
NARCAN NASAL SPRAY	58

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

NARDIL TAB 43
NASACORT OTC NASAL SPRAY 199
NASCOBAL NASAL SPRAY 175
NATACYN OPHTH SUSP 204
NATAZIA TAB 127
nateglinide tab 55
NATPARA INJ 158
NATROBA SUSP 152
NAVANE CAP 105
NAYZILAM SPRAY 34
nebivolol hcl tab 116
NEBUSAL NEB SOLN 135
NECON TAB 127
NEFAZODONE TAB 45
nefazodone tab 50mg, 250mg 45
neomycin tab 5
NEOMYCIN/POLYMIXIN /GRAMICIDIN OPHTH SOLN 204
neomycin/polymixin/hydrocoritisone otic soln 213
neomycin/polymixin/hydrocoritisone otic susp 213
neomycin/polymyxin/dexamethasone ophth oint 208
neomycin/polymyxin/dexamethasone ophth soln 208
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN 208
NEONATAL 19 TAB 196
NEONATAL FE TAB 196
NEOSPORIN OPHTH SOLN 204
NEOTUSS-D LIQUID 133
NEPHROCAP 195
NEPHRON FA TAB 177
NEPTAZANE TAB 155
NERLYNX TAB 94
NEUMEGA INJ 175
NEUPRO PATCH 100
NEURONTIN CAP 37
NEURONTIN CAP 100MG 37
NEURONTIN SOLN 37
NEURONTIN TAB 600MG 37
NEURONTIN TAB 800MG 37
NEVANAC OPHTH SUSP 211
NEVIRAPINE ER TAB 100MG 108
nevirapine ER tab 400mg 108
NEVIRAPINE SUSP 109
nevirapine tab 109
NEXAVAR TAB 94
NEXICLON XR SUSP 71
NEXICLON XR TAB 71
NEXPLANON IMPLANT 129
niacin cap 240
niacin CR tab 240
niacin ER tab 68
niacin tab 240
NIACIN TR TAB 240
niacinamide tab 241
nicotine gum 223
NICOTINE KIT 223
nicotine lozenge 223
nicotine patch 224
NICOTROL INHALER 224
NICOTROL NASAL SPRAY 224
nifedipine cap 118
nifedipine ER tab 119
nilutamide tab 88
nimodipine cap 119
NIMOTOP CAP 119
NINLARO CAP 94
nitazoxanide tab 78
NITRO-BID OINT 22
NITRO-DUR PATCH 23

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	23
nitrofurantoin macrocrystals cap	81
nitrofurantoin monohydrate cap	81
nitroglycerin lingual spray	23
nitroglycerin patch	23
nitroglycerin SL tab	23
NITROLINGUAL PUMP SPRAY	23
NITROSTAT SL TAB	23
NIVESTYM INJ	175
NIZATIDINE CAP	230
NIZATIDINE SOLN	230
nizoral a-d shampoo	140
NIZORAL SHAMPOO	140
norethindrone tab	129
norethindrone/ethinyl estradiol 21 tab	127
norethindrone/ethinyl estradiol FE tab	127
NORITATE CREAM	151
NOROXIN TAB	166
NORPACE CAP	25
NORPRAMIN TAB	47
NOR-QD TAB	129
nortrel tab	127
nortriptyline cap	47
nortriptyline oral soln	47
NORTRIPTYLINE SOLN	47
NORVASC TAB	119
NORVIR CAP	109
NORVIR POWDER PACK	109
NORVIR SOLN	109
NORVIR TAB	109
NOVOLIN 70/30 FLEXPEN INJ	54
NOVOLIN 70/30 INJ	54
NOVOLIN N FLEXPEN INJ	55
NOVOLIN N INJ	55
NOVOLIN R FLEXPEN INJ	55
NOVOLIN R INJ	55
NOVOLOG FLEXPEN INJ	55
NOVOLOG INJ	55
NOVOLOG MIX FLEXPEN INJ	55
NOVOLOG MIX INJ	55
NOVOLOG PENFILL INJ	55
NOXAFIL SUSP	62
NOXAFIL TAB	62
np thyroid tab	227
NUBEQA TAB	89
NUCALA INJ	26
NUCORT LOTION	147
NUCYNTA TAB	15
NUEDEXTA CAP	223
NULYTELY SOLN	182
NURTEC ODT	188
NUTRITIONAL SUPPLEMENT LIQUID	154
NUTRITIONAL SUPPLEMENT POWDER	154
NUVARING	128
NUVIGIL TAB	5
nystatin cream	140
nystatin oint	140
nystatin powder	61
nystatin susp	194
nystatin tab	61
nystatin topical powder	140
NYSTATIN VAGINAL TAB	238
nystatin/triamcinolone cream	140
nystatin/triamcinolone oint	140
O	
OCALIVA TAB	167
octreotide inj	163
OCTREOTIDE INJ 100MCG	163

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

OCUFEN OPHTH SOLN	211	ondansetron tab	59	ORTHO-EVRA PATCH	128
OCUFLOX OPHTH SOLN	204	ONFI TAB	34	oseltamivir cap	113
ODEFSEY TAB	109	ONGENTYS CAP	101	oseltamivir cap 30mg	113
ODOMZO CAP	87	OPSUMIT TAB	122	oseltamivir susp	113
OFEV CAP	225	OPTIVAR OPHTH SOLN	211	OSMOPREP TAB	183
ofloxacin ophth soln	205	ORACIT SOLN	170	OTEZLA STARTER PACK	10
ofloxacin otic soln	212	ORAP TAB	223	OTEZLA TAB	10
ofloxacin tab	166	ORAPRED ODT TAB	130	OTOZIN OTIC DROPS	213
OGESTREL TAB	127	ORAPRED SOLN	131	OVACE PLUS CREAM	143
olanzapine ODT	104	ORAXYL CAP	226	OVACE PLUS GEL	143
olanzapine tab	104	ORENCIA CLICK INJ	10	OVACE PLUS SHAMPOO	143
olanzapine/fluoxetine cap	221	ORENCIA SC INJ 125MG/ML	10	OVCON 35 TAB	128
OLEPTRO TAB	45			OVIDE LOTION	152
olmesartan tab	70	ORENCIA SC INJ 50MG/0.4ML	10	oxacillin inj	218
olmesartan/hydrochlorothiazide tab	75			OXANDRIN TAB	18
		ORENCIA SC INJ 87.5MG/0.7ML	10	oxandrolone tab	19
olopatadine ophth soln 0.1%	211			oxcarbazepine susp	37
		ORENITRAM TAB	121	oxcarbazepine tab	38
olopatadine ophth soln 0.2%	211	ORGOVYX TAB	89	oxiconazole nitrate cream	140
		ORIAHNN CAP	164	OXSORALEN ULTRA CAP	142
OLUMIANT TAB	6	ORILISSA TAB 150MG	159		
OLUX FOAM	147	ORILISSA TAB 200MG	159	oxybutynin ER tab	232
omega-3-acid ethyl esters cap	64	ORKAMBI GRANULES PACKET	224	oxybutynin syrup	232
				oxybutynin tab	232
omeprazole DR cap	230	ORKAMBI TAB	224	oxycodone soln	15
OMNICEF SUSP	125	ORTHO TRI-CYCLEN (LO) TAB	127	oxycodone tab	15
ondansetron ODT	59			oxycodone/acetaminophen tab	17
ondansetron soln	59	ORTHO-CYCLEN TAB	127		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

oxycodone/aspirin tab 17
OXYTROL PATCH (OTC) 232
OZEMPIC INJ 52

P

PALGIC SOLN 63
PALGIC TAB 63
paliperidone ER tab 102
PALYNZIQ INJ 161
PAMELOR CAP 47
PAMINE TAB 229
PANRETIN GEL 141
pantoprazole EC tab 230
PARAFON FORTE TAB 198
PARAGARD IUD 129
paricalcitol cap 161
PARLODEL CAP 100
PARLODEL TAB 100
PARNATE TAB 43
paromomycin cap 5
paroxetine ER tab 44
paroxetine oral susp 44
paroxetine tab 44
PATANOL OPHTH SOLN 211
PAXIL CR TAB 44
PAXIL ORAL SUSP 44
PAXIL TAB 44
PCE TAB 184
PEAK FLOW METER 187
PEDIATEX TDM SUSP 133
pediatric multiple vitamins/fluoride chew tab 196
pediatric multiple vitamins/fluoride soln 196
pediatric multiple vitamins/fluoride/iron soln 196
PEDIAZOLE SUSP 78
peg 3350 soln (100 gram Moviprep equiv) 182
peg 3350/electrolytes soln 182
PEGASYS INJ 112
PEG-INTRON INJ 112
PEMAZYRE TAB 94
penicillamine tab 192
PENICILLIN G PROCAINE INJ 216
PENICILLIN G SODIUM INJ 216
penicillin vk soln 216
penicillin vk tab 216
pentamidine neb soln 77
pentoxifylline ER tab 173
PEPCID SUSP 230
PEPCID TAB 230
PERCOCET TAB 17
PERCODAN TAB 17
PERFOROMIST NEB SOLN 31
PERIDEX SOLN 194
permethrin cream 152
perphenazine tab 105
PERPHENAZINE/ AMITRIPTYLINE TAB 221
PERSANTINE TAB 174
PEXEVA TAB 45
PFIZERPEN G INJ 216
phenazopyridine tab 172
phenelzine tab 43
phenobarbital elixir 179
phenobarbital tab 179
phenoxybenzamine cap 70
phentermine cap 2
phentermine tab 2
phenylephrine ophth soln 202
phenytoin cap 41
phenytoin chew tab 41
phenytoin susp 41
PHISOHEX LIQUID 105
phlexy-10 tab 200
PHOSLO CAP 169
PHOSLYRA SOLN 169
phospha 250 neutral tab 191
PHOSPHOLINE OPHTH SOLN 202

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

phytonadione tab 240
PICATO GEL 141
PIFELTRO TAB 109
pilocarpine ophth soln 202
pilocarpine tab 195
PILOPINE HS OPHTH GEL 202
pimecrolimus cream 149
PIMOZIDE TAB 223
pindolol tab 117
pioglitazone tab 55
piperacillin/tazobactam inj 217
PIQRAY TAB 94
piroxicam cap 9
PLAN B TAB 129
PLAQUENIL TAB 82
PLAVIX TAB 75MG 174
PLEGRIDY INJ 222
PLEGRIDY PEN INJ 223
PLENDIL TAB 119
PLETAL TAB 174
PNEUMOVAX INJ 233
PODOCON SOLN 149
podofilox soln 149
POLYCITRA CRYSTAL PACK 170
POLYCITRA-LC SOLN 170
polyethylene glycol 3350 powder 183
POLYETHYLENE GLYCOL 8000 GRANULES 218
polymyxin b/trimethoprim ophth soln 205
POLYTRIM OPHTH SOLN 205
POMALYST CAP 89
posaconazole DR tab 62
POTABA CAP 241
POTABA POWDER PACKET 241
POTABA TAB 241
potassium bicarbonate effer tab 191
potassium chloride ER cap 191
potassium chloride ER tab 191
potassium chloride micro tab 191
potassium chloride powder packet 191
potassium chloride soln 191
potassium citrate CR tab 170
potassium citrate/citric acid powder pack 170
potassium citrate/citric acid soln 170
PRADAXA CAP 33
PRALUENT INJ 68
pramipexole tab 100
pramoxine/hydrocortisone cream 21
pramoxine-HC AQ otic soln 213
PRANDIN TAB 56
prasugrel tab 174
PRAVACHOL TAB 67
pravastatin tab 67
praziquantel tab 22
prazosin cap 71
PRECISION XTRA METER 187
PRECISION XTRA TEST STRIP 153
PRECOSE TAB 48
PRED FORTE OPHTH SUSP 208
PRED MILD OPHTH SOLN 208
PRED-G OPHTH SOLN 208
PREDNICARBATE CREAM 147
PREDNICARBATE OIN 147

