



Express Scripts Medicare (PDP) 2020 Formulary (List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION
ABOUT SOME OF THE DRUGS COVERED BY THIS PLAN**

Formulary ID Number: 20064, v6

This formulary was updated on 08/19/2019. For more recent information or to price a medication, you can visit us on the Web at express-scripts.com. Or you can contact **Express Scripts Medicare® (PDP)** Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

Note to current members: This formulary has changed since last year. Please review this document to understand your plan's drug coverage.

When this drug list (formulary) refers to "we," "us" or "our," it means *Medco Containment Life Insurance Company* or *Medco Containment Insurance Company of New York (for employer plans domiciled in New York)*. When it refers to "plan" or "our plan," it means *Express Scripts Medicare*.

This document includes the list of the covered drugs (formulary) for our plan, which is current as of August 19, 2019. For more recent information, please contact us. Our contact information, along with the date we last updated the formulary, appears above and on the back cover.

You must use network pharmacies to fill your prescriptions to get the most from your benefit. Benefits, premium and/or copayments/coinsurance may change on January 1, 2021. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

This document is available in braille. Please contact Customer Service if you need plan information in another format.

What is the Express Scripts Medicare formulary?

The list of drugs covered by the plan is also known as the “formulary.” It contains a list of highly utilized Medicare Part D drugs selected by Express Scripts Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of Express Scripts Medicare’s standard formulary rules. **Your specific plan may provide coverage of additional drugs that are not listed in this formulary, and your plan may have different plan rules and coverage.** For more information on your plan’s specific drug coverage, please review your other plan materials, visit us on the Web at express-scripts.com or contact Customer Service.

Express Scripts Medicare will generally cover a drug as long as the drug is medically necessary, the prescription is filled at an Express Scripts Medicare network pharmacy and other plan rules are followed. For more information on how to fill your prescriptions, please review your other plan materials.

Can my drug coverage change?

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

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

- **New generic drugs.** We may immediately remove a brand-name drug on our formulary if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, if applicable, we must notify affected members of the change at least 30 days before the change becomes effective or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year.

To get current information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back covers.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular, Hypertension/Lipids.”

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 103. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the “Drug Name” column of the list.

What are generic drugs?

Both brand-name drugs and generic drugs are covered under this plan. A generic drug is approved by the FDA as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** You or your doctor is required to get prior authorization for certain drugs. This means that you will need to get approval from the plan before you fill your prescriptions. If you don't get approval, the drugs may not be covered. These drugs are noted with “PA” next to them in the formulary.

Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.

- **Quantity Limits:** For certain drugs, the amount of the drug that will be covered by the plan is limited. The plan may limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for

a certain drug, we may limit coverage for your prescription to no more than one pill per day. These drugs are noted with “QL” next to them in the formulary.

- **Step Therapy:** In some cases, you are required to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. These drugs are noted with “ST” next to them in the formulary.

You may be able to find out if your drug has any additional requirements or limits by looking in the drug list that begins on page 1. Note: This drug list includes all possible restrictions and limits on coverage. **The requirements and limits may not apply to your plan’s specific coverage.** To confirm whether a particular drug is covered, visit us on the Web at express-scripts.com or contact Customer Service.

You can ask us to make an exception to these restrictions or limits. See the section “How do I request an exception to the formulary?” below for information about how to request an exception.

What if my drug is not listed on this formulary?

If your drug is not included in this list of covered drugs, you should first contact Customer Service and ask if your drug is covered.

If you learn that your drug is not covered, you have two options:

- You can ask our Customer Service department for a list of similar drugs that are covered. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.
- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

You should talk to your doctor to decide if you should switch to an appropriate drug that the plan covers or request an exception so that the plan will cover the drug you are taking.

How do I request an exception to the formulary?

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

- You can request coverage of a drug that is not currently covered by this plan. If approved, the drug will be covered at a pre-determined cost-sharing level, and you will not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level. If your drug is contained in our Non-Preferred Drug tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in our Preferred Brand Drug tier instead. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Express Scripts Medicare limits the amount of the drug it will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

You should contact us to ask for an initial coverage decision for an exception, utilization restriction exception or to ask the plan to cover a drug that is not currently covered. **When you are requesting an**

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

Generally, your request for an exception will only be approved if the alternative drugs that are covered, the lower-tiered drugs or the additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

How do I request an appeal?

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. To start an appeal, you, your doctor or your representative must contact us.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

For more information about the appeals process, you may contact Customer Service using the information provided on the front and back covers of this document.

Can I get a temporary transition supply while I wait for an exception decision?

As a new or continuing member in our plan, you may be taking drugs that are not covered from one year to the next. Or, you may be taking a drug that is covered but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request an exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, or while you wait for a coverage decision from us, we may cover a temporary transition supply of your drug in certain cases during the first 90 days that you are enrolled in the plan or at the start of a new coverage year.

For each of your drugs that is not on our formulary, or if your ability to get drugs is limited, we will cover a temporary transition supply when you go to a network pharmacy. This temporary transition supply will be for a one-month supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum of a one-month supply of medication. After your first refill of a one-month supply, we will not pay for these drugs, even if you have been a plan member less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary, or if your ability to get your drug is limited but you are past the first 90 days of membership in our plan, we will cover a minimum of a 31-day emergency transition supply of that drug while you pursue an exception.

Other times when we will cover at least a temporary 30-day transition supply (or less, if you have a prescription written for fewer days) include:

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility

- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

Express Scripts Medicare will send you a letter within 3 business days of your filling a temporary transition supply notifying you that this was a temporary supply and explaining your options.

Other coverage that your plan may provide

Your plan **may** also cover categories of “excluded” drugs that are not normally covered by a Medicare prescription drug plan and are not listed in the formulary. **Drugs in the following categories may be covered subject to the rules and limitations of your specific plan:**

- Prescription drugs when used for anorexia, weight loss or weight gain
- Prescription drugs when used to promote fertility
- Prescription drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs)
- Drugs when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR[®], XELODA[®])
- Non-prescription drugs, also known as over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

Please contact Customer Service for additional information about your plan’s specific drug coverage and your cost-sharing amount. **Please note:** Costs for excluded drugs not normally covered by a Medicare prescription drug plan will not count toward your Medicare prescription drug yearly deductible (if applicable), total drug costs or yearly out-of-pocket expenses.

Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by this plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 103.

The “Drug Name” column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., CRESTOR[®]) and generic drugs are listed in lowercase italics (e.g., *atorvastatin*). The information in the “Requirements/Limits” column tells you if there are any special requirements for coverage of that particular drug.

If you are not sure whether your drug is covered, please visit our website or contact Customer Service using the information provided on the front and back covers of this formulary.

Your Costs

The amount you pay for a covered drug will depend on:

- **Your coverage stage.** Your plan has different stages of coverage. In each stage, the amount you pay for a drug may change. Please refer to your other plan documents for more information about your specific prescription drug benefit.
- **The drug tier for your drug.** Each covered drug is in one of three drug tiers. Each tier may have a different cost-sharing amount. The “Drug Tiers” chart below explains what types of drugs are included in each tier and shows how costs may change with each tier.

Your other plan materials have more information about your plan’s coverage stages and list the specific cost-sharing amounts for each tier.

Drug Tiers

Tier	Includes	Helpful tips
Tier 1: Generic Drugs	This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.	Use Tier 1 drugs for the lowest cost-sharing amount.
Tier 2: Preferred Brand Drugs	This tier includes preferred brand-name drugs as well as some generic drugs.	Drugs in this tier will generally have lower cost-sharing amounts than non-preferred drugs.
Tier 3: Non-Preferred Drugs	This tier includes non-preferred brand-name drugs as well as some generic drugs.	Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred brand-name drug may be right for you.

If you qualify for Extra Help

If you qualify for Extra Help from Medicare to help pay for your prescription drugs, your cost-sharing amounts may be lower than your plan’s standard benefit. Members who qualify for Extra Help will receive a notice called “Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs” (“Low Income Rider” or “LIS Rider”). Please read it to find out what your costs are. You can also contact Customer Service with any questions using the information listed on the front and back covers of this formulary.

For more information

For more detailed information about your Medicare prescription drug coverage and your plan’s specific costs, please review your other plan materials.

If you need additional information on network pharmacies or if you have any other questions, please contact our Customer Service department using the information provided on the front and back covers of this formulary.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or visit <https://www.medicare.gov>.

Below is a list of abbreviations that may appear on the following pages in the “Requirements/Limits” column that tells you if there are any special requirements for coverage of your drug.

Note: The following drug list includes all possible restrictions and limitations. **Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list.**

To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

List of abbreviations

LA: Limited Availability. This prescription drug may be available only at certain pharmacies. For more information, contact Customer Service using the information provided on the front and back covers of this formulary.

MO: Mail-Order Drug. This prescription drug is available through our home delivery service, as well as through our retail network pharmacies. Consider using home delivery for your long-term (maintenance) medications, such as high blood pressure medications. Retail network pharmacies may be more appropriate for short-term prescriptions, such as antibiotics.

PA: Prior Authorization. The plan requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescription. If you don't get approval, we may not cover this drug.