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

prednisolone ODT 131
PREDNISOLONE ODT TAB 131
PREDNISOLONE OPHTH SUSP 208
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN 208
prednisolone soln 131
prednisolone syrup 131
PREDNISONE SOLN 131
prednisone tab 131
PREFEST TAB 164
pregabalin cap 38
pregabalin cap 225mg 38
pregabalin cap 300mg 38
pregabalin soln 38
PREMARIN TAB 165
PREMARIN VAGINAL CREAM 239
PREMPHASE TAB, PREMPRO TAB 164
PRENATABS RX TAB 197
PRENATAL 19 CHEW TAB 197
PRENATAL 19 TAB 197
PRENATAL VITAMINS (NON-PREFERRED) 197
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS) 240
PRETOMANID TAB 83
PREVNAR 13 INJ 233
PREVNAR 20 INJ 233
PREVPAC KIT 231
PREZCOBIX TAB 109
PREZISTA SUSP 109
PREZISTA TAB 109
PRIFTIN TAB 83
PRIMAQUINE TAB 82
primidone tab 38
PRIMSOL SOLN 77
PRINIVIL TAB, ZESTRIL TAB 69
PRISTIQ TAB 46
PROAMATINE TAB 239
probenecid tab 172
PROCARDIA CAP 119
prochlorperazine supp 105
prochlorperazine tab 105
PROCTOCORT CREAM 147
proctosol HC cream 21
progesterone cap 218
PROGESTERONE SUPP 239
PROGLYCEM SUSP 51
PROLENSA OPHTH SOLN 211
PROLIA INJ 158
PROMACTA TAB 176
promethazine DM syrup 133
promethazine supp 63
promethazine syrup 64
promethazine tab 64
promethazine VC syrup 133
promethazine VC/codeine syrup 134
promethazine/codeine syrup 134
PROMETHEGAN SUPP 64
PROMETRIUM CAP 218
propafenone ER cap 25
propafenone tab 25
proparacaine ophth soln 206
propranolol ER cap 117
propranolol oral soln 20mg/5ml 117
PROPRANOLOL SOLN 117
propranolol tab 117
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB 75
propylthiouracil tab 227
PROSCAR TAB 171
PROSOM TAB 180

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

pro-stat liquid	200
PROSTIGMIN TAB	82
PROTOPIC OINT	149
protriptyline tab	47
PROVERA TAB	218
PROVIGIL TAB	5
PROZAC CAP	45
PROZAC SOLN	45
pseudoephedrine/bromphe niramine/codeine liquid	134
PULMICORT INH SUSP	28
PULMOZYME INH SOLN	224
PURINETHOL TAB	85
PYLERA CAP	231
pyrazinamide tab	83
pyridostigmine CR tab	82
pyridostigmine tab	82
pyridstigmine soln	82
pyrimethamine tab	82

Q

QBRELIS SOLN	69
QINLOCK TAB	95
QSYMIA CAP	2
QUALAQUIN CAP	82
QUESTRAN LITE POWDER	65
QUESTRAN LITE POWDER PACK	65
QUESTRAN POWDER	65
QUESTRAN POWDER PACK	65
quetiapine tab	104
quetiapine XR tab	104
QUFLORA PEDIATRIC CHEW TAB	196
quinapril tab	69
quinapril/hydrochlorothiaz ide tab	75
quinidine gluconate CR tab	25
QUINIDINE SULFATE ER TAB	25
quinidine sulfate tab	25
quinine sulfate cap	82

R

raloxifene tab	160
ramelteon tab	180
ramipril cap	69
RANEXA TAB	22
ranolazine tab	22
rasagiline tab	101
RAZADYNE ER CAP	220
RAZADYNE TAB	220
REBETOL SOLN	112
REGLAN TAB	167
REGRANEX GEL	152
RELENZA DISKHALER	113
REMERON SOLUTAB	42
REMERON TAB	42
RENAGEL TAB 800MG	169
renaphro cap	195
RENOVA CREAM	138
RENVELA TAB	169
repaglinide tab	56
REPATHA INJ	68
REPATHA PUSHTRONEX INJ	68
REQUIP TAB	100
RESCON TAB	134
RESCRIPTOR TAB	109
RESERPINE TAB	71
RESTASIS OPHTH EMULSION	206
RESTORIL CAP 15MG	180
RESTORIL CAP 22.5MG	180
RESTORIL CAP 30MG	180
RESTORIL CAP 7.5MG	180
RETACRIT INJ	176
RETEVMO CAP	95
RETIN-A CREAM	137
REVATIO TAB	122
REVIA TAB	58
REVLIMID CAP	114
REYATAZ POWDER PACK	109

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

REYVOW TAB	189	RITUXAN INJ	86	SALAGEN TAB	195
REZIRA SOLN	134	rivastigmine cap	221	SALEX SHAMPOO	149
RHEUMATREX TAB	6	rivastigmine patch	221	salsalate tab	12
ribavirin cap	112	rizatriptan ODT	189	SANCTURA TAB	232
ribavirin tab	112	rizatriptan tab	189	SANCUSO PATCH	59
RIDAURA CAP	7	ROBAXIN TAB	198	SANDIMMUNE SOLN 100MG/ML	115
rifabutin cap	83	ROBINUL TAB	229	SANTYL OINT	149
RIFADIN CAP	84	ROCALTROL CAP	161	SAPHRIS SL TAB	104
RIFAMATE CAP	83	ROCALTROL SOLN	161	sapropterin dihydrochloride powder packet	161
rifampin cap	84	ropinirole tab	100	sapropterin dihydrochloride soluble tab	161
RIFATER TAB	83	ROSULA PAD	143	SAVELLA PAK	221
riluzole tab	200	rosuvastatin tab 10mg	67	SAVELLA TAB	221
RIMANTADINE TAB	113	rosuvastatin tab 20mg	67	scopolamine patch	60
RINVOQ ER TAB	6	rosuvastatin tab 40mg	67	SEASONIQUE TAB	128
RIOMET ER SUSP	50	rosuvastatin tab 5mg	67	seb-prev cream	143
RIOMET SOLN	50	ROXICODONE TAB	15	SECTRAL CAP	116
risedronate DR tab	158	ROZEREM TAB	180	selegiline cap	101
risedronate tab	158	ROZLYTREK CAP	95	selegiline tab	101
RISPERDAL CONSTA INJ	102	RUBRACA TAB	95	selenium sulfide lotion	143
RISPERDAL M ODT	103	rufinamide susp	38	selenium sulfide shampoo	143
RISPERDAL SOLN	103	rufinamide tab	38	SELZENTRY SOLN	109
RISPERDAL TAB	103	RUKOBIA ER TAB	109	SELZENTRY TAB	110
RISPERIDONE ODT	103	RUZURGI TAB	83	SEMPREX-D CAP	134
risperidone soln	103	RYBELSUS TAB	52		
risperidone tab	103	RYDAPT CAP	95		
RITALIN LA CAP	5	RYTHMOL SR CAP	25		
RITALIN TAB	5	RYTHMOL TAB	25		
ritonavir tab	109				

S

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

SEREVENT DISKUS INHALER	31	SINGULAIR TAB	27	sodium fluoride/potassium nitrate paste	194
SEROQUEL TAB	104	sirolimus soln	192	sodium polystyrene powder	115
SEROQUEL XR TAB	104	sirolimus tab	115	sodium polystyrene susp	115
sertraline conc	45	SIVEXTRO TAB	80	sodium sulfacetamide gel	143
sertraline tab	45	SKELAXIN TAB	198	sodium sulfacetamide lotion	137
sevelamer hydrochloride tab	169	SKELID TAB	159	sodium sulfacetamide shampoo	143
sevelamer powder pak	169	SKLICE LOTION	152	sodium sulfacetamide/sulfur emulsion 10-5%	137
sevelamer tab	169	SKYRIZI INJ 150MG/ML	142	sodium sulfacetamide/sulfur wash 9-4.5%	137
SFROWASA ENEMA	168	SKYRIZI INJ 75MG/0.83ML	142	sodium sulfacetamide/urea pad	143
SHINGRIX INJ	236	SLO-NIACIN TAB	241	SOFOSBUVIR/VELPATASVIR TAB	112
SIGNIFOR INJ	163	smz/tmp (DS) tab	78	SOLARAZE GEL	141
sildenafil tab	121	smz/tmp susp	78	solifenacin tab	232
sildenafil tab 20mg	122	sodium chloride 0.9% irr soln	171	SOMA TAB	198
SILVADENE CREAM	143	sodium chloride inj	191	SOMAVERT INJ	159
silver sulfadiazine cream	143	sodium chloride neb soln	135	SONATA CAP	180
SIMBRINZA OPHTH SUSP	203	sodium citrate/citric acid soln	170	sotalol AF tab	117
SIMPONI AUTO-INJECTOR 100MG	7	sodium fluoride cream	194	sotalol tab	117
SIMPONI INJ 100MG	7	sodium fluoride gel	194		
simvastatin tab	67	SODIUM FLUORIDE LOZENGE	190		
SINEMET CR TAB	100	sodium fluoride paste	194		
SINEMET TAB	100	sodium fluoride rinse	194		
SINGULAIR CHEW TAB	27	sodium fluoride soln	190		
SINGULAIR GRANULE PACK	27	SODIUM FLUORIDE TAB	190		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

SOTYLIZE SOLN 5MG/ML 117
SPECTRACEF TAB 125
SPINOSAD SUSP 152
SPIRIVA HANDIHALER 26
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT 27
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT 27
spironolactone tab 156
spironolactone/hydrochlorothiazide tab 155
SPORANOX CAP 62
SPORANOX SOLN 62
sprintec 28 tab 128
SPRYCEL TAB 95
SPS SUSP 192
STARLIX TAB 56
STAVUDINE CAP 110
stavudine soln 110
STEGLATRO TAB 56
STELARA INJ 142
STENDRA TAB 121
STIMATE NASAL SOLN 162
STIOLTO INHALER 31
STIVARGA TAB 95
STRENSIQ INJ 162
STRIBILD TAB 110
STRIVERDI RESPIMAT INHALER 31
STROMECTOL TAB 22
STROVITE TAB 195
SUBOXONE SL FILM 18
sucralfate susp 231
sucralfate tab 230
sulfacetamide sodium ophth soln 205
sulfacetamide sodium/prednisolone ophth soln 208
SULFACETAMIDE/PREDNISOLONE OPHTH SOLN 209
SULFADIAZINE TAB 225
SULFAMYLON CREAM 143
sulfasalazine EC tab 168
sulfasalazine tab 168
sulindac tab 9
SUMATRIPTAN INJ 189
SUMATRIPTAN INJ 6MG/0.5ML 189
sumatriptan tab 189
sunitinib malate cap 95
SUNOSI TAB 3
SUPRAX CAP 125
SUPRAX CHEW TAB 125
SUPRAX SUSP 125
SUPRAX SUSP 500MG/5ML 125
SUPRAX TAB 125
SUPREP SOLN 182
SURMONTIL CAP 47
SUTTAR SF SYRUP 134
SYMAX DUOTAB 229
SYMBICORT INHALER 31
SYMBYAX CAP 221
SYMDEKO TAB 224
SYMJEPI INJ 239
SYMPROIC TAB 169
SYMTUZA TAB 110
SYNAREL NASAL SOLN 160
SYNERA PATCH 150
SYNJARDY TAB 49
SYNJARDY XR TAB 10-1000MG, 25-1000MG 49
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG 49
SYNTHROID TAB 227

T

TABLOID TAB 85
TABRECTA TAB 95
tacrolimus cap 115
tacrolimus oint 149

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

tadalafil tab	121	TEGRETOL TAB	38	terconazole cream	238
tadalafil tab (PAH)	122	TEGRETOL XR TAB	38	TERCONAZOLE CREAM 0.8%	238
tadalafil tab 2.5mg, 5mg	121	TEGSEDI INJ	224	terconazole supp	238
TAFINLAR CAP	95	TEKAMLO TAB	75	TESSALON CAP	132
TAGRISSO TAB	87	TEKTURNA HCT TAB	75	testosterone cypionate inj	20
TALTZ INJ	142	TEKTURNA TAB	76	testosterone gel 1% 25mg	20
TALZENNA CAP 0.25MG	95	telmisartan tab	70	testosterone gel 1% 50mg	20
TALZENNA CAP 1MG	96	temazepam cap 15mg	180	testosterone gel 1% pump	20
TAMBOCOR TAB	25	temazepam cap 22.5mg	180	testosterone gel 1.62% 1.25gm	20
TAMIFLU CAP	113	temazepam cap 30mg	180	testosterone gel 1.62% 2.5gm	20
TAMIFLU CAP 30MG	114	temazepam cap 7.5mg	180	TESTOSTERONE GEL PUMP	20
tamoxifen tab	89	TEMOVATE CREAM	147	testosterone gel pump 1.62%	20
tamsulosin cap	171	TEMOVATE GEL	147	TETANUS/DIPHTHERIA TOXOID INJ	228
TAPAZOLE TAB	227	TEMOVATE OINT	147	tetrabenazine tab	222
TARGRETIN GEL	141	TEMOVATE SOLN	147	tetracycline cap	226
TASIGNA CAP	96	TEMOVATE-E CREAM	147	TEVETEN HCT TAB	76
TASMAR TAB	99	temozolomide cap	85	TEVETEN TAB	70
TAVALISSE TAB	173	TENEX TAB	71	THALOMID CAP	114
tazarotene cream 0.1%	142	tenofovir disoproxil fumarate tab	110	THEO-24 CAP	32
TAZORAC CREAM	142	TENORETIC TAB	76	THEOPHYLLINE ER TAB	32
TAZORAC CREAM 0.05%	142	TENORMIN TAB	116	theophylline soln	32
TAZVERIK TAB	96	TEPMETKO TAB	96		
TECHLITE INSULIN SYRINGE	187	TERAZOL CREAM	238		
TECHLITE PEN NEEDLE	187	TERAZOL SUPP	238		
TEGRETOL CHEW TAB	38	terazosin cap	71		
TEGRETOL SUSP	38	terbinafine tab	61		
		terbutaline sulfate tab	31		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