QL: Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

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

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits			
ANTI - INFECTIVES								
ANTIFUNGAL AGENTS								
ABELCET	2	PA; MO	NOXAFIL ORAL	2	MO			
AMBISOME	2	PA; MO	<i>nystatin oral suspension</i>	1	MO			
<i>amphotericin b</i>	3	PA; MO	<i>nystatin oral tablet</i>	1	MO			
ANCOBON	3	MO	ORAVIG	3	MO			
CANCIDAS	3	PA; MO	SPORANOX	3	MO			
<i>caspofungin</i>	1	PA	<i>terbinafine hcl oral</i>	1	MO			
<i>clotrimazole mucous membrane</i>	1	MO	TOLSURA	3	MO			
CRESEMBA ORAL	2	MO	VFEND	3	MO			
DIFLUCAN	3	MO	VFEND IV	3	PA; MO			
ERAXIS(WATER DILUENT)	3	MO	<i>voriconazole intravenous</i>	1	PA; MO			
<i>fluconazole</i>	1	MO	<i>voriconazole oral</i>	1	MO			
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	1	PA; MO	ANTIVIRALS					
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	1	PA	<i>abacavir</i>	1	MO			
<i>flucytosine</i>	1	MO	<i>abacavir-lamivudine</i>	1	MO			
<i>griseofulvin microsize</i>	1	MO	<i>abacavir-lamivudine-zidovudine</i>	1	MO			
<i>griseofulvin ultramicrosize</i>	1	MO	<i>acyclovir oral capsule</i>	1	MO			
<i>itraconazole</i>	1	MO	<i>acyclovir oral suspension 200 mg/5 ml</i>	1	MO			
<i>ketoconazole oral</i>	1	MO	<i>acyclovir oral tablet</i>	1	MO			
MYCAMINE	2	MO	<i>acyclovir sodium intravenous solution</i>	3	PA; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
APTIVUS ORAL SOLUTION	2		EPIVIR HBV ORAL SOLUTION	2	MO
<i>atazanavir</i>	1	MO	EPIVIR HBV ORAL TABLET	3	MO
ATRIPLA	2	MO	EPZICOM	3	MO
BARACLUDE ORAL SOLUTION	2	MO	EVOTAZ	3	MO
BARACLUDE ORAL TABLET	3	MO	<i>famciclovir</i>	1	MO
BIKTARVY	2	MO	FLUMADINE ORAL TABLET	3	MO
CIMDUO	2	MO	<i>fosamprenavir</i>	1	MO
COMBIVIR	3	MO	FUZEON SUBCUTANEOUS RECON SOLN	2	MO
COMPLERA	2	MO	GENVOYA	2	MO
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	2	MO	HARVONI	2	PA; MO; QL (28 per 28 days)
DAKLINZA ORAL TABLET 30 MG, 60 MG	3	PA; MO; QL (28 per 28 days)	HEPSERA	3	MO
DELSTRIGO	3	MO	INTELENCE	2	MO
DESCOVY	2	MO	INVIRASE ORAL TABLET	2	MO
<i>didanosine oral capsule, delayed release(dr/ec) 250 mg, 400 mg</i>	1	MO	ISENTRESS	2	MO
DOVATO	2	MO	ISENTRESS HD	2	MO
EDURANT	2	MO	JULUCA	3	MO
<i>efavirenz</i>	1	MO	KALETRA ORAL SOLUTION	3	MO
EMTRIVA	2	MO	KALETRA ORAL TABLET	2	MO
<i>entecavir</i>	1	MO	<i>lamivudine</i>	1	MO
EPCLUSIA	2	PA; MO; QL (28 per 28 days)	<i>lamivudine-zidovudine</i>	1	MO
EPIVIR	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
LEDIPASVIR-SOFOSBUVIR	3	PA; MO; QL (28 per 28 days)	PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	2	MO
LEXIVA ORAL SUSPENSION	2	MO	REBETOL ORAL SOLUTION	2	MO
LEXIVA ORAL TABLET	3	MO	RELENZA DISKHALER	2	MO
<i>lopinavir-ritonavir</i>	1	MO	SCRIPTOR ORAL TABLET	2	MO
MAVYRET	3	PA; MO; QL (84 per 28 days)	RETROVIR ORAL CAPSULE	3	MO
<i>nevirapine oral suspension</i>	1		RETROVIR ORAL SYRUP	3	MO
<i>nevirapine oral tablet</i>	1	MO	REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	3	MO
<i>nevirapine oral tablet extended release 24 hr</i>	1	MO	REYATAZ ORAL POWDER IN PACKET	2	MO
NORVIR ORAL POWDER IN PACKET	2	MO	<i>ribasphere oral capsule</i>	1	MO
NORVIR ORAL SOLUTION	2	MO	<i>ribasphere oral tablet 600 mg</i>	1	MO
NORVIR ORAL TABLET	3	MO	<i>ribasphere ribapak oral tablets, dose pack 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)</i>	1	MO
ODEFSEY	2	MO	<i>ribavirin oral capsule</i>	1	MO
<i>oseltamivir</i>	1	MO	<i>ribavirin oral tablet 200 mg</i>	1	MO
PIFELTRO	3	MO	<i>rimantadine</i>	1	MO
PREVYMIS ORAL	2	MO; QL (30 per 30 days)	<i>ritonavir</i>	1	MO
PREZCOBIX	3	MO			
PREZISTA ORAL SUSPENSION	2	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
SELZENTRY	2	MO	VEMLIDY	2	MO
SOFOSBUVIR-VELPATASVIR	3	PA; MO; QL (28 per 28 days)	VIDEX 4 GRAM PEDIATRIC	2	MO
SOVALDI	3	PA; MO; QL (28 per 28 days)	VIDEX EC ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 125 MG, 250 MG, 400 MG	3	MO
<i>stavudine oral capsule</i>	1	MO	VIDEX EC ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 200 MG	2	MO
STRIBILD	2	MO	VIEKIRA PAK	3	PA; MO; QL (112 per 28 days)
SUSTIVA	3	MO	VIRACEPT ORAL TABLET	2	MO
SYMFI	2	MO	VIRAMUNE	3	MO
SYMFI LO	2	MO	VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR 400 MG	3	MO
SYMTUZA	3	MO	VIREAD ORAL POWDER	2	MO
TAMIFLU	3	MO	VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	2	MO
<i>tenofovir disoproxil fumarate</i>	1	MO	VIREAD ORAL TABLET 300 MG	3	MO
TIVICAY	2	MO	VOSEVI	3	PA; MO; QL (28 per 28 days)
TRIUMEQ	2	MO	XOFLUZA	2	MO
TRIZIVIR	3	MO			
TRUVADA	2	MO			
TYBOST	3	MO			
<i>valacyclovir oral tablet 1 gram</i>	1	MO; QL (120 per 30 days)			
<i>valacyclovir oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)			
VALCYTE	3	MO			
<i>valganciclovir</i>	1	MO			
VALTREX ORAL TABLET 1 GRAM	3	MO; QL (120 per 30 days)			
VALTREX ORAL TABLET 500 MG	3	MO; QL (60 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ZEPATIER	3	PA; MO; QL (28 per 28 days)	<i>cefaezolin injection recon soln 1 gram, 500 mg</i>	1	MO
ZIAGEN	3	MO	<i>cefaezolin injection recon soln 10 gram</i>	1	
<i>zidovudine</i>	1	MO	<i>cefdinir</i>	1	MO
ZOVIRAX ORAL CAPSULE	3	MO	<i>cefepime injection</i>	1	MO
ZOVIRAX ORAL SUSPENSION	3	MO	<i>cefixime oral suspension for reconstitution</i>	1	MO
ZOVIRAX ORAL TABLET 800 MG	3	MO	<i>cefotetan injection</i>	1	
CEPHALOSPORINS			<i>cefoxitin intravenous recon soln 1 gram, 2 gram</i>	1	MO
AVYCAZ	3	MO	<i>cefoxitin intravenous recon soln 10 gram</i>	1	
<i>cefaclor oral capsule</i>	1	MO	<i>cefpodoxime</i>	1	MO
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	1	MO	<i>cefprozil</i>	1	MO
<i>cefaclor oral suspension for reconstitution 375 mg/5 ml</i>	1		<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	1	MO
<i>cefaclor oral tablet extended release 12 hr</i>	1	MO	<i>ceftazidime injection recon soln 6 gram</i>	1	
<i>cefadroxil oral capsule</i>	1	MO	<i>ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg</i>	1	MO
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	1	MO	<i>ceftriaxone injection recon soln 10 gram</i>	1	
<i>cefadroxil oral tablet</i>	1	MO	<i>cefuroxime axetil oral tablet</i>	1	MO
			<i>cefuroxime sodium injection recon soln 750 mg</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	1	MO	ERYTHROMYCINS / OTHER MACROLIDES		
<i>cefuroxime sodium intravenous recon soln 7.5 gram</i>	1		<i>azithromycin intravenous</i>	1	MO
<i>cephalexin</i>	1	MO	<i>azithromycin oral packet</i>	1	MO
MAXIPIME INJECTION RECON SOLN 1 GRAM	3	MO	<i>azithromycin oral suspension for reconstitution</i>	1	MO
MAXIPIME INTRAVENOUS RECON SOLN 2 GRAM	3		<i>azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 600 mg</i>	1	MO
SUPRAX ORAL CAPSULE	3	MO	<i>azithromycin oral tablet 500 mg (3 pack)</i>	1	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION N 100 MG/5 ML, 200 MG/5 ML	3	MO	<i>clarithromycin</i>	1	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION N 500 MG/5 ML	3		<i>DIFICID</i>	3	MO
SUPRAX ORAL TABLET,CHEWABLE	3	MO	<i>e.e.s. 400 oral tablet</i>	1	MO
<i>tazicef injection recon soln 1 gram</i>	1		<i>E.E.S. GRANULES</i>	3	MO
<i>tazicef injection recon soln 2 gram, 6 gram</i>	1	MO	<i>ERYPED 200</i>	3	MO
TEFLARO	3	MO	<i>ERYPED 400</i>	3	MO
ZERBAXA	3		<i>ery-tab oral tablet,delayed release (dr/ec) 250 mg, 333 mg</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	2	MO	<i>amikacin injection solution 500 mg/2 ml</i>	1	MO
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	1	MO	ARIKAYCE	2	PA; MO; LA
<i>erythromycin ethylsuccinate oral tablet</i>	1	MO	<i>atovaquone</i>	1	MO
<i>erythromycin oral capsule,delayed release(dr/ec)</i>	1	MO	<i>atovaquone-proguanil</i>	1	MO
<i>erythromycin oral tablet</i>	1	MO	AZACTAM	3	MO
ZITHROMAX INTRAVENOUS	3	MO	<i>aztreonam injection recon soln 1 gram</i>	1	MO
ZITHROMAX ORAL PACKET	3	MO	BENZNIDAZOLE	2	
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	3	MO	BETHKIS	2	PA; MO; QL (224 per 28 days)
ZITHROMAX ORAL TABLET 250 MG, 500 MG	3	MO	BILTRICIDE	3	MO
ZITHROMAX TRI-PAK	3	MO	CAYSTON	2	PA; MO; LA; QL (84 per 28 days)
ZITHROMAX Z-PAK	3	MO	<i>chloroquine phosphate</i>	1	MO
MISCELLANEOUS ANTIINFECTIVES			CLEOCIN HCL	3	MO
<i>albendazole</i>	1	MO	CLEOCIN IN 5 % DEXTROSE INTRAVENOUS PIGGYBACK 300 MG/50 ML, 900 MG/50 ML	3	
ALINIA	2	MO	CLEOCIN IN 5 % DEXTROSE INTRAVENOUS PIGGYBACK 600 MG/50 ML	3	MO
			CLEOCIN INJECTION	3	MO
			CLEOCIN PEDIATRIC	3	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>clindamycin hcl</i>	1	MO	<i>gentamicin in nacl (iso-osm)</i>	1	MO
<i>clindamycin in 5 % dextrose</i>	1	MO	<i>intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml</i>		
<i>clindamycin pediatric</i>	1	MO	<i>gentamicin in nacl (iso-osm)</i>	1	
<i>clindamycin phosphate injection</i>	1	MO	<i>intravenous piggyback 80 mg/100 ml</i>		
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	1	MO	<i>gentamicin injection solution 40 mg/ml</i>	1	MO
COARTEM	2	MO	<i>hydroxychloroquine</i>	1	MO
<i>colistin (colistimethate na)</i>	1	MO	<i>imipenem-cilastatin</i>	1	MO
CUBICIN	3	MO	INVANZ INJECTION	3	MO
DALVANCE	3	MO	<i>isoniazid oral</i>	1	MO
<i>dapsone oral</i>	1	MO	<i>ivermectin</i>	1	MO
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	2	MO	KITABIS PAK	3	MO
<i>daptomycin intravenous recon soln 500 mg</i>	1	MO	KRINTAFEL	3	MO
DARAPRIM	2	PA; MO	<i>linezolid</i>	1	MO
EMVERM	2	MO	<i>linezolid in dextrose 5%</i>	1	
<i>ertapenem</i>	1	MO	MALARONE	3	MO
<i>ethambutol</i>	1	MO	MALARONE PEDIATRIC	3	MO
FIRVANQ	3	MO	<i>mefloquine</i>	1	MO
FLAGYL	3	MO	MEPRON	3	MO
			<i>meropenem</i>	1	MO
			MERREM INTRAVENOUS RECON SOLN 500 MG	3	