thioridazine tab 105
thiothixene cap 105
THYROLAR TAB 227
tiagabine tab 40
TIAZAC CAP 119
TIBSOVO TAB 96
TICLOPIDINE TAB 174
TICOVAC INJ 237
TIGAN CAP 60
TIKOSYN CAP 26
TIMENTIN INJ 217
timolol maleate ophth gel 201
timolol maleate ophth soln 201
timolol maleate tab 117
TIMOLOL OPHTH GEL SOLN 201
TIMOPTIC OPHTH SOLN 201
TIMOPTIC-XE OPHTH GEL 201
TINDAMAX TAB 77
tinidazole tab 77
tiopronin tab 172
TIROSINT-SOL 228
TIVICAY PD TAB 110
TIVICAY TAB 110
tizanidine tab 198
TOBI PODHALER 5
TOBRADEX OPHTH OINT 209
TOBRADEX OPHTH SOLN 209
TOBRADEX ST OPHTH SUSP 209
tobramycin neb soln 5
tobramycin ophth soln 205
tobramycin/dexamethasone ophth soln 209
TOBREX OPHTH OINT 205
TOBREX OPHTH SOLN 205
TODAY SPONGE 237
TOFRANIL PM CAP 47
TOFRANIL TAB 47
TOLAZAMIDE TAB 57
TOLBUTAMIDE TAB 57
tolcapone tab 99
TOLMETIN TAB 10
tolterodine SR cap 232
tolterodine tab 232
TOPAMAX SPRINKLE CAP 38
TOPAMAX TAB 38
TOPICORT CREAM 148
TOPICORT OINT 148
topiramate sprinkle cap 38
topiramate tab 39
TOPROL XL TAB 116
toremifene tab 89
torsemide tab 156
TRACLEER TAB 32MG 122
tramadol ER tab 15
tramadol tab 16
tramadol/acetaminophen tab 17
TRANDATE TAB 115
tranexamic acid inj 179
tranexamic acid tab 179
TRANSDERM-SCOP PATCH 60
tranylcypromine tab 43
TRAVATAN Z DROPS 212
travoprost ophth soln 212
trazodone tab 45
TRECATOR TAB 84
TRELEGY ELLIPTA INHALER 31
TRELSTAR INJ 89
TREMFYA INJ 143
TRENTAL TAB 173
tretinoin cap 84
tretinoin cream 137
tretinoin gel 138
TRETIN-X CREAM 138
triamcinolone cream 148

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

triamcinolone in orabase paste 194
triamcinolone lotion 148
triamcinolone oint 148
triamcinolone OTC nasal spray 199
TRIAMINIC SYRUP 134
triamterene/hydrochlorothiazide cap 155
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg 155
triamterene/hydrochlorothiazide tab 155
triazolam tab 180
tricitrates soln 170
tricon cap 177
TRICOR TAB 66
trientine cap 192
trifluoperazine tab 105
TRIFLURIDINE OPHTH SOLN 205
trihexyphenidyl elixir 101
trihexyphenidyl tab 99
TRIKAFTA TAB 225
tri-legest tab 128
TRILEPTAL SUSP 39
TRILEPTAL TAB 39
TRI-LUMA CREAM 150
trilyte soln 182
trimethobenzamide cap 60
TRIMETHOPRIM TAB 77
trimipramine cap 47
TRI-NORINYL TAB 128
TRINTELLIX TAB 45
tri-sprintec tab 128
TRIUMEQ TAB 110
tropicamide ophth soln 202
trospium chloride SR cap 232
trospium tab 232
TRUEPLUS INSULIN SYRINGE 187
TRUEPLUS PEN NEEDLE 187
TRULANCE TAB 166
TRULICITY INJ 52
TRUMENBA INJ 233
TRUSELTIQ PACK 100MG 96
TRUSELTIQ PACK 50MG, 125MG 96
TRUSELTIQ PACK 75MG 96
TRUSOPT OPHTH SOLN 211
TUKYSA TAB 86
TURALIO CAP 96
TUSNEL SYRUP 134
tussigon tab 132
TUSSIONEX SUSP 134
TUSSI-ORGANI SYRUP 134
TYBLUME TAB 128
TYLENOL/CODEINE TAB 18
TYMLOS INJ 159
TYVASO INH SOLN 121
TYZINE NASAL SOLN 199

U

UBRELVY TAB 188
UCERIS RECTAL FOAM 21
UCERIS TAB 131
U-CORT CREAM 148
UKONIQ TAB 97
ULORIC TAB 172
ULTRAM TAB 16
ULTRAVATE CREAM 148
ULTRAVATE OINT 148
UNIPHYL TAB 32
UPNEEQ SOLN 211
UPTRAVI TAB 123
URECHOLINE TAB 233
UROCIT-K TAB 171
UROQID #2 TAB 231
UROXATRAL TAB 171
URSO FORTE TAB 167
ursodiol cap 167

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

ursodiol tab 167

V

VAGIFEM TAB 239
valacyclovir tab 113
VALCHLOR GEL 141
VALCYTE TAB 111
valganciclovir soln 111
valganciclovir tab 111
VALIUM TAB 2MG, 10MG 24
VALIUM TAB 5MG 24
valproic acid cap 42
valproic acid syrup 42
valsartan tab 70
valsartan/hydrochlorothiazide tab 76
VALTOCO NASAL SPRAY 34
VALTREX TAB 113
VALTURNA TAB 76
VANCOCIN CAP 79
vancomycin cap 79
VANIQA CREAM 149
VANTIN TAB 125
vardenafil ODT 121
vardenafil tab 121
VARIVAX INJ 237
VARUBI TAB 61
VASERETIC TAB 76
VASOTEC TAB 69
VAXNEUVANCE INJ 234
V-C FORTE CAP 195
VELPHORO CHEW TAB 169
VEMLIDY TAB 112
VENCLEXTA STARTER PACK 86
VENCLEXTA TAB 86
VENELEX OINT 152
venlafaxine ER cap 46
venlafaxine tab 46
VENTAVIS INH SOLN 122
VENTOLIN HFA INHALER 31
verapamil SR cap 119
VERAPAMIL SR CAP 360mg 119
verapamil SR tab 119
verapamil tab 119
VERELAN CAP 119
VERELAN PM CAP 119
VERELAN PM ER CAP 100MG, 300MG 119
VERELAN SR CAP 360mg 119
VERZENIO TAB 97
VESICARE TAB 232
VEXOL OPHTH SUSP 209
VFEND SUSP 62
VFEND TAB 62
V-GO INJ KIT 187
VIBRAMYCIN CAP 226
VIBRAMYCIN SUSP 226
VIBRAMYCIN SYRUP 226
VICTOZA INJ 52
VICTRELIS CAP 112
VIDEX SOLN 110
vigabatrin powder pack 40
vigabatrin tab 40
vigadrone powder pack 40
VIGAMOX OPHTH SOLN 205
VIMPAT SOLN 39
VIMPAT TAB 39
viorele tab, kariva tab 128
VIRACEPT POWDER 110
VIRACEPT TAB 110
VIREAD TAB 150MG, 200MG, 250MG 111
VIROPTIC OPHTH SOLN 205
VISICOL TAB 183
VISTARIL CAP 24
VITAFOL STRIPS 197
vitamin D cap 240
vitamin D cap 1000unit 240
vitamin D cap 400unit 240

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

VITAMIN D 400UNIT TAB 240
VITEKTA TAB 111
VITRAKVI CAP 100MG 97
VITRAKVI CAP 25MG 97
VITRAKVI SOLN 97
VIVACTIL TAB 47
VIVELLE-DOT PATCH 165
VIVOTIF CAP 234
VIZIMPRO TAB 87
VOLTAREN GEL 140
VOLTAREN OPTH SOLN 212
VOLTAREN TAB 10
VOLTAREN XR TAB 10
voriconazole susp 62
voriconazole tab 62
VOSEVI TAB 112
VOSOL HC OTIC SOLN 214
VOSOL OTIC SOLN 212
VOSPIRE ER TAB 31
VOTRIENT TAB 97
VP-PNV-DHA CAP 197
VYNDAMAX CAP 123
VYNDAQEL CAP 123
VYTORIN TAB 64
VYVANSE CAP 1
VYVANSE CHEW TAB 1

W

WAKIX TAB 3
warfarin tab 32
WELLBUTRIN SR TAB 43
WELLBUTRIN XL TAB 43
wymzya FE tab 128

X

XADAGO TAB 101
XALATAN OPHTH SOLN 212
XALKORI CAP 97
XARELTO STARTER PACK 32
XARELTO TAB 32
XATMEP SOLN 85
XCOPRI PAK 100-150MG 39
XCOPRI PAK 150-200MG 39
XCOPRI PAK 50-200MG 39
XCOPRI TAB 150MG, 200MG 39
XCOPRI TAB 50MG, 100MG 40
XCOPRI TITRATION PAK 12.5-25MG 40
XCOPRI TITRATION PAK 150-200MG 40
XCOPRI TITRATION PAK 50-100MG 40
XELJANZ SOLN 6
XELJANZ TAB 6
XELJANZ XR TAB 6
XEMBIFY INJ 215
XENLETA TAB 80
XIFAXAN TAB 200MG 77
XIFAXAN TAB 550MG 77
XOPENEX NEB SOLN 31
XOSPATA TAB 97
XPOVIO PAK 89
XTAMPZA ER CAP 16
XYLOCAINE SOLN 150
XYREM SOLN 219

Y

YODOXIN TAB 5

Z

zafemy patch 128
zafirlukast tab 27
zaleplon cap 180
ZANAFLEX TAB 198
ZANOSAR INJ 85
ZANTAC GRANULE PACKET 230
ZARONTIN CAP 41
ZARONTIN SOLN 41
ZAROXOLYN TAB 157
ZARXIO INJ 176

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered | **generic** =small letters | **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

ZEBETA TAB	116	ZOCOR TAB	67	ZYVOX SUSP	80
ZEGALOGUE INJ	51	ZOFRAN ODT	59	ZYVOX TAB	80
ZEGERID CAP OTC	231	ZOFRAN SOLN	59		
ZEJULA CAP	97	ZOFRAN TAB	59		
ZELAPAR ODT	101	ZOKINVY CAP	193		
ZELBORAF TAB	97	ZOLINZA CAP	97		
ZEMPLAR CAP	162	zolmitriptan tab	189		
ZEPOSIA CAP	223	ZOLOFT CONC	45		
ZEPOSIA STARTER PACK	223	ZOLOFT TAB	45		
		zolpidem ER tab	180		
ZERIT SOLN	111	zolpidem tab	179		
ZESTORETIC TAB	76	ZONEGRAN CAP	39		
ZETONNA NASAL SPRAY	199	zonisamide cap	39		
		ZONTIVITY TAB	174		
ZIAC TAB	76	ZORPRIN TAB	12		
ZIANA GEL	138	ZOSTAVAX INJ	237		
zidovudine cap	111	ZOVIRAX CAP	113		
zidovudine syrup	111	ZOVIRAX SUSP	113		
zidovudine tab	111	ZOVIRAX TAB	113		
ZIEXTENZO INJ	176	ZUTRIPRO LIQUID	135		
zinc sulfate cap	192	ZYDELIG TAB	98		
ziprasidone cap	102	ZYKADIA CAP	98		
ZIRGAN OPHTH GEL	205	ZYKADIA TAB	98		
ZITHROMAX POWDER PACK	183	ZYLET OPHTH SUSP	209		
		ZYLOPRIM TAB	172		
ZITHROMAX SUSP	183	ZYMAXID OPHTH SOLN	205		
ZITHROMAX TAB	183	ZYPREXA TAB	104		
ZMAX SUSP	183	ZYPREXA ZYDIS TAB	104		

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

EXC	Plan Exclusion	INF	Infertility	KMSP	Kroger Mandatory Specialty Pharmacy Program
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	ONC	Oral Anticancer medication <= $250 up to 30 day supply/Rx	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program
ST	Step Therapy	VAC	Vaccine Program		

L.A. CARE HOME INFUSION DRUG LIST
Alphabetical Index

1/1/2022

Search Tip:
This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar or using the CTRL+F search function from your keyboard. It will then display a search box for you to type in the name of the drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.
** Products listed may not be all inclusive and are subject to change.
***Products are limited to the L.A. Care Home Infusion Network Pharmacies.

L.A. Care Home Infusion List

Alphabetical Index

Last Updated 1/1/2022

Drug Name	Special Code	Tier	Category
ABECMA INJ	-	EXC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABELCET INJ	-	F	ANTIFUNGALS
ABRAXANE INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ACTEMRA INJ	PA	F	ANALGESICS - ANTI-INFLAMMATORY
ACTHAR HP GEL INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
acyclovir sodium IV soln	-	F	ANTIVIRALS
ADAKVEO INJ	PA	F	HEMATOPOIETIC AGENTS
ADCETRIS INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ADRIAMYCIN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ADUHELM INJ	-	EXC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ADVATE INJ, KOVALTRY INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ADYNOVATE INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
AFSTYLA KIT	-	NC	HEMATOLOGICAL AGENTS - MISC.
A-HYDROCORT INJ, SOLU-CORTEF INJ	-	F	CORTICOSTEROIDS
ALBUMINAR INJ	-	F	HEMATOLOGICAL AGENTS - MISC.
ALDURAZYME INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALIMTA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALIQOPA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
allopurinol inj	-	F	GOUT AGENTS
ALOXI IV SOLN	-	F	ANTIEMETICS
ALPHANATE INJ, HUMATE-P INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ALPHANINE SD INJ, MONONINE INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ALPROLIX INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
AMBISOME INJ	-	F	ANTIFUNGALS
amikacin inj	-	F	AMINOGLYCOSIDES
aminophylline inj	-	F	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AMINOSYN II INJ	-	F	NUTRIENTS
AMINOSYN-RF INJ	-	F	NUTRIENTS
amiodarone inj	-	F	ANTIARRHYTHMICS
AMONDYS 45 INJ	-	NC	NEUROMUSCULAR AGENTS

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
AMPHOTERICIN INJ	-	F	ANTIFUNGALS
AMPICILLIN INJ	-	F	PENICILLINS
AMPICILLIN/SULBACTAM INJ	-	F	PENICILLINS
ARALAST NP INJ	PA	F	RESPIRATORY AGENTS - MISC.
ARGATROBAN INJ	-	F	ANTICOAGULANTS
ARRANON INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
arsenic trioxide inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ARZERRA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ASPARLAS INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ATGAM INJ	-	F	MISCELLANEOUS THERAPEUTIC CLASSES
ATROPINE SULFATE INJ	-	F	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
AVASTIN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AVSOLA INJ	PA	F	GASTROINTESTINAL AGENTS - MISC.
AVYCAZ INJ	-	F	CEPHALOSPORINS
azacitidine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AZATHIOPRINE INJ	-	F	MISCELLANEOUS THERAPEUTIC CLASSES
AZEDRA INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
azithromycin inj	-	F	MACROLIDES
aztreonam inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
BACTOCILL/DEXTROSE INJ	-	F	PENICILLINS
BALEODAQ INJ (Only available through Walgreens 888-347-3416)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BAVENCIO INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BAXDELA INJ	-	F	FLUOROQUINOLONES
BENDEKA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BENEFIX INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
BENLYSTA IV SOLN	PA	F	ASSORTED CLASSES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
benztropine inj	-	F	ANTIPARKINSON AGENTS
BERINERT INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
BESPONSA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BICILLIN C-R INJ	-	F	PENICILLINS
BLENREP INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bleomycin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BLINCYTO INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BONIVA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BORTEZOMIB INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BORTEZOMIB INJ	PA--	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOTOX INJ	PA	F	NEUROMUSCULAR AGENTS
busulfan inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
butorphanol inj	-	F	ANALGESICS - OPIOID
CABENUVA SUSP (QL=1 kit/month)	QL	F	ANTIVIRALS
CALCIUM GLUCONATE INJ	-	F	MINERALS & ELECTROLYTES
CAMPATH INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CANCIDAS INJ	-	F	ANTIFUNGALS
CAPASTAT INJ	-	F	ANTIMYCOBACTERIAL AGENTS
carboplatin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CARDENE INJ	-	F	CALCIUM CHANNEL BLOCKERS
CARIMUNE NANOFILTERED INJ	PA	F	PASSIVE IMMUNIZING AGENTS
carmustine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
caspofungin acetate iv soln	-	F	ANTIFUNGALS
CATHFLO ACTIVASE INJ	-	F	HEMATOLOGICAL AGENTS - MISC.
CEFAZOLIN INJ	-	F	CEPHALOSPORINS
CEFAZOLIN/DEXTROSE SOLN	-	F	CEPHALOSPORINS
cefepime inj	-	F	CEPHALOSPORINS
CEFEPIME IV SOLN	-	F	CEPHALOSPORINS
cefotaxime inj	-	F	CEPHALOSPORINS

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
cefotetan inj	-	F	CEPHALOSPORINS
cefoxitin inj	-	F	CEPHALOSPORINS
CEFTAZIDIME INJ	-	F	CEPHALOSPORINS
CEFTRIAXONE INJ	-	F	CEPHALOSPORINS
CEFTRIAXONE/DEXTROSE INJ	-	F	CEPHALOSPORINS
cefuroxime inj	-	F	CEPHALOSPORINS
CEREZYME INJ	PA	F	HEMATOPOIETIC AGENTS
CHLORAMPHENICOL INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.
chlorothiazide inj (DIURIL IV INJ equiv)	-	F	DIURETICS
CHROMIUM CHLORIDE INJ	-	F	MINERALS & ELECTROLYTES
cidofovir inj	-	F	ANTIVIRALS
cilastatin/imipenem inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
CINQAIR INJ	PA	F	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
CINRYZE INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
CINVANTI INJ	-	F	ANTIEMETICS
ciprofloxacin inj	-	F	FLUOROQUINOLONES
CISPLATIN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cladribine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CLAFORAN INJ	-	F	CEPHALOSPORINS
CLEOCIN INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.
clindamycin inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
CLINIMIX E INJ	-	F	NUTRIENTS
CLINIMIX INJ	-	F	NUTRIENTS
clofarabine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
colistimethate inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
colistimethate inj	-	NC	ANTI-INFECTIVE AGENTS - MISC.
COSELA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CRYSVITA INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
CUPRIC CHLORIDE INJ	-	F	MINERALS & ELECTROLYTES
cyclophosphamide inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclosporine inj	-	F	ASSORTED CLASSES
CYRAMZA INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
cytarabine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
D5W/LYTES INJ	-	F	MINERALS & ELECTROLYTES
dacarbazine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
dactinomycin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DALVANCE INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.
DANYELZA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
daptomycin inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
DAPTOMYCIN IV SOLN	-	F	ANTI-INFECTIVE AGENTS - MISC.
DARZALEX SOLN	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DARZALEX SOLN FASPRO	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
daunorubicin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
decitabine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
deferoxamine mesylate inj	-	F	ANTIDOTES
DEPO-MEDROL INJ	-	F	CORTICOSTEROIDS
DEPO-PROVERA SC INJ	-	F	CONTRACEPTIVES
DEXAMETHASONE INJ	-	F	CORTICOSTEROIDS
dexamethasone phosphate inj	-	F	CORTICOSTEROIDS
dexrazoxane inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
dextrose 5% in lactated ringers	-	F	MINERALS & ELECTROLYTES
dextrose inj	-	F	NUTRIENTS
dextrose w/ nacl inj	-	F	MINERALS & ELECTROLYTES
DEXTROSE W/NACL INJ	-	F	MINERALS & ELECTROLYTES
DEXTROSE/SODIUM CHLORIDE INJ	-	F	MINERALS & ELECTROLYTES
diazepam inj	-	F	ANTIANXIETY AGENTS
DILAUDID PF INJ	-	F	ANALGESICS - OPIOID
diltiazem inj	-	F	CALCIUM CHANNEL BLOCKERS
diphenhydramine inj	-	F	ANTIHISTAMINES
DOBUTAMINE/D5W INJ	-	F	CARDIOTONICS
docetaxel inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
docetaxel IV soln	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
dopamine inj	-	F	CARDIOTONICS
doxercalciferol inj (HECTOROL INJ equiv)	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
doxycyclline hyclate inj	-	F	TETRACYCLINES
DUROLANE	PA	F	MUSCULOSKELETAL THERAPY AGENTS
DYSPORT	PA	F	NEUROMUSCULAR AGENTS
ELAPRASE INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
ELITEK INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ELOCTATE INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
EMEND INJ	-	F	ANTIEMETICS
ENHERTU INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ENTYVIO INJ	PA	F	GASTROINTESTINAL AGENTS - MISC.
EPINEPHRINE INJ	-	F	VASOPRESSORS
EPINEPHRINE INJ	-	NC	VASOPRESSORS
EPINEPHRINE IV SOLN	-	F	VASOPRESSORS
epirubicin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
epoprostenol inj (Only available through Accredo 888-773-7376)	LD-PA	F	CARDIOVASCULAR AGENTS - MISC.
ERAXIS INJ	-	F	ANTIFUNGALS
ERBITUX INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ertapenem inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
ERWINAZE INJ	-	EXC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERYTHROCIN INJ	-	F	MACROLIDES
esomeprazole inj (NEXIUM IV equiv)	-	F	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
ETOPOPHOS INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
etoposide inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
EUFLEXXA	-	NC	MUSCULOSKELETAL THERAPY AGENTS
EVENITY INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
EVKEEZA INJ (Only available through Orsini Pharmacy 800-410-8575)	LD-PA	F	ANTIHYPERLIPIDEMICS
EXONDYS 51 SOLN	-	NC	NEUROMUSCULAR AGENTS
FABRAZYME INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
FAMOTIDINE INJ	-	F	ULCER DRUGS
famotidine inj (PEPCID equiv)	-	F	ULCER DRUGS
FASENRA INJ	PA	F	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FEIBA INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
FERAHEME INJ	-	NC	HEMATOPOIETIC AGENTS
ferric gluconate IV soln	-	F	HEMATOPOIETIC AGENTS
FERRLECIT INJ	-	NC	HEMATOPOIETIC AGENTS
ferumoxytol inj	-	F	HEMATOPOIETIC AGENTS
FIRMAGON INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FLEBOGAMMA INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
FLOLAN INJ, VELETRI INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
fluconazole/nacl inj	-	F	ANTIFUNGALS
fludarabine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fluorouracil inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
folic acid inj	-	F	HEMATOPOIETIC AGENTS
FOLOTYN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fomepizole inj	-	F	ANTIDOTES
FORTAZ INJ	-	F	CEPHALOSPORINS
fosaprepitant dimeglumine soln	-	F	ANTIEMETICS
foscarnet sodium inj	-	F	ANTIVIRALS
FOSCAVIR INJ	-	NC	ANTIVIRALS
fosphenytoin inj	-	F	ANTICONVULSANTS
furosemide inj	-	F	DIURETICS
GAMMAGARD INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
GAMMAGARD SD INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
GAMMAPLEX INJ	PA	F	PASSIVE IMMUNIZING AGENTS
ganciclovir inj	-	F	ANTIVIRALS
GAZYVA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GEL-ONE	-	NC	MUSCULOSKELETAL THERAPY AGENTS
GELSYN-3	-	NC	MUSCULOSKELETAL THERAPY AGENTS
gemcitabine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
gentamicin inj	-	F	AMINOGLYCOSIDES
gentamicin/ nacl inj	-	F	AMINOGLYCOSIDES
GENTAMICIN/NACL INJ	-	F	AMINOGLYCOSIDES
GENVISC 850	-	NC	MUSCULOSKELETAL THERAPY AGENTS
GLASSIA INJ	PA	F	RESPIRATORY AGENTS - MISC.
GLYRX-PF SOLN	-	F	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
granisetron HCl inj (KYTRIL INJ equiv)	-	F	ANTIEMETICS
HAEGARDA INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
HALAVEN INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HECTOROL INJ	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
HEMOFIL M INJ, KOATE-DVI INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
HEPAGAM B INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
HEPARIN LOCK FLUSH IV SOLN	-	F	ANTICOAGULANTS
heparin lock flush soln	-	F	ANTICOAGULANTS
heparin sodium inj	-	F	ANTICOAGULANTS
HEPARIN SODIUM/D5W INJ	-	F	ANTICOAGULANTS
heparin sodium/nacl inj	-	F	ANTICOAGULANTS
HERCEPTIN HYLECTA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HERCEPTIN INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
HERZUMA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HYALGAN	-	NC	MUSCULOSKELETAL THERAPY AGENTS
hydralazine inj	-	F	ANTIHYPERTENSIVES
hydromorphone inj	-	F	ANALGESICS - OPIOID
hydroxyprogesterone capro inj	-	NC	PROGESTINS
HYMOVIS	-	NC	MUSCULOSKELETAL THERAPY AGENTS
HYPERHEP B INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
ibandronate sodium inj (BONIVA equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
idarubicin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IDELVION SOLN	-	NC	HEMATOLOGICAL AGENTS - MISC.
IFEX INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ifosfamide inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ILARIS INJ	PA	F	ANALGESICS - ANTI-INFLAMMATORY
IMFINZI INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INFED INJ	-	F	HEMATOPOIETIC AGENTS
INFLECTRA INJ 100MG	PA	F	GASTROINTESTINAL AGENTS - MISC.
INFUGEM SOLN	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INFUVITE INJ	-	F	MULTIVITAMINS
INJECTAFER INJ	-	F	HEMATOPOIETIC AGENTS
INTRALIPID INJ	-	F	NUTRIENTS
IONOSOL-MB INJ D5W	-	F	MINERALS & ELECTROLYTES
IRINOTECAN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ISOLYTE-P/ D5W INJ	-	F	MINERALS & ELECTROLYTES
ISOLYTE-S INJ	-	F	MINERALS & ELECTROLYTES
ISTODAX (OVERFILL) INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IXEMPRA KIT INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IXINITY INJ, RIXUBIS INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
JEMPERLI SOLN (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JEVTANA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JIVI INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
KADCYLA IV SOLN	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KALBITOR INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
KANJINTI INJ (Restricted to Oncology or Hematology Specialist)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
kcl/ d5w inj	-	F	MINERALS & ELECTROLYTES
kcl/ d5w/ nacl inj	-	F	MINERALS & ELECTROLYTES
kcl/ nacl inj	-	F	MINERALS & ELECTROLYTES
KCL/D5W/LR INJ	-	F	MINERALS & ELECTROLYTES
KCL/DEXTROSE/NACL INJ	-	F	MINERALS & ELECTROLYTES
KEPIVANCE INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KEYTRUDA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KEYTRUDA IV SOLN	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KHAPZORY SOLN	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOGENATE FS INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
KRYSTEXXA INJ	PA	F	GOUT AGENTS
KYPROLIS SOLN	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
labetalol inj	-	F	BETA BLOCKERS
LACTATED RINGERS INJ	-	F	MINERALS & ELECTROLYTES
LARTRUVO INJ (Only available through Accredo 888-773-7376)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEMTRADA INJ	PA	F	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
leucovorin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leuprolide inj	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
levetiracetam inj	-	F	ANTICONVULSANTS
levofloxacin inj	-	F	FLUOROQUINOLONES
levofloxacin/d5w inj	-	F	FLUOROQUINOLONES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
LEVOLEUCOVORIN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
levothyroxine inj	-	F	THYROID AGENTS
LIBTAYO INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
lidocaine inj	-	F	LOCAL ANESTHETICS-PARENTERAL
lincomycin inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
linezolid IV soln	-	F	ANTI-INFECTIVE AGENTS - MISC.
liothyronine inj (TRIOSTAT equiv)	-	F	THYROID AGENTS
lipodox inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LIPOSYN	-	F	NUTRIENTS
lorazepam inj	-	F	ANTIANXIETY AGENTS
LUMOXITI INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUPRON DEPO-PED INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT INJ/ELIGARD INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUPRON DEPOT PEDIATRIC INJ/LUPRON DEPOT INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
magnesium sulfate inj	-	F	MINERALS & ELECTROLYTES
magnesium sulfate/d5w inj	-	F	MINERALS & ELECTROLYTES
MANGANESE SULFATE INJ	-	F	MINERALS & ELECTROLYTES
mannitol inj	-	F	DIURETICS
MARGENZA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MARQIBO INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
medroxyprogesterone inj	-	F	CONTRACEPTIVES
melphalan inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meropenem inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
mesna inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methylprednisolone acetate inj (DEPO-MEDROL INJ equiv)	-	F	CORTICOSTEROIDS
methylprednisolone inj (SOLU-MEDROL INJ equiv)	-	F	CORTICOSTEROIDS
METHYLPREDNISOLONE POWDER	-	F	CORTICOSTEROIDS
metoclopramide inj	-	F	GASTROINTESTINAL AGENTS - MISC.