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>metronidazole in nacl (iso-os)</i>	1	MO	SIRTURO	2	MO; LA
<i>metronidazole oral</i>	1	MO	SIVEXTRO INTRAVENOUS	3	
MYAMBUTOL ORAL TABLET 400 MG	3	MO	SIVEXTRO ORAL	3	MO
MYCOBUTIN	3	MO	SOLOSEC	3	MO
NEBUPENT	2	PA; MO; QL (1 per 28 days)	STREPTOMYCIN	2	MO
<i>neomycin</i>	1	MO	STROMECTOL	3	MO
<i>paromomycin</i>	3	MO	<i>tigecycline</i>	1	
PASER	2	MO	<i>tinidazole</i>	1	MO
PENTAM	3	MO	TOBI	3	PA; MO; QL (280 per 28 days)
PLAQUENIL	3	MO	TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	2	MO; QL (224 per 28 days)
<i>polymyxin b sulfate</i>	1	MO	<i>tobramycin in 0.225 % nacl</i>	1	PA; MO; QL (280 per 28 days)
<i>praziquantel</i>	1	MO	<i>tobramycin sulfate injection solution</i>	1	MO
PRIFTIN	2	MO	TRECATOR	2	MO
PRIMAQUINE	2	MO	TYGACIL	3	MO
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	3	MO	VABOMERE	3	
<i>pyrazinamide</i>	1	MO	VANCOCIN	3	MO
QUALAQUIN	3	MO	<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	1	MO
<i>quinine sulfate</i>	1	MO			
<i>rifabutin</i>	1	MO			
RIFADIN ORAL CAPSULE 150 MG	3	MO			
RIFAMATE	3	MO			
<i>rifampin</i>	1	MO			
RIFATER	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
VANCOMYCIN INTRAVENOUS RECON SOLN 250 MG	3		<i>ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram</i>	1	MO
<i>vancomycin oral capsule</i>	1	MO	<i>ampicillin-sulbactam injection recon soln 15 gram</i>	1	
XIFAXAN ORAL TABLET 200 MG	2	MO; QL (9 per 30 days)	AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	2	MO
XIFAXAN ORAL TABLET 550 MG	2	MO; QL (90 per 30 days)	BICILLIN C-R	2	MO
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	3	MO	BICILLIN L-A	2	MO
ZYVOX ORAL	3	MO	<i>dicloxacillin</i>	1	MO
PENICILLINS			<i>nafcillin injection</i>	1	MO
<i>amoxicillin oral capsule</i>	1	MO	<i>oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	1	
<i>amoxicillin oral suspension for reconstitution</i>	1	MO	<i>oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml</i>	1	MO
<i>amoxicillin oral tablet</i>	1	MO	<i>oxacillin injection recon soln 1 gram, 10 gram</i>	1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	MO	<i>oxacillin injection recon soln 2 gram</i>	1	MO
<i>amoxicillin-pot clavulanate</i>	1	MO			
<i>ampicillin oral capsule 500 mg</i>	1	MO			
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML	2		ZOSYN IN DEXTROSE (ISO- OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	3	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 3 MILLION UNIT/50 ML	2	MO	ZOSYN IN DEXTROSE (ISO- OSM) INTRAVENOUS PIGGYBACK 3.375 GRAM/50 ML	3	MO
<i>penicillin g potassium injection recon soln 20 million unit</i>	1	MO	ZOSYN INTRAVENOUS RECON SOLN 40.5 GRAM	3	MO
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	1	MO	QUINOLONES		
<i>penicillin g sodium</i>	1	MO	AVELOX	3	MO
<i>penicillin v potassium</i>	1	MO	BAXDELA INTRAVENOUS	3	
<i>piperacillin- tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	1	MO	BAXDELA ORAL	3	MO
UNASYN INJECTION RECON SOLN 15 GRAM	3		CIPRO ORAL SUSPENSION,MIC ROCAPSULE RECON	3	MO
UNASYN INJECTION RECON SOLN 3 GRAM	3	MO	CIPRO ORAL TABLET 250 MG, 500 MG	3	MO
			<i>ciprofloxacin hcl oral</i>	1	MO
			<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>ciprofloxacin oral suspension,microcapsule recon 500 mg/5 ml</i>	1		<i>doxycycline hyclate oral capsule</i>	1	MO
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	1	MO	<i>doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg</i>	1	MO
<i>levofloxacin intravenous</i>	1	MO	<i>doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 150 mg, 200 mg, 50 mg, 75 mg</i>	1	MO
<i>levofloxacin oral</i>	1	MO	<i>doxycycline monohydrate oral capsule</i>	1	MO
<i>moxifloxacin oral</i>	1	MO	<i>doxycycline monohydrate oral suspension for reconstitution</i>	1	MO
<i>moxifloxacin-sod.chloride(iso)</i>	1		<i>doxycycline monohydrate oral tablet</i>	1	MO
<i>ofloxacin oral tablet 300 mg</i>	1		<i>MINOCIN ORAL CAPSULE 50 MG</i>	3	ST; MO
<i>ofloxacin oral tablet 400 mg</i>	1	MO	<i>minocycline oral capsule</i>	1	MO
SULFA'S / RELATED AGENTS					
<i>BACTRIM</i>	3	MO	<i>minocycline oral tablet</i>	1	MO
<i>BACTRIM DS</i>	3	MO	<i>minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 65 mg, 80 mg, 90 mg</i>	1	MO
<i>sulfadiazine</i>	3	MO	<i>minocycline oral tablet extended release 24 hr 55 mg</i>	1	ST; MO
<i>sulfamethoxazole-trimethoprim oral</i>	1	MO			
TETRACYCLINES					
<i>demeclacycline</i>	3	MO			
<i>DORYX MPC</i>	3	ST; MO			
<i>DORYX ORAL TABLET,DELAYE D RELEASE (DR/EC) 200 MG, 50 MG</i>	3	ST; MO			
<i>doxy-100</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>monodoxine nl oral capsule 100 mg, 75 mg</i>	1	MO	FURADANTIN	3	
<i>morgidox oral capsule 50 mg</i>	1	MO	HIPREX	3	MO
NUZYRA (7 DAY WITH LOAD DOSE)	3	ST	MACROBID	3	MO
NUZYRA (7 DAY)	3	ST	MACRODANTIN	3	MO
NUZYRA INTRAVENOUS	3		<i>methenamine hippurate</i>	1	MO
NUZYRA ORAL	3	ST; MO	MONUROL	3	MO
ORACEA	3	ST; MO	<i>nitrofurantoin</i>	1	MO
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	3	ST; MO	<i>nitrofurantoin macrocrystal</i>	1	MO
<i>soloxide</i>	1		<i>nitrofurantoin monohyd/m-cryst</i>	1	MO
TARGADOX	3	ST; MO	<i>trimethoprim</i>	1	MO
<i>tetracycline</i>	1	MO	ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
VIBRAMYCIN ORAL CAPSULE 100 MG	3	ST; MO	ADJUNCTIVE AGENTS		
VIBRAMYCIN ORAL SUSPENSION FOR RECONSTITUTION	3	MO	<i>leucovorin calcium oral</i>	1	MO
VIBRAMYCIN ORAL SYRUP	2	MO	MESNEX ORAL	2	MO
XIMINO	3	ST; MO	XGEVA	2	PA; MO
URINARY TRACT AGENTS			ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
			<i>abiraterone</i>	1	PA; MO; QL (120 per 30 days)
			AFINITOR	2	PA; MO; QL (30 per 30 days)
			AFINITOR DISPERZ	2	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ALECENSA	2	PA; MO; QL (240 per 30 days)	CAPRELSA ORAL TABLET 100 MG	2	PA; LA; QL (60 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	3	PA; MO; QL (30 per 30 days)	CAPRELSA ORAL TABLET 300 MG	2	PA; MO; LA; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	3	PA; MO; QL (60 per 30 days)	CASODEX	3	MO
ALUNBRIG ORAL TABLETS,DOSE PACK	3	PA; MO; QL (30 per 30 days)	CELLCEPT	3	PA; MO
<i>anastrozole</i>	1	MO	COMETRIQ	2	PA; MO
ARIMIDEX	3	MO	COPIKTRA	3	PA; MO; LA; QL (60 per 30 days)
AROMASIN	3	MO	COTELLIC	2	PA; MO; LA; QL (63 per 28 days)
ASTAGRAF XL	3	PA; MO	<i>cyclophosphamide oral capsule</i>	1	PA; MO
AZASAN	3	PA; MO	<i>cyclosporine modified</i>	1	PA; MO
<i>azathioprine</i>	1	PA; MO	<i>cyclosporine oral capsule</i>	1	PA; MO
BALVERSA	2	PA; MO; LA	DAURISMO ORAL TABLET 100 MG	3	PA; MO; QL (30 per 30 days)
<i>bexarotene</i>	1	PA; MO	DAURISMO ORAL TABLET 25 MG	3	PA; MO; QL (60 per 30 days)
<i>bicalutamide</i>	1	MO	DROXIA	2	MO
BOSULIF ORAL TABLET 100 MG	2	PA; MO; QL (90 per 30 days)	ELIGARD	3	PA; MO
BOSULIF ORAL TABLET 400 MG, 500 MG	2	PA; MO; QL (30 per 30 days)	ELIGARD (3 MONTH)	3	PA; MO
BRAFTOVI ORAL CAPSULE 75 MG	2	PA; MO; LA; QL (180 per 30 days)	ELIGARD (4 MONTH)	3	PA; MO
CABOMETYX	3	PA; MO; LA	ELIGARD (6 MONTH)	3	PA; MO
CALQUENCE	3	PA; MO; LA; QL (60 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
EMCYT	2	MO	GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	2	MO
ENVARSUS XR	3	PA; MO	HYDREA	3	MO
ERIVEDGE	2	PA; MO; QL (30 per 30 days)	<i>hydroxyurea</i>	1	MO
ERLEADA	2	PA; MO	IBRANCE	2	PA; MO; QL (21 per 28 days)
<i>erlotinib oral tablet 100 mg, 150 mg</i>	1	PA; MO; QL (30 per 30 days)	ICLUSIG ORAL TABLET 15 MG	2	PA; MO; QL (60 per 30 days)
<i>erlotinib oral tablet 25 mg</i>	1	PA; MO; QL (60 per 30 days)	ICLUSIG ORAL TABLET 45 MG	2	PA; MO; QL (30 per 30 days)
exemestane	1	MO	IDHIFA	2	PA; MO; LA; QL (30 per 30 days)
FARESTON	3	MO	<i>imatinib oral tablet 100 mg</i>	1	PA; MO; QL (180 per 30 days)