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
metoprolol inj	-	F	BETA BLOCKERS
METOPROLOL TARTRATE CARTRIDGE	-	F	BETA BLOCKERS
metronidazole/ nacl inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
micafungin inj	-	F	ANTIFUNGALS
milrinone inj	-	F	CARDIOTONICS
MINOCIN INJ	-	F	TETRACYCLINES
MIRCERA INJ	-	NC	HEMATOPOIETIC AGENTS
mitomycin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mitoxantron inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MONJUVI INJ (Only available through Biologics 800-850-4306)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MONOFERRIC INJ (Only available through Biologics 800-850-4306)	LD	F	HEMATOPOIETIC AGENTS
MONOVISC	-	NC	MUSCULOSKELETAL THERAPY AGENTS
MORPHINE SULFATE INJ	-	F	ANALGESICS - OPIOID
MOXIFLOXACIN INJ	-	F	FLUOROQUINOLONES
MOZOBIL INJ	-	F	HEMATOPOIETIC AGENTS
MVASI INJ (Restricted to Oncology, Opthalmology or Hematology Specialist)	RS	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mycophenolate inj	-	F	MISCELLANEOUS THERAPEUTIC CLASSES
MYOZYME/LUMIZYME INJ	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
NAFCILLIN INJ	-	F	PENICILLINS
NAFCILLIN SODIUM IN DEXTROSE INJ	-	F	PENICILLINS
NAGLAZYME INJ (Only available through Walgreens 888-347-3416)	LD-PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
nelarabine iv soln	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NEXTERONE INJ/AMIODARONE INJ	-	F	ANTIARRHYTHMICS
nicardipine inj	-	F	CALCIUM CHANNEL BLOCKERS
NITROGLYCERIN IV SOLN	-	F	ANTIANGINAL AGENTS
NORMOSOL- R/D5W INJ	-	F	MINERALS & ELECTROLYTES
NORMOSOL-M/D5W INJ	-	F	MINERALS & ELECTROLYTES
NORMOSOL-R INJ	-	F	MINERALS & ELECTROLYTES
NOVOEIGHT INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
NPLATE INJ	-	F	HEMATOPOIETIC AGENTS

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
NUCALA INJ	PA	F	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
NULIBRY INJ (Only available through Biologics 800-850-4306)	LD-PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
NULOJIX INJ	-	F	ASSORTED CLASSES
NUWIQ INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
OCREVUS INJ	PA	F	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
OCTAGAM INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
OGIVRI INJ (Restricted to Oncology or Hematology Specialist)	RS	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ONCASPAR INJ (Only available through Walgreens 888-347-3416)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ondansetron (ZOFRAN) inj	-	NC	ANTIEMETICS
ondansetron inj	-	F	ANTIEMETICS
ONPATTRO SOLN	PA	F	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ONTRUZANT INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OPDIVO INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORENCIA INJ	PA	F	ANALGESICS - ANTI-INFLAMMATORY
ORTHOVISC	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ORTHOVISC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
OSMITROL INJ	-	F	DIURETICS
oxacillin inj	-	F	PENICILLINS
oxaliplatin inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OXLUMO INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	F	GENITOURINARY AGENTS - MISCELLANEOUS
paclitaxel inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PADCEV INJ (Only available through Walgreens 888-347-3416)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
palonosetron inj	-	F	ANTIEMETICS
PAMIDRONATE INJ	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
PAMIDRONATE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
pantoprazole inj (PROTONIX INJ equiv)	-	F	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
PANZYGA INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
paricalcitol inj	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
PARSABIV INJ	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
PENICILLIN G PROCAINE INJ	-	F	PENICILLINS
PENICILLIN G SODIUM INJ	-	F	PENICILLINS
penicillin gk inj	-	F	PENICILLINS
PENICILLIN GK/DEXTROSE INJ	-	F	PENICILLINS
pentamidine inj	-	NC	ANTI-INFECTIVE AGENTS - MISC.
PEPAXTO INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PERJETA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PFIZERPEN-G INJ	-	F	PENICILLINS
phenytoin inj	-	F	ANTICONVULSANTS
PHOTOFRIN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
piperacillin/tazobactam inj	-	F	PENICILLINS
PLASMA-LYTE INJ	-	F	MINERALS & ELECTROLYTES
PLASMA-LYTE-A INJ	-	F	MINERALS & ELECTROLYTES
POLIVY INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
polymyxin b inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
PORTRAZZA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
POTASSIUM CHLORIDE INJ	-	F	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE INJ	-	NC	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE/NACL INJ	-	F	MINERALS & ELECTROLYTES
POTASSIUM PHOSPHATE INJ	-	F	MINERALS & ELECTROLYTES
POTELIGEO INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
premasol inj	-	F	NUTRIENTS
PRIMAXIN INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
PRIVIGEN INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
procainamide inj	-	F	ANTIARRHYTHMICS
PROCHLORPERAZINE INJ	-	F	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PROFILNINE INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
progesterone IM inj	-	F	PROGESTINS
PROGRAF INJ	-	F	MISCELLANEOUS THERAPEUTIC CLASSES
PROLASTIN-C INJ	-	NC	RESPIRATORY AGENTS - MISC.
PROLASTIN-C INJ, ZEMAIRA INJ	-	NC	RESPIRATORY AGENTS - MISC.
PROLEUKIN INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PROLIA SOLN	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
propranolol inj	-	F	BETA BLOCKERS
RADICAVA INJ	PA	F	NEUROMUSCULAR AGENTS
REBINYN SOL	-	NC	HEMATOLOGICAL AGENTS - MISC.
RECLAST INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RECOMBINATE INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
REMICADE INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
REMODULIN INJ (Only available through Accredo 888-773-7376)	-	NC	CARDIOVASCULAR AGENTS - MISC.
RENFLEXIS INJ	PA	F	GASTROINTESTINAL AGENTS - MISC.
RIABNI SOLN	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
rifampin inj	-	F	ANTIMYCOBACTERIAL AGENTS
ringers inj	-	F	MINERALS & ELECTROLYTES
RITUXAN HYCELA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RITUXAN INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUCONEST INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
RUXIENCE INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SANDOSTATIN LAR DEPOT KIT (QL=1 kit every 4 weeks)	PA-QL	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
SARCLISA SOLN (Only available through Biologics 800-850-4306)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
SELENIUM INJ	-	F	MINERALS & ELECTROLYTES
SIMPONI ARIA INJ	PA	F	ANALGESICS - ANTI-INFLAMMATORY
SIMULECT INJ	-	F	ASSORTED CLASSES
SMOFLIPID EMULSION	-	F	NUTRIENTS
SODIUIM PHOSPHATE INJ	-	F	MINERALS & ELECTROLYTES
SODIUM BICARBONATE INJ	-	F	MINERALS & ELECTROLYTES
sodium chloride inj	-	F	MINERALS & ELECTROLYTES
sodium phosphate inj	-	F	MINERALS & ELECTROLYTES
SODIUM THIOSULFATE INJ	-	F	ANTIDOTES
SOLIRIS IV SOLN	PA	F	HEMATOLOGICAL AGENTS - MISC.
SOLU-MEDROL INJ	-	F	CORTICOSTEROIDS
SOMATULINE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOTALOL INJ	-	F	BETA BLOCKERS
SPINRAZA INJ (Only available through Accredo 888-773-7376)	LD-PA	F	NEUROMUSCULAR AGENTS
SPRAVATO SOLN	PA	F	ANTIDEPRESSANTS
STERILE DILUENT SOLN (Only available through Accredo 888-773-7376)	LD	F	PHARMACEUTICAL ADJUVANTS
sterile water for inj	-	F	PHARMACEUTICAL ADJUVANTS
STREPTOMYCIN INJ	-	F	AMINOGLYCOSIDES
sulfamethoxazole/trimethoprim inj	-	F	ANTI-INFECTIVE AGENTS - MISC.
SUPARTZ FX INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SYLATRON KIT	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYLVANT INJ	-	F	MISCELLANEOUS THERAPEUTIC CLASSES
SYNAGIS INJ	PA	F	PASSIVE IMMUNIZING AND TREATMENT AGENTS
SYNERCID INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.
SYNRIBO INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYNVISC	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SYNVISC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SYNVISC ONE	-	NC	MUSCULOSKELETAL THERAPY AGENTS

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
TAXOL INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAXOTERE INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TECENTRIQ INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TEFLARO INJ	-	F	CEPHALOSPORINS
temsirolimus soln	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TEPEZZA INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
terbutaline inj (BRETHINE INJ equiv)	-	F	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TESTOSTERONE ENANTHATE INJ	-	F	ANDROGENS-ANABOLIC
thiotepa inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
THYMOGLOBULIN INJ	-	F	ASSORTED CLASSES
tigecycline inj	-	F	TETRACYCLINES
tobramycin inj	-	F	AMINOGLYCOSIDES
topotecan inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TPN ELECTROL INJ	-	F	MINERALS & ELECTROLYTES
tranexamic acid inj	-	F	HEMOSTATICS
TRAZIMERA INJ (Restricted to Oncology or Hematology Specialist)	RS	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TREANDA INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
treprostinil inj (Only available through Accredo 888-773-7376)	LD-PA	F	CARDIOVASCULAR AGENTS - MISC.
triamcinolone acetonide inj	-	F	CORTICOSTEROIDS
TRILURON	-	NC	MUSCULOSKELETAL THERAPY AGENTS
TRIVISC	-	NC	MUSCULOSKELETAL THERAPY AGENTS
TRODELVY SOLN (Only available through Biologics 800-850-4306)	LD-PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TROGARZO INJ	-	NC	ANTIVIRALS
TRUXIMA INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
TYSABRI INJ	PA	F	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ULTOMIRIS INJ	PA	F	HEMATOLOGICAL AGENTS - MISC.
UNITUXIN INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
UPTRAVI INJ	-	EXC	CARDIOVASCULAR AGENTS - MISC.
valproate inj	-	F	ANTICONVULSANTS
VANCOMYCIN INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN/DEXTROSE INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN/NACL INJ	-	F	ANTI-INFECTIVE AGENTS - MISC.
VECTIBIX IV SOLN	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VELCADE INJ, BORTEZOMIB INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENOFER INJ	-	F	HEMATOPOIETIC AGENTS
verapamil inj	-	F	CALCIUM CHANNEL BLOCKERS
VILTEPSO SOLN	-	NC	NEUROMUSCULAR AGENTS
VIMIZIM INJ (Only available through Walgreens 888-347-3416)	LD-PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
VIMPAT INJ	-	F	ANTICONVULSANTS
VINBLASTINE INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
vincristine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
vinorelbine inj	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VISCO-3	-	NC	MUSCULOSKELETAL THERAPY AGENTS
VISUDYNE INJ	PA	F	OPHTHALMIC AGENTS
vitamin K1 inj	-	F	VITAMINS
voriconazole inj	-	F	ANTIFUNGALS
VYONDYS 53 SOLN	-	NC	NEUROMUSCULAR AGENTS
VYXEOS INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XEOMIN INJ	PA	F	NEUROMUSCULAR AGENTS
XERAVA INJ	-	F	TETRACYCLINES
XGEVA INJ	PA	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
XOLAIR INJ	PA	F	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

Symbols and abbreviations are defined on page 1.