FARYDAK	3	PA; MO; QL (6 per 21 days)	<i>imatinib oral tablet 400 mg</i>	1	PA; MO; QL (60 per 30 days)
FEMARA	3	MO	IMBRUVICA ORAL CAPSULE 140 MG	2	PA; MO; QL (120 per 30 days)
FIRMAGON KIT W DILUENT SYRINGE	2	PA; MO	IMBRUVICA ORAL CAPSULE 70 MG	2	PA; MO; QL (30 per 30 days)
flutamide	1	MO	IMBRUVICA ORAL TABLET	2	PA; MO; QL (30 per 30 days)
<i>genograf oral capsule 100 mg, 25 mg</i>	1	PA; MO	IMURAN	3	PA; MO
<i>genograf oral solution</i>	1	PA; MO	INLYTA ORAL TABLET 1 MG	2	PA; MO; QL (180 per 30 days)
GILOTrif	2	PA; MO; QL (30 per 30 days)			
GLEEVEC ORAL TABLET 100 MG	3	PA; MO; QL (180 per 30 days)			
GLEEVEC ORAL TABLET 400 MG	3	PA; MO; QL (60 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
INLYTA ORAL TABLET 5 MG	2	PA; MO; QL (120 per 30 days)	LYSODREN	2	MO
IRESSA	2	PA; MO; QL (30 per 30 days)	MATULANE	2	MO
JAKAFI	2	PA; MO; QL (60 per 30 days)	<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml</i>	1	PA; MO
KISQALI	3	PA; MO	<i>megestrol oral tablet</i>	1	PA; MO
KISQALI FEMARA CO-PACK	3	PA; MO	MEKINIST ORAL TABLET 0.5 MG	2	PA; MO; QL (90 per 30 days)
LENVIMA	2	PA; MO	MEKINIST ORAL TABLET 2 MG	2	PA; MO; QL (30 per 30 days)
<i>letrozole</i>	1	MO	MEKTOVI	2	PA; MO; LA; QL (180 per 30 days)
LEUKERAN	2	MO	<i>mercaptopurine</i>	1	MO
<i>leuprolide subcutaneous kit</i>	1	PA; MO	<i>methotrexate sodium</i>	1	PA; MO
LONSURF	2	PA; MO	<i>methotrexate sodium (pf) injection solution</i>	1	PA; MO
LORBRENA ORAL TABLET 100 MG	2	PA; MO; QL (30 per 30 days)	<i>mycophenolate mofetil</i>	1	PA; MO
LORBRENA ORAL TABLET 25 MG	2	PA; MO; QL (90 per 30 days)	<i>mycophenolate sodium</i>	1	PA; MO
LUPRON DEPOT	2	PA; MO	MYFORTIC	3	PA; MO
LUPRON DEPOT (3 MONTH)	2	PA; MO	NEORAL	3	PA; MO
LUPRON DEPOT (4 MONTH)	2	PA; MO	NERLYNX	2	PA; MO; LA
LUPRON DEPOT (6 MONTH)	2	PA; MO	NEXAVAR	2	PA; MO; LA; QL (120 per 30 days)
LYNPARZA ORAL TABLET	2	PA; MO; QL (120 per 30 days)	NILANDRON	3	MO
			<i>nilutamide</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
NINLARO	2	PA; MO; QL (3 per 28 days)	SOLTAMOX	2	MO
<i>octreotide acetate injection solution</i>	1	MO	SOMATULINE DEPOT	2	MO
ODOMZO	3	PA; MO; LA; QL (30 per 30 days)	SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	2	PA; MO; QL (30 per 30 days)
PIQRAY	2	PA; MO	SPRYCEL ORAL TABLET 20 MG, 70 MG	2	PA; MO; QL (60 per 30 days)
POMALYST	2	PA; MO; LA	STIVARGA	2	PA; MO; QL (84 per 28 days)
PROGRAF ORAL CAPSULE	3	PA; MO	SUTENT	2	PA; MO; QL (30 per 30 days)
PROGRAF ORAL GRANULES IN PACKET	2	PA; MO	SYNRIBO	2	PA; MO
PURIXAN	2		TABLOID	3	MO
RAPAMUNE	3	PA; MO	<i>tacrolimus oral</i>	1	PA; MO
REVLIMID	2	PA; MO; LA; QL (28 per 28 days)	TAFINLAR	2	PA; MO; QL (120 per 30 days)
RUBRACA	2	PA; MO; LA; QL (120 per 30 days)	TAGRISSO	2	PA; MO; LA; QL (30 per 30 days)
RYDAPT	2	PA; MO	TALZENNA ORAL CAPSULE 0.25 MG	3	PA; MO; QL (90 per 30 days)
SANDIMMUNE ORAL CAPSULE	3	PA; MO	TALZENNA ORAL CAPSULE 1 MG	3	PA; MO; QL (30 per 30 days)
SANDIMMUNE ORAL SOLUTION	2	PA; MO	<i>tamoxifen</i>	1	MO
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	3	MO	TARCEVA ORAL TABLET 100 MG, 150 MG	3	PA; MO; QL (30 per 30 days)
SIGNIFOR	2	MO			
<i>sirolimus</i>	1	PA; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
TARCEVA ORAL TABLET 25 MG	3	PA; MO; QL (60 per 30 days)	VITRAKVI ORAL CAPSULE 100 MG	2	PA; MO; LA; QL (60 per 30 days)
TARGRETIN ORAL	3	PA; MO	VITRAKVI ORAL CAPSULE 25 MG	2	PA; MO; LA; QL (180 per 30 days)
TARGRETIN TOPICAL	2	PA; MO	VITRAKVI ORAL SOLUTION	2	PA; MO; LA; QL (300 per 30 days)
TASIGNA ORAL CAPSULE 150 MG, 200 MG	2	PA; MO; QL (112 per 28 days)	VIZIMPRO	3	PA; MO; QL (30 per 30 days)
TASIGNA ORAL CAPSULE 50 MG	2	PA; MO; QL (120 per 30 days)	VOTRIENT	2	PA; MO; QL (120 per 30 days)
THALOMID	2	PA; MO	XALKORI	2	PA; MO; QL (60 per 30 days)
TIBSOVO	2	PA; MO	XATMEP	3	PA; MO
<i>toremifene</i>	1	MO	XERMELO	2	PA; MO; LA; QL (90 per 30 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	2	PA; MO	XOSPATA	2	PA; MO; LA
<i>tretinoin (chemotherapy)</i>	1	MO	XTANDI	2	PA; MO; QL (120 per 30 days)
TREXALL	3	PA; MO	YONSA	2	PA; MO; QL (120 per 30 days)
TYKERB	2	PA; MO; LA; QL (180 per 30 days)	ZEJULA	2	PA; MO; LA; QL (90 per 30 days)
VENCLEXTA	2	PA; MO; LA	ZELBORAF	2	PA; MO; QL (240 per 30 days)
VENCLEXTA STARTING PACK	2	PA; MO; LA; QL (42 per 30 days)	ZOLINZA	2	MO
VERZENIO	2	PA; MO; LA; QL (60 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ZORTRESS	2	PA; MO	CARBATROL	3	MO
ZYDELIG	2	PA; MO; QL (60 per 30 days)	CELONTIN ORAL CAPSULE 300 MG	2	MO
ZYKADIA	2	PA; MO; QL (90 per 30 days)	<i>clobazam oral suspension</i>	1	PA; MO; QL (480 per 30 days)
ZYTIGA ORAL TABLET 250 MG	3	PA; MO; QL (120 per 30 days)	<i>clobazam oral tablet</i>	1	PA; MO; QL (60 per 30 days)
ZYTIGA ORAL TABLET 500 MG	2	PA; MO; QL (60 per 30 days)	<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH			<i>clonazepam oral tablet</i>	1	MO; QL (300 per 30 days)
ANTICONVULSANTS			<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)
APTIOM	3	MO	<i>clonazepam oral tablet,disintegrating 2 mg</i>	1	MO; QL (300 per 30 days)
BANZEL	2	MO	DEPAKOTE	3	MO
BRIVIACT INTRAVENOUS	3		DEPAKOTE ER	3	MO
BRIVIACT ORAL	3	MO	DEPAKOTE SPRINKLES	3	MO
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	1	MO	DIASTAT	3	MO
<i>carbamazepine oral suspension 100 mg/5 ml</i>	1	MO	DIASTAT ACUDIAL	3	MO
<i>carbamazepine oral tablet</i>	1	MO	DILANTIN 30 MG	2	MO
<i>carbamazepine oral tablet extended release 12 hr</i>	1	MO	DILANTIN EXTENDED 100 MG	3	MO
<i>carbamazepine oral tablet,chewable</i>	1	MO	DILANTIN INFATABS 50 MG	3	MO
			DILANTIN-125 125 MG/5 ML	3	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>divalproex</i>	1	MO	GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	2	PA; MO; QL (90 per 30 days)
EPIDIOLEX	2	PA; MO; LA	KEPPRA ORAL	3	MO
<i>epitol</i>	1	MO	KEPPRA XR	3	MO
EQUETRO	3	MO	KLONOPIN ORAL TABLET 0.5 MG, 1 MG	3	MO; QL (90 per 30 days)
<i>ethosuximide</i>	1	MO	KLONOPIN ORAL TABLET 2 MG	3	MO; QL (300 per 30 days)
<i>felbamate</i>	1	MO	LAMICTAL ODT	3	MO
FELBATOL	3	MO	LAMICTAL ORAL TABLET	3	MO
FYCOMPA ORAL SUSPENSION	2	MO	LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	3	MO
FYCOMPA ORAL TABLET	2	MO	LAMICTAL STARTER (BLUE) KIT	3	MO
<i>gabapentin oral capsule 100 mg, 400 mg</i>	1	MO; QL (270 per 30 days)	LAMICTAL STARTER (GREEN) KIT	3	MO
<i>gabapentin oral capsule 300 mg</i>	1	MO; QL (360 per 30 days)	LAMICTAL STARTER (ORANGE) KIT	3	MO
<i>gabapentin oral solution 250 mg/5 ml</i>	1	MO; QL (2160 per 30 days)	LAMICTAL XR	3	MO
<i>gabapentin oral tablet 600 mg</i>	1	MO; QL (180 per 30 days)	LAMICTAL XR STARTER (BLUE)	3	MO
<i>gabapentin oral tablet 800 mg</i>	1	MO; QL (120 per 30 days)	LAMICTAL XR STARTER (GREEN)	3	MO
GABITRIL	3	MO			
GRALISE 30-DAY STARTER PACK	2	PA; QL (78 per 30 days)			
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	2	PA; MO; QL (30 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
LAMICTAL XR STARTER (ORANGE)	3	MO	LYRICA ORAL CAPSULE 225 MG, 300 MG	2	MO; QL (60 per 30 days)
<i>lamotrigine oral tablet</i>	1	MO	LYRICA ORAL SOLUTION	2	MO; QL (900 per 30 days)
<i>lamotrigine oral tablet extended release 24hr</i>	3	MO	MYSOLINE	3	MO
<i>lamotrigine oral tablet, chewable dispersible</i>	1	MO	NEURONTIN ORAL CAPSULE 100 MG, 400 MG	3	MO; QL (270 per 30 days)
<i>lamotrigine oral tablet,disintegrating</i>	3	MO	NEURONTIN ORAL CAPSULE 300 MG	3	MO; QL (360 per 30 days)
<i>lamotrigine oral tablets,dose pack</i>	1	MO	NEURONTIN ORAL SOLUTION	3	MO; QL (2160 per 30 days)
<i>levetiracetam oral solution 100 mg/ml</i>	1	MO	NEURONTIN ORAL TABLET 600 MG	3	MO; QL (180 per 30 days)