Drug Name	Special Code	Tier	Category
XYNTHA INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
YERVOY INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZALTRAP INJ	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZANOSAR INJ	-	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEMDRI INJ	-	F	AMINOGLYCOSIDES
ZERBAXA INJ	-	F	CEPHALOSPORINS
ZINC CHLORIDE INJ	-	F	MINERALS & ELECTROLYTES
ZIRABEV INJ (Restricted to Oncology, Opthalmology or Hematology Specialist)	RS	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
zoledronic acid inj (ZOMETA INJ equiv)	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
zoledronic acid IV soln (RECLAST INJ equiv)	-	F	ENDOCRINE AND METABOLIC AGENTS - MISC.
ZOLGENSMA INJ (Only available through Accredo 888-773-7376)	LD-PA	F	NEUROMUSCULAR AGENTS
ZOMETA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ZOSYN/ DEXTROSE INJ	-	F	PENICILLINS
ZYNLONTA SOLN	PA	F	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYVOX IV SOLN	-	F	ANTI-INFECTIVE AGENTS - MISC.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
amikacin inj	-	F
gentamicin inj	-	F
gentamicin/ nacl inj	-	F
GENTAMICIN/NACL INJ	-	F
STREPTOMYCIN INJ	-	F
tobramycin inj	-	F
ZEMDRI INJ	-	F
ANALGESICS - ANTI-INFLAMMATORY		
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
SIMPONI ARIA INJ	PA	F
INTERLEUKIN-1BETA BLOCKERS		
ILARIS INJ	PA	F
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA INJ	PA	F
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA INJ	PA	F
ANALGESICS - OPIOID		
OPIOID AGONISTS		
DILAUDID PF INJ	-	F
hydromorphone inj	-	F
morphine sulfate inj	-	F
OPIOID PARTIAL AGONISTS		
BUTORPHANOL INJ	-	F
ANDROGENS-ANABOLIC		
ANDROGENS		
TESTOSTERONE ENANTHATE INJ	-	F
ANTIANGINAL AGENTS		
NITRATES		
NITROGLYCERIN IV SOLN	-	F
ANTIANXIETY AGENTS		
BENZODIAZEPINES		
diazepam inj	-	F
lorazepam inj	-	F
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
procainamide inj	-	F
ANTIARRHYTHMICS TYPE III		
amiodarone inj	-	F
NEXTERONE INJ/AMIODARONE INJ	-	F
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
CINQAIR INJ	PA	F
FASENRA INJ	PA	F
NUCALA INJ	PA	F
XOLAIR INJ	PA	F
SYMPATHOMIMETICS		
terbutaline inj (BRETHINE INJ equiv)	-	F
XANTHINES		
aminophylline inj	-	F
ANTICOAGULANTS		
HEPARINS AND HEPARINOID-LIKE AGENTS		
HEPARIN LOCK FLUSH IV SOLN	-	F
heparin lock flush soln	-	F
heparin sodium inj	-	F
HEPARIN SODIUM/D5W INJ	-	F
heparin sodium/nacl inj	-	F
THROMBIN INHIBITORS		
ARGATROBAN INJ	-	F
ANTICONVULSANTS		
ANTICONVULSANTS - MISC.		
levetiracetam inj	-	F
VIMPAT INJ	-	F
HYDANTOINS		
fosphenytoin inj	-	F
phenytoin inj	-	F
VALPROIC ACID		
valproate inj	-	F
ANTIDEPRESSANTS		
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS		
SPRAVATO SOLN	PA	F
ANTIDOTES		
ANTIDOTES		
deferoxamine mesylate inj	-	F
fomepizole inj	-	F
SODIUM THIOSULFATE INJ	-	F
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
ALOXI IV SOLN	-	F
granisetron HCl inj (KYTRIL INJ equiv)	-	F
ondansetron inj	-	F
palonosetron inj	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
ondansetron (ZOFRAN) inj	-	NC
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
CINVANTI INJ	-	F
EMEND INJ	-	F
fosaprepitant dimeglumine soln	-	F
ANTIFUNGALS		
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)		
CANCIDAS INJ	-	F
caspofungin acetate iv soln	-	F
ERAXIS INJ	-	F
micafungin inj	-	F
ANTIFUNGALS		
ABELCET INJ	-	F
AMBISOME INJ	-	F
AMPHOTERICIN INJ	-	F
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole/nacl inj	-	F
voriconazole inj	-	F
ANTIHISTAMINES		
ANTIHISTAMINES - ETHANOLAMINES		
diphenhydramine inj	-	F
ANTIHYPERLIPIDEMICS		
ANGIOPOIETIN-LIKE PROTEIN INHIBITORS		
EVKEEZA INJ (Only available through Orsini Pharmacy 800-410-8575)	LD-PA	F
ANTIHYPERTENSIVES		
VASODILATORS		
hydralazine inj	-	F
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole/ nacl inj	-	F
colistimethate inj	-	NC
pentamidine inj	-	NC
ANTI-INFECTIVE MISC. - COMBINATIONS		
sulfamethoxazole/trimethoprim inj	-	F
CARBAPENEMS		
cilastatin/imipenem inj	-	F
ertapenem inj	-	F
meropenem inj	-	F
PRIMAXIN INJ	-	F
CHLORAMPHENICOLS		
CHLORAMPHENICOL INJ	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
CYCLIC LIPOPEPTIDES		
daptomycin inj	-	F
DAPTOMYCIN IV SOLN	-	F
GLYCOPEPTIDES		
DALVANCE INJ	-	F
VANCOMYCIN INJ	-	F
VANCOMYCIN/DEXTROSE INJ	-	F
VANCOMYCIN/NACL INJ	-	F
LINCOSAMIDES		
CLEOCIN INJ	-	F
clindamycin inj	-	F
lincomycin inj	-	F
MONOBACTAMS		
aztreonam inj	-	F
OXAZOLIDINONES		
LINEZOLID IV SOLN	-	F
ZYVOX IV SOLN	-	F
POLYMYXINS		
colistimethate inj	-	F
polymyxin b inj	-	F
STREPTOGRAMINS		
SYNERCID INJ	-	F
ANTIMYCOBACTERIAL AGENTS		
ANTIMYCOBACTERIAL AGENTS		
CAPASTAT INJ	-	F
rifampin inj	-	F
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
BENDEKA INJ	PA	F
busulfan inj	-	F
carboplatin inj	-	F
carmustine inj	-	F
CISPLATIN INJ	-	F
cyclophosphamide inj	-	F
IFEX INJ	-	F
ifosfamide inj	-	F
melphalan inj	-	F
oxaliplatin inj	-	F
PEPAXTO INJ	PA	F
thiotepa inj	-	F
TREANDA INJ	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
ZANOSAR INJ	-	F
ANTIMETABOLITES		
ALIMTA INJ	PA	F
azacitidine inj	-	F
cladribine inj	-	F
clofarabine inj	-	F
CYTARABINE INJ	-	F
decitabine inj	-	F
fludarabine inj	-	F
fluorouracil inj	-	F
FOLOTYN INJ	-	F
GEMCITABINE INJ	-	F
nelarabine iv soln	-	F
ARRANON INJ	-	NC
INFUGEM SOLN	-	NC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
AVASTIN INJ	-	F
CYRAMZA INJ	-	F
MVASI INJ (Restricted to Oncology, Opthalmology or Hematology Specialist)	RS	F
ZALTRAP INJ	PA	F
ZIRABEV INJ (Restricted to Oncology, Opthalmology or Hematology Specialist)	RS	F
ANTINEOPLASTIC - ANTIBODIES		
ADCETRIS INJ	PA	F
ARZERRA INJ	PA	F
BAVENCIO INJ	PA	F
BESPONSA INJ	PA	F
BLINCYTO INJ	PA	F
DARZALEX SOLN	PA	F
ENHERTU INJ	PA	F
GAZYVA INJ	PA	F
IMFINZI INJ	PA	F
JEMPERLI SOLN (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	F
KADCYLA IV SOLN	PA	F
KEYTRUDA INJ	PA	F
KEYTRUDA IV SOLN	PA	F
LIBTAYO INJ	PA	F
LUMOXITI INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	F
MONJUVI INJ (Only available through Biologics 800-850-4306)	LD-PA	F
OPDIVO INJ	PA	F
PADCEV INJ (Only available through Walgreens 888-347-3416)	LD-PA	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
POLIVY INJ	PA	F
POTELIGEO INJ	-	F
RUXIENCE INJ	PA	F
SARCLISA SOLN (Only available through Biologics 800-850-4306)	LD-PA	F
TECENTRIQ INJ	PA	F
TRUXIMA INJ	PA	F
YERVOY INJ	PA	F
ZYNLONTA SOLN	PA	F
BLENREP INJ	-	NC
CAMPATH INJ	-	NC
DANYELZA INJ	-	NC
RIABNI SOLN	-	NC
RITUXAN INJ	-	NC
UNITUXIN INJ	-	NC
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
MARGENZA INJ	PA	F
OGIVRI INJ (Restricted to Oncology or Hematology Specialist)	RS	F
PERJETA INJ	PA	F
TRAZIMERA INJ (Restricted to Oncology or Hematology Specialist)	RS	F
HERCEPTIN INJ	-	NC
HERZUMA INJ	-	NC
KANJINTI INJ (Restricted to Oncology or Hematology Specialist)	-	NC
ONTRUZANT INJ	-	NC
ANTINEOPLASTIC - CELLULAR IMMUNOTHERAPY		
ABECMA INJ	-	EXC
ANTINEOPLASTIC - EGFR INHIBITORS		
ERBITUX INJ	PA	F
PORTRAZZA INJ	PA	F
VECTIBIX IV SOLN	PA	F
ANTINEOPLASTIC - HORMONAL AGENTS		
leuprolide inj	PA	F
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
FIRMAGON INJ	-	F
LUPRON DEPOT INJ/ELIGARD INJ	PA	F
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS		
LARTRUVO INJ (Only available through Accredo 888-773-7376)	LD-PA	F
ANTINEOPLASTIC ANTIBIOTICS		
ADRIAMYCIN INJ	-	F
bleomycin inj	-	F
dactinomycin inj	-	F
daunorubicin inj	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
epirubicin inj	-	F
idarubicin inj	-	F
lipodox inj	-	F
mitomycin inj	-	F
mitoxantron inj	-	F
ANTINEOPLASTIC COMBINATIONS		
DARZALEX SOLN FASPRO	PA	F
HERCEPTIN HYLECTA INJ	-	NC
RITUXAN HYCELA INJ	-	NC
VYXEOS INJ	-	NC
ANTINEOPLASTIC ENZYME INHIBITORS		
BALEODAQ INJ (Only available through Walgreens 888-347-3416)	LD-PA	F
BORTEZOMIB INJ	PA	F
ISTODAX (OVERFILL) INJ	PA	F
KYPROLIS SOLN	PA	F
temsirolimus soln	-	F
ALIQOPA INJ	-	NC
BORTEZOMIB INJ	-	NC
VELCADE INJ, BORTEZOMIB INJ	-	NC
ANTINEOPLASTIC ENZYMES		
ERWINAZE INJ	-	EXC
ASPARLAS INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	F
ONCASPAR INJ (Only available through Walgreens 888-347-3416)	LD-PA	F
ANTINEOPLASTIC RADIOPHARMACEUTICALS		
AZEDRA INJ	-	F
ANTINEOPLASTICS MISC.		
arsenic trioxide inj	-	F
dacarbazine inj	-	F
PHOTOFRIN INJ	-	F
PROLEUKIN INJ	-	F
SYLATRON KIT	-	F
SYNRIBO INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	F
CHEMOTHERAPY ADJUNCTS		
ELITEK INJ	-	F
KEPIVANCE INJ	-	F
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
dexrazoxane inj	-	F
KHAPZORY SOLN	-	F
leucovorin inj	-	F
LEVOLEUCOVORIN INJ	-	F
mesna inj	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
LEUCOVORIN INJ	-	F
COSELA INJ	-	NC
MITOTIC INHIBITORS		
ABRAXANE INJ	PA	F
docetaxel inj	-	F
docetaxel IV soln	-	F
ETOPOPHOS INJ	-	F
etoposide inj	-	F
HALAVEN INJ	PA	F
IXEMPRA KIT INJ	-	F
JEVTANA INJ	PA	F
MARQIBO INJ	-	F
paclitaxel inj	-	F
TAXOL INJ	-	F
TAXOTERE INJ	-	F
VINBLASTINE INJ	-	F
vincristine inj	-	F
vinorelbine inj	-	F
TOPOISOMERASE I INHIBITORS		
IRINOTECAN INJ	-	F
topotecan inj	-	F
TRODELVY SOLN (Only available through Biologics 800-850-4306)	LD-PA	F
ANTIPARKINSON AGENTS		
ANTIPARKINSON ANTICHOLINERGICS		
benztropine inj	-	F
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
PHENOTHIAZINES		
prochlorperazine inj	-	F
ANTIVIRALS		
ANTIRETROVIRALS		
CABENUVA SUSP (QL=1 kit/month)	QL	F
TROGARZO INJ	-	NC
CMV AGENTS		
cidofovir inj	-	F
foscarnet sodium inj	-	F
ganciclovir inj	-	F
FOSCAVIR INJ	-	NC
HERPES AGENTS		
acyclovir sodium IV soln	-	F
ASSORTED CLASSES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
IMMUNOSUPPRESSIVE AGENTS		
cyclosporine inj	-	F
NULOJIX INJ	-	F
SIMULECT INJ	-	F
THYMOGLOBULIN INJ	-	F
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA IV SOLN	PA	F
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
labetalol inj	-	F
BETA BLOCKERS CARDIO-SELECTIVE		
metoprolol inj	-	F
METOPROLOL TARTRATE CARTRIDGE	-	F
BETA BLOCKERS NON-SELECTIVE		
propranolol inj	-	F
SOTALOL INJ	-	F
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKERS		
CARDENE INJ	-	F
DILTIAZEM INJ	-	F
nicardipine inj	-	F
verapamil inj	-	F
CARDIOTONICS		
INOTROPES		
DOBUTAMINE/D5W INJ	-	F
dopamine inj	-	F
milrinone inj	-	F
CARDIOVASCULAR AGENTS - MISC.		
PROSTAGLANDIN VASODILATORS		
epoprostenol inj (Only available through Accredo 888-773-7376)	LD-PA	F
treprostinil inj (Only available through Accredo 888-773-7376)	LD-PA	F
FLOLAN INJ, VELETRI INJ	-	NC
REMODULIN INJ (Only available through Accredo 888-773-7376)	-	NC
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI INJ	-	EXC
CEPHALOSPORINS		
CEPHALOSPORIN COMBINATIONS		
AVYCAZ INJ	-	F
ZERBAXA INJ	-	F
CEPHALOSPORINS - 1ST GENERATION		
CEFAZOLIN INJ	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
CEFAZOLIN/DEXTROSE SOLN	-	F
CEPHALOSPORINS - 2ND GENERATION		
cefotetan inj	-	F
cefoxitin inj	-	F
cefuroxime inj	-	F
CEPHALOSPORINS - 3RD GENERATION		
cefotaxime inj	-	F
ceftazidime inj	-	F
ceftriaxone inj	-	F
CEFTRIAXONE/DEXTROSE INJ	-	F
CLAFORAN INJ	-	F
FORTAZ INJ	-	F
CEPHALOSPORINS - 4TH GENERATION		
CEFEPIME INJ	-	F
CEFEPIME IV SOLN	-	F
CEPHALOSPORINS - 5TH GENERATION		
TEFLARO INJ	-	F
CONTRACEPTIVES		
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA SC INJ	-	F
medroxyprogesterone inj	-	F
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
A-HYDROCORT INJ, SOLU-CORTEF INJ	-	F
DEPO-MEDROL INJ	-	F
DEXAMETHASONE INJ	-	F
dexamethasone phosphate inj	-	F
methylprednisolone acetate inj (DEPO-MEDROL INJ equiv)	-	F
methylprednisolone inj (SOLU-MEDROL INJ equiv)	-	F
METHYLPREDNISOLONE POWDER	-	F
SOLU-MEDROL INJ	-	F
triamcinolone acetonide inj	-	F
DIURETICS		
LOOP DIURETICS		
furosemide inj	-	F
OSMOTIC DIURETICS		
mannitol inj	-	F
OSMITROL INJ	-	F
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
chlorothiazide inj (DIURIL IV INJ equiv)	-	F
ENDOCRINE AND METABOLIC AGENTS - MISC.		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
BONE DENSITY REGULATORS		
EVENITY INJ	PA	F
PAMIDRONATE INJ	-	F
PROLIA SOLN	PA	F
XGEVA INJ	PA	F
zoledronic acid inj (ZOMETA INJ equiv)	-	F
zoledronic acid IV soln (RECLAST INJ equiv)	-	F
BONIVA INJ	-	NC
ibandronate sodium inj (BONIVA equiv)	-	NC
PAMIDRONATE INJ	-	NC
RECLAST INJ	-	NC
ZOMETA INJ	-	NC
CORTICOTROPIN		
ACTHAR HP GEL INJ	-	NC
INSULIN-LIKE GROWTH FACTOR RECEPTOR INHIBITORS		
TEPEZZA INJ	PA	F
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPO-PED INJ	PA	F
LUPRON DEPOT PEDIATRIC INJ/LUPRON DEPOT INJ	PA	F
METABOLIC MODIFIERS		
ALDURAZYME INJ	PA	F
CRYSVITA INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	F
doxercalciferol inj (HECTOROL INJ equiv)	-	F
ELAPRASE INJ	PA	F
FABRAZYME INJ	PA	F
HECTOROL INJ	-	F
MYOZYME/LUMIZYME INJ	-	F
NAGLAZYME INJ (Only available through Walgreens 888-347-3416)	LD-PA	F
NULIBRY INJ (Only available through Biologics 800-850-4306)	LD-PA	F
paricalcitol inj	-	F
PARSABIV INJ	-	F
VIMIZIM INJ (Only available through Walgreens 888-347-3416)	LD-PA	F
SOMATOSTATIC AGENTS		
SANDOSTATIN LAR DEPOT KIT (QL=1 kit every 4 weeks)	PA-QL	F
SOMATULINE INJ	-	NC
FLUOROQUINOLONES		
FLUOROQUINOLONES		
BAXDELA INJ	-	F
ciprofloxacin inj	-	F
levofloxacin inj	-	F
levofloxacin/d5w inj	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
MOXIFLOXACIN INJ	-	F
GASTROINTESTINAL AGENTS - MISC.		
GASTROINTESTINAL STIMULANTS		
metoclopramide inj	-	F
INFLAMMATORY BOWEL AGENTS		
AVSOLA INJ	PA	F
ENTYVIO INJ	PA	F
INFLECTRA INJ 100MG	PA	F
RENFLEXIS INJ	PA	F
REMICADE INJ	-	NC
GENITOURINARY AGENTS - MISCELLANEOUS		
HYPEROXALURIA AGENTS		
OXLUMO INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	F
GOUT AGENTS		
GOUT AGENTS		
allopurinol inj	-	F
KRYSTEXXA INJ	PA	F
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
ADYNOVATE INJ	PA	F
FEIBA INJ	PA	F
ADVATE INJ, KOVALTRY INJ	-	NC
AFSTYLA KIT	-	NC
ALPHANATE INJ, HUMATE-P INJ	-	NC
ALPHANINE SD INJ, MONONINE INJ	-	NC
ALPROLIX INJ	-	NC
BENEFIX INJ	-	NC
ELOCTATE INJ	-	NC
HEMOFIL M INJ, KOATE-DVI INJ	-	NC
IDELVION SOLN	-	NC
IXINITY INJ, RIXUBIS INJ	-	NC
JIVI INJ	-	NC
KOGENATE FS INJ	-	NC
NOVOEIGHT INJ	-	NC
NUWIQ INJ	-	NC
PROFILNINE INJ	-	NC
REBINYN SOL	-	NC
RECOMBINATE INJ	-	NC
XYNTHA INJ	-	NC
COMPLEMENT INHIBITORS		
BERINERT INJ	PA	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
CINRYZE INJ	PA	F
HAEGARDA INJ	PA	F
RUCONEST INJ	PA	F
SOLIRIS IV SOLN	PA	F
ULTOMIRIS INJ	PA	F
PLASMA KALLIKREIN INHIBITORS		
KALBITOR INJ	PA	F
PLASMA PROTEINS		
ALBUMINAR INJ	-	F
THROMBOLYTIC ENZYMES		
CATHFLO ACTIVASE INJ	-	F
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
CEREZYME INJ	PA	F
AGENTS FOR SICKLE CELL DISEASE		
ADAKVEO INJ	PA	F
FOLIC ACID/FOLATES		
folic acid inj	-	F
HEMATOPOIETIC GROWTH FACTORS		
NPLATE INJ	-	F
MIRCERA INJ	-	NC
IRON		
ferric gluconate IV soln	-	F
ferumoxytol inj	-	F
INFED INJ	-	F
INJECTAFER INJ	-	F
MONOFERRIC INJ (Only available through Biologics 800-850-4306)	LD	F
VENOFER INJ	-	F
FERAHEME INJ	-	NC
FERRLECIT INJ	-	NC
STEM CELL MOBILIZERS		
MOZOBIL INJ	-	F
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
tranexamic acid inj	-	F
LOCAL ANESTHETICS-PARENTERAL		
LOCAL ANESTHETICS - AMIDES		
lidocaine inj	-	F
MACROLIDES		
AZITHROMYCIN		
azithromycin inj	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
MACROLIDES Cont.		
ERYTHROMYCINS		
ERYTHROCIN INJ	-	F
MINERALS & ELECTROLYTES		
BICARBONATES		
sodium bicarbonate inj	-	F
CALCIUM		
CALCIUM GLUCONATE INJ	-	F
ELECTROLYTE MIXTURES		
D5W/LYTES INJ	-	F
dextrose 5% in lactated ringers	-	F
dextrose w/ nacl inj	-	F
DEXTROSE W/NACL INJ	-	F
DEXTROSE/SODIUM CHLORIDE INJ	-	F
IONOSOL-MB INJ D5W	-	F
ISOLYTE-P/ D5W INJ	-	F
ISOLYTE-S INJ	-	F
kcl/ d5w inj	-	F
kcl/ d5w/ nacl inj	-	F
kcl/ nacl inj	-	F
KCL/D5W/LR INJ	-	F
KCL/DEXTROSE/NACL INJ	-	F
LACTATED RINGERS INJ	-	F
NORMOSOL- R/D5W INJ	-	F
NORMOSOL-M/D5W INJ	-	F
NORMOSOL-R INJ	-	F
PLASMA-LYTE INJ	-	F
PLASMA-LYTE-A INJ	-	F
POTASSIUM CHLORIDE INJ	-	F
POTASSIUM CHLORIDE/NACL INJ	-	F
ringers inj	-	F
TPN ELECTROL INJ	-	F
MAGNESIUM		
magnesium sulfate inj	-	F
magnesium sulfate/d5w inj	-	F
MANGANESE		
MANGANESE SULFATE INJ	-	F
PHOSPHATE		
POTASSIUM PHOSPHATE INJ	-	F
SODIUIM PHOSPHATE INJ	-	F
sodium phosphate inj	-	F
POTASSIUM		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
POTASSIUM CHLORIDE INJ	-	F
POTASSIUM CHLORIDE INJ	-	NC
SODIUM		
sodium chloride inj	-	F
TRACE MINERALS		
CHROMIUM CHLORIDE INJ	-	F
CUPRIC CHLORIDE INJ	-	F
SELENIUM INJ	-	F
ZINC		
ZINC CHLORIDE INJ	-	F
MISCELLANEOUS THERAPEUTIC CLASSES		
IMMUNOSUPPRESSIVE AGENTS		
ATGAM INJ	-	F
AZATHIOPRINE INJ	-	F
mycophenolate inj	-	F
PROGRAF INJ	-	F
LYMPHATIC AGENTS		
SYLVANT INJ	-	F
MULTIVITAMINS		
MULTIVITAMINS		
INFUVITE INJ	-	F
PEDIATRIC MULTIPLE VITAMINS		
INFUVITE INJ	-	F
MUSCULOSKELETAL THERAPY AGENTS		
VISCOSUPPLEMENTS		
DUROLANE	PA	F
EUFLEXXA	-	NC
GEL-ONE	-	NC
GELSYN-3	-	NC
GENVISC 850	-	NC
HYALGAN	-	NC
HYMOVIS	-	NC
MONOVISC	-	NC
ORTHOVISC	-	NC
ORTHOVISC INJ	-	NC
SUPARTZ FX INJ	-	NC
SYNVISC	-	NC
SYNVISC INJ	-	NC
SYNVISC ONE	-	NC
TRILURON	-	NC
TRIVISC	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
VISCO-3	-	NC
NEUROMUSCULAR AGENTS		
ALS AGENTS		
RADICAVA INJ	PA	F
MUSCULAR DYSTROPHY AGENTS		
AMONDYS 45 INJ	-	NC
EXONDYS 51 SOLN	-	NC
VILTEPSO SOLN	-	NC
VYONDYS 53 SOLN	-	NC
NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS		
BOTOX INJ	PA	F
DYSPORT	PA	F
XEOMIN INJ	PA	F
SPINAL MUSCULAR ATROPHY AGENTS (SMA)		
SPINRAZA INJ (Only available through Accredo 888-773-7376)	LD-PA	F
ZOLGENSMA INJ (Only available through Accredo 888-773-7376)	LD-PA	F
NUTRIENTS		
CARBOHYDRATES		
DEXTROSE INJ	-	F
LIPIDS		
INTRALIPID INJ	-	F
LIPOSYN	-	F
SMOFLIPID EMULSION	-	F
PROTEINS		
AMINOSYN II INJ	-	F
AMINOSYN-RF INJ	-	F
CLINIMIX E INJ	-	F
CLINIMIX INJ	-	F
premasol inj	-	F
OPHTHALMIC AGENTS		
OPHTHALMIC PHOTODYNAMIC THERAPY AGENTS		
VISUDYNE INJ	PA	F
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
CARIMUNE NANOFILTERED INJ	PA	F
GAMMAGARD INJ	PA	F
GAMMAGARD SD INJ	PA	F
GAMMAPLEX INJ	PA	F
PRIVIGEN INJ	PA	F
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
IMMUNE SERUMS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
PASSIVE IMMUNIZING AND TREATMENT AGENTS Cont.		
CARIMUNE NANOFILTERED INJ	PA	F
FLEBOGAMMA INJ	PA	F
GAMMAGARD INJ	PA	F
GAMMAGARD SD INJ	PA	F
HEPAGAM B INJ	PA	F
HYPERHEP B INJ	PA	F
OCTAGAM INJ	PA	F
PANZYGA INJ	PA	F
PRIVIGEN INJ	PA	F
MONOCLONAL ANTIBODIES		
SYNAGIS INJ	PA	F
PENICILLINS		
AMINOPENICILLINS		
ampicillin inj	-	F
NATURAL PENICILLINS		
PENICILLIN G PROCAINE INJ	-	F
PENICILLIN G SODIUM INJ	-	F
penicillin gk inj	-	F
PENICILLIN GK/DEXTROSE INJ	-	F
PFIZERPEN-G INJ	-	F
PENICILLIN COMBINATIONS		
ampicillin/sulbactam inj	-	F
BICILLIN C-R INJ	-	F
piperacillin/tazobactam inj	-	F
ZOSYN/ DEXTROSE INJ	-	F
PENICILLINASE-RESISTANT PENICILLINS		
BACTOCILL/DEXTROSE INJ	-	F
nafcillin inj	-	F
NAFCILLIN SODIUM IN DEXTROSE INJ	-	F
oxacillin inj	-	F
PHARMACEUTICAL ADJUVANTS		
LIQUID VEHICLES		
STERILE DILUENT SOLN (Only available through Accredo 888-773-7376)	LD	F
sterile water for inj	-	F
PROGESTINS		
PROGESTINS		
progesterone IM inj	-	F
hydroxyprogesterone capro inj	-	NC
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ANTIDEMENTIA AGENTS		
ADUHELM INJ	-	EXC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
MULTIPLE SCLEROSIS AGENTS		
LEMTRADA INJ	PA	F
OCREVUS INJ	PA	F
TYSABRI INJ	PA	F
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
ONPATTRO SOLN	PA	F
RESPIRATORY AGENTS - MISC.		
ALPHA-PROTEINASE INHIBITOR (HUMAN)		
ARALAST NP INJ	PA	F
GLASSIA INJ	PA	F
PROLASTIN-C INJ	-	NC
PROLASTIN-C INJ, ZEMAIRA INJ	-	NC
TETRACYCLINES		
FLUOROCYCLINES		
XERAVA INJ	-	F
GLYCYLCYCLINES		
tigecycline inj	-	F
TETRACYCLINES		
doxycyclline hyclate inj	-	F
MINOCIN INJ	-	F
THYROID AGENTS		
THYROID HORMONES		
levothyroxine inj	-	F
liothyronine inj (TRIOSTAT equiv)	-	F
ULCER DRUGS		
H-2 ANTAGONISTS		
FAMOTIDINE INJ	-	F
famotidine inj (PEPCID equiv)	-	F
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTISPASMODICS		
ATROPINE SULFATE INJ	-	F
GLYRX-PF SOLN	-	F
PROTON PUMP INHIBITORS		
esomeprazole inj (NEXIUM IV equiv)	-	F
pantoprazole inj (PROTONIX INJ equiv)	-	F
VASOPRESSORS		
VASOPRESSORS		
epinephrine inj	-	F
EPINEPHRINE IV SOLN	-	F
EPINEPHRINE INJ	-	NC
VITAMINS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