<i>levetiracetam oral tablet</i>	1	MO	NEURONTIN ORAL TABLET 800 MG	3	MO; QL (120 per 30 days)
<i>levetiracetam oral tablet extended release 24 hr</i>	1	MO	ONFI ORAL SUSPENSION	3	PA; MO; QL (480 per 30 days)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG	3	PA; MO; QL (30 per 30 days)	ONFI ORAL TABLET 10 MG, 20 MG	3	PA; MO; QL (60 per 30 days)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG	3	PA; MO; QL (60 per 30 days)	<i>oxcarbazepine</i>	1	MO
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	2	MO; QL (90 per 30 days)	OXTELLAR XR	3	MO
			PEGANONE	2	MO
			<i>phenobarbital</i>	1	PA; MO
			PHENYTEK	3	MO
			<i>phenytoin oral suspension 125 mg/5 ml</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>phenytoin oral tablet, chewable</i>	1	MO	<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	1	MO
<i>phenytoin sodium extended</i>	1	MO	<i>vigabatrin</i>	1	MO; LA
<i>primidone</i>	1	MO	<i>vigadronate</i>	1	MO; LA
QUDEXY XR	3	PA; MO	VIMPAT ORAL SOLUTION	2	MO
<i>roweepra</i>	1	MO	VIMPAT ORAL TABLET	2	MO
<i>roweepra xr</i>	1	MO	ZARONTIN	3	MO
SABRIL	3	MO; LA	ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	3	PA; MO
SPRITAM	3	MO	zonisamide	1	PA; MO
SYMPAZAN	3	PA; MO; QL (60 per 30 days)	ANTIPARKINSONISM AGENTS		
TEGRETOL ORAL SUSPENSION	3	MO	APOKYN	2	MO; LA
TEGRETOL ORAL TABLET	3	MO	AZILECT	3	MO
TEGRETOL XR	3	MO	<i>benztropine oral</i>	1	PA; MO
<i>tiagabine</i>	3	MO	<i>bromocriptine</i>	3	MO
TOPAMAX	3	PA; MO	<i>carbidopa</i>	1	MO
<i>topiramate oral capsule, sprinkle</i>	1	PA; MO	<i>carbidopa-levodopa</i>	1	MO
TOPIRAMATE ORAL CAPSULE, SPRINKLE, ER 24HR	3	PA; MO	<i>carbidopa-levodopa-entacapone</i>	3	MO
<i>topiramate oral tablet</i>	1	PA; MO	COMTAN	3	MO
TRILEPTAL	3	MO	DUOPA	3	PA; MO
TROKENDI XR	3	PA; MO	<i>entacapone</i>	1	MO
<i>valproic acid</i>	1	MO	GOCOVRI ORAL CAPSULE, EXTENDED RELEASE 24HR 137 MG	3	PA; MO; QL (60 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 68.5 MG	3	PA; MO; QL (30 per 30 days)	STALEVO 75	3	MO
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	3	PA; MO	TASMAR ORAL TABLET 100 MG	3	MO
LODOSYN	3	MO	<i>tolcapone</i>	1	MO
MIRAPEX	3	MO	XADAGO	3	MO
MIRAPEX ER	3	MO	ZELAPAR	3	MO
NEUPRO	2	MO	MIGRAINE / CLUSTER HEADACHE THERAPY		
OSMOLEX ER	3	PA; MO	AIMOVIG AUTOINJECTOR	2	PA; MO; QL (1 per 30 days)
PARLODEL	3	MO	AJOVY	3	PA; MO; QL (1.5 per 30 days)
<i>pramipexole</i>	1	MO	<i>almotriptan malate oral tablet 12.5 mg</i>	1	MO; QL (24 per 28 days)
<i>rasagiline</i>	1	MO	<i>almotriptan malate oral tablet 6.25 mg</i>	1	MO; QL (18 per 28 days)
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 6 MG	3	MO	AMERGE	3	MO; QL (18 per 28 days)
<i>ropinirole</i>	1	MO	CAFERGOT	3	MO
RYTARY	3	MO	<i>dihydroergotamine nasal</i>	1	MO; QL (8 per 28 days)
<i>selegiline hcl</i>	1	MO	<i>eletriptan</i>	1	MO; QL (18 per 28 days)
SINEMET	3	MO	EMGALITY PEN	2	PA; MO; QL (2 per 30 days)
SINEMET CR	3	MO	EMGALITY SUBCUTANEOUS SYRINGE 100 MG/ML	2	PA; MO; QL (3 per 30 days)
STALEVO 100	3	MO	EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	2	PA; MO; QL (2 per 30 days)
STALEVO 125	3	MO			
STALEVO 150	3	MO			
STALEVO 200	3	MO			
STALEVO 50	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>ergotamine-caffeine</i>	1	MO	<i>naratriptan</i>	1	MO; QL (18 per 28 days)
FROVA	3	MO; QL (27 per 28 days)	ONZETRA XSAIL	3	MO; QL (32 per 28 days)
<i>frovatriptan</i>	1	MO; QL (27 per 28 days)	RELPAX	3	MO; QL (18 per 28 days)
IMITREX NASAL SPRAY, NON-AEROSOL 20 MG/ACTUATION	3	MO; QL (18 per 28 days)	<i>rizatriptan</i>	1	MO; QL (36 per 28 days)
IMITREX NASAL SPRAY, NON-AEROSOL 5 MG/ACTUATION	3	MO; QL (36 per 28 days)	<i>sumatriptan nasal spray, non-aerosol 20 mg/actuation</i>	1	MO; QL (18 per 28 days)
IMITREX ORAL	3	MO; QL (18 per 28 days)	<i>sumatriptan nasal spray, non-aerosol 5 mg/actuation</i>	1	MO; QL (36 per 28 days)
IMITREX STATDOSE SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML	3	MO; QL (8 per 28 days)	<i>sumatriptan succinate oral</i>	1	MO; QL (18 per 28 days)
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	3	MO; QL (8 per 28 days)	<i>sumatriptan succinate subcutaneous cartridge</i>	1	MO; QL (8 per 28 days)
IMITREX SUBCUTANEOUS	3	MO; QL (8 per 28 days)	<i>sumatriptan succinate subcutaneous pen injector</i>	1	MO; QL (8 per 28 days)
MAXALT ORAL TABLET 10 MG	3	MO; QL (36 per 28 days)	<i>sumatriptan succinate subcutaneous solution</i>	1	MO; QL (8 per 28 days)
MAXALT-MLT	3	MO; QL (36 per 28 days)	<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	1	MO; QL (8 per 28 days)
<i>migergot</i>	1	MO	<i>sumatriptan-naproxen</i>	1	MO; QL (18 per 28 days)
MIGRANAL	3	MO; QL (8 per 28 days)	TREXIMET ORAL TABLET 10-60 MG	3	MO; QL (9 per 28 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
TREXIMET ORAL TABLET 85-500 MG	3	MO; QL (18 per 28 days)	<i>donepezil oral tablet,disintegrating</i>	1	MO
ZEMBRACE SYMTOUCH	3	MO; QL (8 per 28 days)	EXELON TRANSDERMAL	3	MO
<i>zolmitriptan</i>	1	MO; QL (18 per 28 days)	FIRDAPSE	2	PA; MO; LA
ZOMIG	3	MO; QL (18 per 28 days)	<i>galantamine</i>	1	MO
ZOMIG ZMT	3	MO; QL (18 per 28 days)	GILENYA ORAL CAPSULE 0.5 MG	2	PA; MO
MISCELLANEOUS NEUROLOGICAL THERAPY					
AMPYRA	3	PA; MO; LA	<i>glatiramer subcutaneous syringe 20 mg/ml</i>	1	PA; MO; QL (30 per 30 days)
ARICEPT	3	MO	<i>glatiramer subcutaneous syringe 40 mg/ml</i>	1	PA; MO; QL (12 per 28 days)
AUBAGIO	3	PA; MO	<i>glatopa subcutaneous syringe 20 mg/ml</i>	1	PA; MO; QL (30 per 30 days)
AUSTEDO ORAL TABLET 12 MG, 9 MG	3	PA; MO; LA; QL (120 per 30 days)	<i>glatopa subcutaneous syringe 40 mg/ml</i>	1	PA; MO; QL (12 per 28 days)
AUSTEDO ORAL TABLET 6 MG	3	PA; MO; LA; QL (60 per 30 days)	HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG	3	PA; MO; QL (30 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	3	PA; MO; QL (30 per 30 days)	HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG	3	PA; MO; QL (60 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	2	PA; MO; QL (12 per 28 days)	INGREZZA	3	PA; MO; LA; QL (30 per 30 days)
<i>dalfampridine</i>	1	PA; MO	INGREZZA INITIATION PACK	3	PA; MO; LA; QL (28 per 28 days)
<i>donepezil oral tablet 10 mg, 5 mg</i>	1	MO	KEVEYIS	3	PA; MO
<i>donepezil oral tablet 23 mg</i>	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
MAVENCLAD (10 TABLET PACK)	3	PA; MO; LA	NAMENDA XR	3	PA; MO
MAVENCLAD (4 TABLET PACK)	3	PA; MO; LA	NAMZARIC	2	PA; MO
MAVENCLAD (5 TABLET PACK)	3	PA; MO; LA	NUEDEXTA	2	PA; MO
MAVENCLAD (6 TABLET PACK)	3	PA; MO; LA	RAZADYNE ER	3	MO
MAVENCLAD (7 TABLET PACK)	3	PA; MO; LA	RAZADYNE ORAL TABLET	3	MO
MAVENCLAD (8 TABLET PACK)	3	PA; MO; LA	<i>rivastigmine</i>	1	MO
MAVENCLAD (9 TABLET PACK)	3	PA; MO; LA	<i>rivastigmine tartrate</i>	1	MO
MAYZENT ORAL TABLET 0.25 MG	3	PA; MO; QL (120 per 30 days)	TECFIDERA	2	PA; MO; LA
MAYZENT ORAL TABLET 2 MG	3	PA; MO; QL (30 per 30 days)	TEGSEDI	3	PA; MO; LA
<i>memantine oral capsule,sprinkle,er 24hr</i>	1	PA; MO	<i>tetrabenazine oral tablet 12.5 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>memantine oral solution</i>	1	PA; MO	<i>tetrabenazine oral tablet 25 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>memantine oral tablet</i>	1	PA; MO	XENAZINE ORAL TABLET 12.5 MG	3	PA; MO; LA; QL (240 per 30 days)
MEMANTINE ORAL TABLETS,DOSE PACK	3	PA; MO	XENAZINE ORAL TABLET 25 MG	3	PA; MO; LA; QL (120 per 30 days)
NAMENDA ORAL TABLET	3	PA; MO	MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
NAMENDA TITRATION PAK	3	PA; MO	<i>baclofen oral tablet 10 mg, 20 mg</i>	1	MO
			BACLOFEN ORAL TABLET 5 MG	3	MO
			<i>cyclobenzaprine oral tablet</i>	3	PA; MO
			DANTRIUM ORAL CAPSULE 25 MG, 50 MG	3	MO
			<i>dantrolene</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
FEXMID	3	PA	ACTIQ	3	PA; MO; QL (120 per 30 days)
MESTINON ORAL SYRUP	2	MO	ARYMO ER	3	PA; MO; QL (120 per 30 days)
MESTINON ORAL TABLET	3	MO	BELBUCA	2	PA; MO; QL (60 per 30 days)
MESTINON TIMESPAN	3	MO	<i>buprenorphine hcl sublingual</i>	1	MO
<i>pyridostigmine bromide oral syrup</i>	1	MO	<i>buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour</i>	1	PA; MO; QL (4 per 28 days)
PYRIDOSTIGMINE BROMIDE ORAL TABLET 30 MG	3		BUPRENORPHINE TRANSDERMAL PATCH WEEKLY 7.5 MCG/HOUR	3	PA; MO; QL (4 per 28 days)
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	MO	BUTRANS	3	PA; MO; QL (4 per 28 days)
<i>pyridostigmine bromide oral tablet extended release</i>	1	MO	<i>codeine sulfate oral tablet 30 mg, 60 mg</i>	1	MO; QL (180 per 30 days)
tizanidine	1	MO	DILAUDID ORAL LIQUID	3	MO; QL (2400 per 30 days)
ZANAFLEX ORAL CAPSULE	3	MO	DILAUDID ORAL TABLET	3	MO; QL (180 per 30 days)
NARCOTIC ANALGESICS					
ABSTRAL	3	PA; MO; QL (120 per 30 days)	DOLOPHINE ORAL TABLET 10 MG	3	PA; MO; QL (120 per 30 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	1	MO; QL (4500 per 30 days)	DOLOPHINE ORAL TABLET 5 MG	3	PA; MO; QL (240 per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	1	MO; QL (360 per 30 days)			
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	1	MO; QL (180 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
DURAGESIC	3	PA; MO; QL (10 per 30 days)	<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	1	MO; QL (390 per 30 days)
<i>doramorph (pf) injection solution 0.5 mg/ml</i>	1	MO; QL (4000 per 30 days)	<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>doramorph (pf) injection solution 1 mg/ml</i>	1	QL (2000 per 30 days)	<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	MO; QL (50 per 30 days)
<i>dvorah</i>	1	QL (300 per 30 days)	<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	1	MO; QL (240 per 30 days)
EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL	3	PA; MO; QL (90 per 30 days)	<i>hydromorphone injection syringe 2 mg/ml</i>	1	QL (150 per 30 days)
<i>endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)	<i>hydromorphone oral liquid</i>	1	MO; QL (2400 per 30 days)
<i>fentanyl</i>	1	PA; MO; QL (10 per 30 days)	<i>hydromorphone oral tablet</i>	1	MO; QL (180 per 30 days)
<i>fentanyl citrate buccal lozenge on a handle</i>	1	PA; MO; QL (120 per 30 days)	<i>hydromorphone oral tablet extended release 24 hr</i>	1	PA; MO; QL (60 per 30 days)
FENTANYL CITRATE BUCCAL TABLET, EFFERVESCENT	3	PA; QL (120 per 30 days)	HYSINGLA ER	3	PA; MO; QL (60 per 30 days)
FENTORA	3	PA; MO; QL (120 per 30 days)	<i>ibuprofen-oxycodone</i>	1	MO; QL (28 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	1	MO; QL (5550 per 30 days)	KADIAN ORAL CAPSULE,EXTEN D.RELEASE PELLETS 200 MG, 30 MG, 40 MG, 50 MG	3	PA; MO; QL (90 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
LAZANDA NASAL SPRAY, NON-AEROSOL 100 MCG/SPRAY	3	PA; MO; QL (45 per 30 days)	MORPHABOND ER	3	PA; MO; QL (120 per 30 days)
LAZANDA NASAL SPRAY, NON-AEROSOL 300 MCG/SPRAY	3	PA; QL (23 per 30 days)	<i>morphine concentrate oral solution</i>	1	MO; QL (900 per 30 days)
LAZANDA NASAL SPRAY, NON-AEROSOL 400 MCG/SPRAY	3	PA; MO; QL (30 per 30 days)	<i>morphine injection syringe 10 mg/ml</i>	1	MO; QL (200 per 30 days)
<i>levorphanol tartrate oral tablet 2 mg</i>	1	MO; QL (120 per 30 days)	<i>morphine injection syringe 2 mg/ml</i>	1	MO; QL (1000 per 30 days)
LEVORPHANOL TARTRATE ORAL TABLET 3 MG	3	MO; QL (120 per 30 days)	<i>morphine injection syringe 4 mg/ml</i>	1	MO; QL (500 per 30 days)
<i>lorcet (hydrocodone)</i>	1	MO; QL (360 per 30 days)	<i>morphine injection syringe 5 mg/ml</i>	1	QL (400 per 30 days)
<i>lorcet hd</i>	1	MO; QL (360 per 30 days)	MORPHINE INTRAVENOUS SYRINGE 8 MG/ML	3	QL (250 per 30 days)
<i>lorcet plus oral tablet 7.5-325 mg</i>	1	MO; QL (360 per 30 days)	<i>morphine oral capsule, er multiphase 24 hr</i>	1	PA; MO; QL (60 per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	1	PA; MO; QL (600 per 30 days)	<i>morphine oral capsule, extend.release pellets</i>	1	PA; MO; QL (90 per 30 days)
<i>methadone oral solution 5 mg/5 ml</i>	1	PA; MO; QL (1200 per 30 days)	<i>morphine oral solution</i>	1	MO; QL (900 per 30 days)
<i>methadone oral tablet 10 mg</i>	1	PA; MO; QL (120 per 30 days)	<i>morphine oral tablet</i>	1	MO; QL (180 per 30 days)
<i>methadone oral tablet 5 mg</i>	1	PA; MO; QL (240 per 30 days)	<i>morphine oral tablet extended release</i>	1	PA; MO; QL (120 per 30 days)
			MS CONTIN	3	PA; MO; QL (120 per 30 days)
			NORCO	3	MO; QL (360 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
OPANA ORAL TABLET 10 MG	3	MO; QL (360 per 30 days)	<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
OPANA ORAL TABLET 5 MG	3	MO; QL (180 per 30 days)	<i>oxycodone-aspirin</i>	1	MO; QL (360 per 30 days)
OXAYDO	3	MO; QL (360 per 30 days)	OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	2	PA; MO; QL (90 per 30 days)
<i>oxycodone oral capsule</i>	1	MO; QL (360 per 30 days)	OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	2	PA; MO; QL (60 per 30 days)
<i>oxycodone oral concentrate</i>	1	MO; QL (180 per 30 days)	<i>oxymorphone oral tablet 10 mg</i>	1	MO; QL (360 per 30 days)
<i>oxycodone oral solution</i>	1	MO; QL (1200 per 30 days)	<i>oxymorphone oral tablet 5 mg</i>	1	MO; QL (180 per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	1	MO; QL (180 per 30 days)	<i>oxymorphone oral tablet extended release 12 hr</i>	1	PA; MO; QL (90 per 30 days)
<i>oxycodone oral tablet 5 mg</i>	1	MO; QL (360 per 30 days)	PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	3	MO; QL (360 per 30 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 20 MG, 40 MG	3	PA; MO; QL (90 per 30 days)	PRIMLEV	3	MO; QL (390 per 30 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 15 MG, 30 MG, 60 MG	3	PA; MO; QL (90 per 30 days)	ROXICODONE ORAL TABLET 15 MG, 30 MG	3	MO; QL (180 per 30 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	3	PA; MO; QL (60 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ROXICODONE ORAL TABLET 5 MG	3	QL (360 per 30 days)	BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG	3	MO; QL (60 per 30 days)
ROXYBOND ORAL TABLET, ORAL ONLY 15 MG, 30 MG	3	QL (180 per 30 days)	<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	1	MO; QL (60 per 30 days)
ROXYBOND ORAL TABLET, ORAL ONLY 5 MG	3	QL (360 per 30 days)	<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY	3	PA; MO; QL (120 per 30 days)	<i>buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg</i>	1	MO; QL (90 per 30 days)
TREZIX ORAL CAPSULE 320.5-30-16 MG	3	MO; QL (300 per 30 days)	<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
TYLENOL-CODEINE #3	3	MO; QL (360 per 30 days)	<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	1	MO; QL (90 per 30 days)
XTAMPZA ER	3	PA; MO; QL (90 per 30 days)	butorphanol tartrate nasal	1	MO; QL (10 per 28 days)
ZOHYDRO ER CAPSULE, ORAL ONLY, ER 12HR	3	PA; MO; QL (90 per 30 days)	CAMBIA	3	ST; MO; QL (9 per 30 days)
NON-NARCOTIC ANALGESICS					
ARTHROTEC 50	3	ST; MO	CELEBREX	3	MO
ARTHROTEC 75	3	ST; MO	<i>celecoxib</i>	1	MO
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	3	MO; QL (30 per 30 days)	CONZIP	3	PA; MO; QL (30 per 30 days)
			DAYPRO	3	ST; MO
			DICLOFENAC EPOLAMINE	3	PA; MO; QL (60 per 30 days)
			<i>diclofenac potassium</i>	1	MO
			<i>diclofenac sodium oral</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>diclofenac sodium topical drops</i>	1	MO; QL (300 per 28 days)	LODINE ORAL TABLET	3	ST
<i>diclofenac sodium topical gel 1 %</i>	1	MO; QL (1000 per 28 days)	LUCEMYRA	3	PA; MO