DrugName	Special Code	Tier
VITAMINS Cont.		
OIL SOLUBLE VITAMINS		
vitamin K1 inj	-	F

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

Symbols and abbreviations are defined on page 1.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ABRAXANE INJ	F
ACTEMRA INJ	F
ADAKVEO INJ	F
ADCETRIS INJ	F
ADYNOVATE INJ	F
ALDURAZYME INJ	F
ALIMTA INJ	F
ARALAST NP INJ	F
ARZERRA INJ	F
ASPARLAS INJ	F
AVSOLA INJ	F
BALEODAQ INJ	F
BAVENCIO INJ	F
BENDEKA INJ	F
BENLYSTA IV SOLN	F
BERINERT INJ	F
BESPONSA INJ	F
BLINCYTO INJ	F
BORTEZOMIB INJ	F
BOTOX INJ	F
CARIMUNE NANOFILTERED INJ	F
CEREZYME INJ	F
CINQAIR INJ	F
CINRYZE INJ	F
CRYSVITA INJ	F
DARZALEX SOLN	F
DARZALEX SOLN FASPRO	F
DUROLANE	F
DYSPORT	F
ELAPRASE INJ	F
ENHERTU INJ	F
ENTYVIO INJ	F
epoprostenol inj	F
ERBITUX INJ	F
EVENITY INJ	F
EVKEEZA INJ	F
FABRAZYME INJ	F

Symbols and abbreviations are defined on page 1.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
FASENRA INJ	F
FEIBA INJ	F
FLEBOGAMMA INJ	F
GAMMAGARD INJ	F
GAMMAGARD SD INJ	F
GAMMAPLEX INJ	F
GAZYVA INJ	F
GLASSIA INJ	F
HAEGARDA INJ	F
HALAVEN INJ	F
HEPAGAM B INJ	F
HYPERHEP B INJ	F
ILARIS INJ	F
IMFINZI INJ	F
INFLECTRA INJ 100MG	F
ISTODAX (OVERFILL) INJ	F
JEMPERLI SOLN	F
JEVTANA INJ	F
KADCYLA IV SOLN	F
KALBITOR INJ	F
KEYTRUDA INJ	F
KEYTRUDA IV SOLN	F
KRYSTEXXA INJ	F
KYPROLIS SOLN	F
LARTRUVO INJ	F
LEMTRADA INJ	F
leuprolide inj	F
LIBTAYO INJ	F
LUMOXITI INJ	F
LUPRON DEPO-PED INJ	F
LUPRON DEPOT INJ/ELIGARD INJ	F
LUPRON DEPOT PEDIATRIC INJ/LUPRON DEPOT INJ	F
MARGENZA INJ	F
MONJUVI INJ	F
NAGLAZYME INJ	F
NUCALA INJ	F
NULIBRY INJ	F

Symbols and abbreviations are defined on page 1.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
OCREVUS INJ	F
OCTAGAM INJ	F
ONCASPAR INJ	F
ONPATTRO SOLN	F
OPDIVO INJ	F
ORENCIA INJ	F
OXLUMO INJ	F
PADCEV INJ	F
PANZYGA INJ	F
PEPAXTO INJ	F
PERJETA INJ	F
POLIVY INJ	F
PORTRAZZA INJ	F
PRIVIGEN INJ	F
PROLIA SOLN	F
RADICAVA INJ	F
RENFLEXIS INJ	F
RUCONEST INJ	F
RUXIENCE INJ	F
SANDOSTATIN LAR DEPOT KIT	F
SARCLISA SOLN	F
SIMPONI ARIA INJ	F
SOLIRIS IV SOLN	F
SPINRAZA INJ	F
SPRAVATO SOLN	F
SYNAGIS INJ	F
SYNRIBO INJ	F
TECENTRIQ INJ	F
TEPEZZA INJ	F
treprostinil inj	F
TRODELVY SOLN	F
TRUXIMA INJ	F
TYSABRI INJ	F
ULTOMIRIS INJ	F
VECTIBIX IV SOLN	F
VIMIZIM INJ	F
VISUDYNE INJ	F

Symbols and abbreviations are defined on page 1.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
XEOMIN INJ	F
XGEVA INJ	F
XOLAIR INJ	F
YERVOY INJ	F
ZALTRAP INJ	F
ZOLGENSMA INJ	F
ZYNLONTA SOLN	F

Symbols and abbreviations are defined on page 1.

L.A. Care Home Infusion List

Last Updated* 1/1/2022

Mandatory Specialty Pharmacy (MSP)

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

ASPARLAS INJ	BALEODAQ INJ	CRYSVITA INJ	epoprostenol inj
EVKEEZA INJ	JEMPERLI SOLN	LARTRUVO INJ	LUMOXITI INJ
MONJUVI INJ	MONOFERRIC INJ	NAGLAZYME INJ	NULIBRY INJ
ONCASPAR INJ	OXLUMO INJ	PADCEV INJ	SARCLISA SOLN
SPINRAZA INJ	sterile diluent soln	SYNRIBO INJ	treprostinil inj
TRODELVY SOLN	VIMIZIM INJ	ZOLGENSMA INJ	

Symbols and abbreviations are defined on page 1.

L.A. Care Home Infusion List
Last Updated* 1/1/2022
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
CABENUVA SUSP	QL=1 kit/month
SANDOSTATIN LAR DEPOT KIT	QL=1 kit every 4 weeks

Symbols and abbreviations are defined on page 1.

L.A. Care
HEALTH PLAN®

Toll Free: **1.855.270.2327** | TTY: **711**

lacare.org