<i>diclofenac-misoprostol</i>	1	MO	<i>meclofenamate</i>	1	MO
<i>diflunisal</i>	1	MO	<i>mefenamic acid</i>	1	MO
DUEXIS	3	ST; MO	<i>meloxicam oral tablet 15 mg</i>	1	MO
<i>etodolac</i>	1	MO	<i>meloxicam oral tablet 7.5 mg</i>	1	MO; QL (30 per 30 days)
EVZIO INJECTION AUTO-INJECTOR 2 MG/0.4 ML	3	MO; QL (0.8 per 30 days)	MOBIC ORAL TABLET 15 MG	3	ST; MO
FELDENE	3	ST; MO	MOBIC ORAL TABLET 7.5 MG	3	ST; MO; QL (30 per 30 days)
FENOPROFEN ORAL CAPSULE 400 MG	3	ST; MO	<i>nabumetone</i>	1	MO
<i>fenoprofen oral tablet</i>	1	MO	NALFON ORAL TABLET	3	ST
FLECTOR	3	PA; MO; QL (60 per 30 days)	<i>naloxone</i>	1	MO
<i>flurbiprofen</i>	1	MO	<i>naltrexone</i>	1	MO
<i>ibu oral tablet 600 mg, 800 mg</i>	1	MO	NAPRELAN CR	3	ST; MO
<i>ibuprofen oral suspension</i>	1	MO	<i>naproxen</i>	1	MO
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	MO	<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	MO
<i>ketoprofen oral capsule 25 mg</i>	1	MO	<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	1	MO
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	1	MO	NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	2	MO
			NUCYNTA ER	3	PA; MO; QL (60 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
NUCYNTA ORAL TABLET 100 MG	3	MO; QL (181 per 30 days)	<i>tolmetin oral tablet 600 mg</i>	1	MO
NUCYNTA ORAL TABLET 50 MG	3	MO; QL (362 per 30 days)	TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 17-83	3	PA; MO; QL (30 per 30 days)
NUCYNTA ORAL TABLET 75 MG	3	MO; QL (242 per 30 days)	TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 25-75 100 MG, 200 MG	3	PA; MO; QL (30 per 30 days)
<i>oxaprozin</i>	1	MO	<i>tramadol oral tablet</i>	1	MO; QL (240 per 30 days)
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	3	ST; MO; QL (224 per 28 days)	<i>tramadol oral tablet extended release 24 hr</i>	1	PA; MO; QL (30 per 30 days)
<i>piroxicam</i>	1	MO	<i>tramadol oral tablet, er multiphase 24 hr</i>	1	PA; MO; QL (30 per 30 days)
QMIIZ ODT ORAL TABLET,DISINTE GRATING 15 MG	3	ST; MO	<i>tramadol-acetaminophen</i>	1	MO; QL (240 per 30 days)
QMIIZ ODT ORAL TABLET,DISINTE GRATING 7.5 MG	3	ST; MO; QL (30 per 30 days)	ULTRACET	3	MO; QL (240 per 30 days)
SPRIX	3	ST	ULTRAM	3	MO; QL (240 per 30 days)
SUBOXONE SUBLINGUAL FILM 12-3 MG	3	MO; QL (60 per 30 days)	VIMOVO	3	ST; MO
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	3	MO; QL (360 per 30 days)	VIVITROL	2	MO
SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG	3	MO; QL (90 per 30 days)	VIVLODEX ORAL CAPSULE 10 MG	3	ST; MO
<i>sulindac</i>	1	MO	VIVLODEX ORAL CAPSULE 5 MG	3	ST; MO; QL (30 per 30 days)
TIVORBEX	3	ST; MO; QL (90 per 30 days)			
<i>tolmetin oral capsule</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
VOLTAREN TOPICAL	3	ST; MO; QL (1000 per 28 days)	ANAFRANIL	3	MO
ZIPSOR	3	ST; MO	APLENZIN	3	MO; QL (30 per 30 days)
ZORVOLEX	3	ST; MO	APTENSIO XR	3	MO
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG	2	MO; QL (30 per 30 days)	<i>aripiprazole oral solution</i>	1	MO
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	2	MO; QL (60 per 30 days)	<i>aripiprazole oral tablet</i>	1	MO; QL (30 per 30 days)
PSYCHOTHERAPEUTIC DRUGS					
ABILITY MAINTENA	2	MO	ARISTADA	2	MO
ABILITY ORAL TABLET	3	MO; QL (30 per 30 days)	ARISTADA INITIO	2	MO
ADDERALL ORAL TABLET 20 MG, 5 MG, 7.5 MG	3	MO	<i>armodafinil</i>	3	PA; MO
ADDERALL XR	3	MO	ATIVAN ORAL TABLET 0.5 MG, 1 MG	3	PA; MO; QL (90 per 30 days)
ADZENYS ER	3	MO	ATIVAN ORAL TABLET 2 MG	3	PA; MO; QL (150 per 30 days)
ADZENYS XR-ODT	3	MO	<i>atomoxetine</i>	1	MO
AMBIEN	3	MO; QL (30 per 30 days)	BELSOMRA	3	MO; QL (30 per 30 days)
AMBIEN CR	3	MO; QL (30 per 30 days)	BRISDELLE	3	MO; QL (30 per 30 days)
<i>amitriptyline</i>	1	MO	<i>bupropion hcl oral tablet</i>	1	MO
<i>amoxapine</i>	1	MO	<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	1	MO; QL (90 per 30 days)
<i>amphetamine sulfate</i>	1	PA; MO	<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	1	MO; QL (30 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
BUPROPION HCL ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	3	MO; QL (30 per 30 days)	CLOZAPINE ORAL TABLET,DISINTE GRATING 150 MG, 200 MG	3	
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	1	MO; QL (60 per 30 days)	CLOZARIL	3	
<i>buspirone</i>	1	MO	CONCERTA	3	MO
CELEXA ORAL TABLET	3	MO; QL (30 per 30 days)	COTEMPLA XR-ODT	3	MO
<i>chlorpromazine oral</i>	1	MO	CYMBALTA	3	MO; QL (60 per 30 days)
<i>citalopram oral solution</i>	1	MO	DAYTRANA	3	MO
<i>citalopram oral tablet</i>	1	MO; QL (30 per 30 days)	<i>desipramine</i>	1	MO
<i>clomipramine</i>	3	MO	DESOXYN	3	PA; MO
<i>clonidine hcl oral tablet extended release 12 hr</i>	1	MO	DESVENLAFAKIN E ORAL TABLET EXTENDED RELEASE 24 HR 100 MG	3	MO; QL (120 per 30 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	1	PA; MO; QL (180 per 30 days)	DESVENLAFAKIN E ORAL TABLET EXTENDED RELEASE 24 HR 50 MG	3	MO; QL (30 per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	1	PA; MO; QL (90 per 30 days)	<i>desvenlafaxine succinate</i>	1	MO; QL (30 per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	1	PA; MO; QL (360 per 30 days)	DEXEDRINE SPANSULE	3	MO
<i>clozapine oral tablet</i>	1	MO	<i>dexamphetamine</i>	1	MO
<i>clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg</i>	1		<i>dextroamphetamine oral capsule, extended release</i>	1	MO
			<i>dextroamphetamine oral tablet</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>dextroamphetamine-amphetamine</i>	1	MO	<i>escitalopram oxalate oral tablet</i>	1	MO; QL (30 per 30 days)
<i>diazepam oral concentrate</i>	1	PA; MO; QL (240 per 30 days)	<i>eszopiclone</i>	3	MO; QL (30 per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	1	PA; MO; QL (1200 per 30 days)	EVEKEO	3	PA; MO
<i>diazepam oral tablet</i>	1	PA; MO; QL (120 per 30 days)	FANAPT ORAL TABLET	3	MO; QL (60 per 30 days)
<i>doxepin oral</i>	3	MO	FANAPT ORAL TABLETS,DOSE PACK	3	MO; QL (8 per 28 days)
<i>duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	1	MO; QL (60 per 30 days)	FAZACLO	3	
<i>duloxetine oral capsule,delayed release(dr/ec) 40 mg</i>	1	MO; QL (90 per 30 days)	FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	2	MO; QL (28 per 28 days)
DYANAVEL XR	3	MO	FETZIMA ORAL CAPSULE,EXTEN DED RELEASE 24 HR	2	MO; QL (30 per 30 days)
EFFEXOR XR ORAL CAPSULE,EXTEN DED RELEASE 24HR 150 MG, 37.5 MG	3	MO; QL (30 per 30 days)	<i>fluoxetine oral capsule 10 mg</i>	1	MO; QL (30 per 30 days)
EFFEXOR XR ORAL CAPSULE,EXTEN DED RELEASE 24HR 75 MG	3	MO; QL (90 per 30 days)	<i>fluoxetine oral capsule 20 mg</i>	1	MO
EMSAM	2	MO	<i>fluoxetine oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>ergoloid</i>	3	MO	<i>fluoxetine oral capsule,delayed release(dr/ec)</i>	1	MO; QL (4 per 28 days)
<i>escitalopram oxalate oral solution</i>	1	MO	<i>fluoxetine oral solution</i>	1	MO
			<i>fluoxetine oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
			<i>fluoxetine oral tablet 20 mg, 60 mg</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>fluphenazine decanoate</i>	1	MO	HETLIOZ	3	PA; MO; QL (30 per 30 days)
<i>fluphenazine hcl</i>	1	MO	<i>imipramine hcl</i>	3	MO
<i>fluvoxamine oral capsule,extended release 24hr</i>	3	MO; QL (60 per 30 days)	<i>imipramine pamoate</i>	3	MO
<i>fluvoxamine oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)	INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 9 MG	3	MO; QL (30 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)	INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	3	MO; QL (60 per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	1	MO; QL (60 per 30 days)	INVEGA SUSTENNA	3	MO
FOCALIN	3	MO	INVEGA TRINZA	3	MO
FOCALIN XR	3	MO	KAPVAY	3	MO
FORFIVO XL	3	MO; QL (30 per 30 days)	KHEDEZLA ORAL TABLET EXTENDED RELEASE 24HR 100 MG	3	MO; QL (120 per 30 days)
GEODON INTRAMUSCULAR	3	MO	KHEDEZLA ORAL TABLET EXTENDED RELEASE 24HR 50 MG	3	MO; QL (30 per 30 days)
GEODON ORAL	3	MO; QL (60 per 30 days)	LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	3	MO; QL (30 per 30 days)
<i>guanidine</i>	1	MO	LATUDA ORAL TABLET 80 MG	3	MO; QL (60 per 30 days)
HALDOL	3	MO	LEXAPRO ORAL TABLET	3	MO; QL (30 per 30 days)
HALDOL DECANOATE	3	MO			
<i>haloperidol</i>	1	MO			
<i>haloperidol decanoate</i>	1	MO			
<i>haloperidol lactate injection</i>	1	MO			
<i>haloperidol lactate oral</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>lithium carbonate</i>	1	MO	<i>methylphenidate hcl oral tablet extended release</i>	1	MO
<i>lithium citrate oral solution 8 meq/5 ml</i>	1	MO	<i>methylphenidate hcl oral tablet extended release 24hr 18 mg (bx rating), 27 mg (bx rating), 36 mg (bx rating), 54 mg (bx rating)</i>	1	
LITHOBID	3	MO	<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg</i>	1	
<i>lorazepam oral concentrate</i>	1	PA; MO; QL (150 per 30 days)	METHYLPHENIDATE HCL ORAL TABLET EXTENDED RELEASE 24HR 72 MG	3	MO
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	1	PA; MO; QL (90 per 30 days)	<i>methylphenidate hcl oral tablet, chewable</i>	1	MO
<i>lorazepam oral tablet 2 mg</i>	1	PA; MO; QL (150 per 30 days)	<i>mirtazapine</i>	1	MO
<i>loxapine succinate</i>	1	MO	<i>modafinil</i>	1	PA; MO
LUNESTA	3	MO; QL (30 per 30 days)	<i>molindone</i>	1	
<i>maprotiline</i>	1	MO	<i>MYDAYIS</i>	3	MO
MARPLAN	2	MO	<i>NARDIL</i>	3	MO
<i>metadate er</i>	1	MO	<i>nefazodone</i>	1	MO
<i>methamphetamine</i>	1	PA; MO	<i>NORPRAMIN ORAL TABLET 10 MG, 25 MG</i>	3	MO
METHYLIN ORAL SOLUTION	3	MO	<i>nortriptyline</i>	1	MO
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	1	MO	<i>NUPLAZID ORAL CAPSULE</i>	3	PA; MO; QL (30 per 30 days)
<i>methylphenidate hcl oral capsule, er biphasic 50-50</i>	1	MO			
<i>methylphenidate hcl oral solution</i>	1	MO			
<i>methylphenidate hcl oral tablet</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
NUPLAZID ORAL TABLET 10 MG	3	PA; MO; QL (30 per 30 days)	PAXIL ORAL TABLET 10 MG, 20 MG, 40 MG	3	MO; QL (30 per 30 days)
NUVIGIL	3	PA; MO	PAXIL ORAL TABLET 30 MG	3	MO; QL (60 per 30 days)
<i>olanzapine intramuscular</i>	1	MO	<i>perphenazine</i>	1	MO
<i>olanzapine oral</i>	1	MO; QL (30 per 30 days)	PERSERIS	3	MO
<i>olanzapine-fluoxetine</i>	1	MO	PEXEVA ORAL TABLET 10 MG, 20 MG, 40 MG	3	MO; QL (30 per 30 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	1	MO; QL (30 per 30 days)	PEXEVA ORAL TABLET 30 MG	3	MO; QL (60 per 30 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	1	MO; QL (60 per 30 days)	<i>phenelzine</i>	1	MO
PAMELOR	3	MO	<i>pimozide</i>	1	MO
PARNATE	3	MO	PRISTIQ	3	MO; QL (30 per 30 days)
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	1	MO; QL (30 per 30 days)	<i>procentra</i>	1	MO
<i>paroxetine hcl oral tablet 30 mg</i>	1	MO; QL (60 per 30 days)	<i>protriptyline</i>	1	MO
<i>paroxetine hcl oral tablet extended release 24 hr</i>	1	MO; QL (60 per 30 days)	PROVIGIL	3	PA; MO
<i>paroxetine mesylate(menop.sym)</i>	1	MO; QL (30 per 30 days)	PROZAC ORAL CAPSULE 10 MG	3	MO; QL (30 per 30 days)
PAXIL CR	3	MO; QL (60 per 30 days)	PROZAC ORAL CAPSULE 20 MG	3	MO
PAXIL ORAL SUSPENSION	3	MO	PROZAC ORAL CAPSULE 40 MG	3	MO; QL (60 per 30 days)
			<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	MO; QL (90 per 30 days)
			<i>quetiapine oral tablet 300 mg, 400 mg</i>	1	MO; QL (60 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	1	MO; QL (30 per 30 days)	<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	1	MO; QL (60 per 30 days)	<i>risperidone oral tablet,disintegrating 4 mg</i>	1	MO; QL (120 per 30 days)
QUILLCHEW ER	3	MO	RITALIN	3	MO
QUILLIVANT XR	3	MO	RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG, 20 MG, 30 MG, 40 MG	3	MO
RELEXXII	3		ROZEREM	2	MO; QL (30 per 30 days)
REMERON ORAL TABLET 15 MG, 30 MG	3	MO	SAPHRIS	2	MO; QL (60 per 30 days)
REMERON SOLTAB	3	MO	SARAFEM ORAL TABLET 10 MG, 20 MG	3	MO
REXULTI	3	MO; QL (30 per 30 days)	SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG	3	MO; QL (90 per 30 days)
RISPERDAL CONSTA	2	MO	SEROQUEL ORAL TABLET 300 MG, 400 MG	3	MO; QL (60 per 30 days)
RISPERDAL ORAL SOLUTION	3	MO	SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG	3	MO; QL (30 per 30 days)
RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG	3	MO; QL (60 per 30 days)			
RISPERDAL ORAL TABLET 4 MG	3	MO; QL (120 per 30 days)			
<i>risperidone oral solution</i>	1	MO			
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)			
<i>risperidone oral tablet 4 mg</i>	1	MO; QL (120 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 400 MG, 50 MG	3	MO; QL (60 per 30 days)	VALIUM	3	PA; MO; QL (120 per 30 days)
<i>sertraline oral concentrate</i>	1	MO	<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	1	MO; QL (30 per 30 days)
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	MO; QL (60 per 30 days)	<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	1	MO; QL (90 per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)	<i>venlafaxine oral tablet</i>	1	MO; QL (90 per 30 days)
SILENOR	3	MO; QL (30 per 30 days)	VENLAFAKINE ORAL TABLET EXTENDED RELEASE 24HR	3	MO; QL (30 per 30 days)
STRATTERA	3	MO	VERSACLOZ	2	
SURMONTIL	3	MO	VIIBRYD ORAL TABLET	2	MO; QL (30 per 30 days)
SYMBYAX ORAL CAPSULE 12-50 MG, 3-25 MG, 6-25 MG, 6-50 MG	3	MO	VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23)	2	MO; QL (30 per 30 days)
<i>thioridazine</i>	3	MO	VRAYLAR ORAL CAPSULE	3	MO; QL (30 per 30 days)
<i>thiothixene</i>	1	MO	VRAYLAR ORAL CAPSULE,DOSE PACK	3	MO; QL (7 per 30 days)
TOFRANIL	3	MO	VYVANSE	3	MO
TRANXENE T-TAB ORAL TABLET 7.5 MG	3	PA; MO; QL (360 per 30 days)	WELLBUTRIN SR	3	MO; QL (60 per 30 days)
<i>tranylcypromine</i>	3	MO	WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	3	MO; QL (90 per 30 days)
<i>trazodone</i>	1	MO			
<i>trifluoperazine</i>	1	MO			
<i>trimipramine</i>	3	MO			
TRINTELLIX	2	MO; QL (30 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	3	MO; QL (30 per 30 days)	ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	3	MO
XYREM	2	PA; MO; LA; QL (540 per 30 days)	ZYPREXA ZYDIS	3	MO; QL (30 per 30 days)
<i>zaleplon oral capsule 10 mg</i>	3	MO; QL (60 per 30 days)	CARDIOVASCULAR, HYPERTENSION / LIPIDS		
<i>zaleplon oral capsule 5 mg</i>	3	MO; QL (30 per 30 days)	ANTIARRHYTHMIC AGENTS		
<i>zenzedi oral tablet 10 mg, 5 mg</i>	1	MO	<i>amiodarone oral</i>	1	MO
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	3	MO	BETAPACE AF	3	MO
<i>ziprasidone hcl</i>	1	MO; QL (60 per 30 days)	<i>dofetilide</i>	1	MO
ZOLOFT ORAL TABLET 100 MG, 50 MG	3	MO; QL (60 per 30 days)	<i>flecainide</i>	1	MO
ZOLOFT ORAL TABLET 25 MG	3	MO; QL (30 per 30 days)	<i>mexiletine</i>	1	MO
<i>zolpidem oral</i>	1	MO; QL (30 per 30 days)	MULTAQ	3	MO
ZYPREXA INTRAMUSCULAR	3	MO	<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	1	MO
ZYPREXA ORAL	3	MO; QL (30 per 30 days)	<i>propafenone</i>	1	MO
			<i>quinidine gluconate oral</i>	1	MO
			<i>quinidine sulfate oral tablet</i>	1	MO
			RYTHMOL SR	3	MO
			<i>sorine oral tablet 120 mg, 160 mg, 80 mg</i>	1	MO
			<i>sorine oral tablet 240 mg</i>	1	
			<i>sotalol af oral tablet 120 mg</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
sotalol oral	1	MO	AZOR	3	ST; MO
SOTYLIZE	2	MO	benazepril	1	MO
TIKOSYN	3	MO	benazepril-hydrochlorothiazide	1	MO
ANTIHYPERTENSIVE THERAPY					
ACCUPRIL	3	MO	BENICAR	3	ST; MO
ACCURETIC	3	MO	BENICAR HCT	3	ST; MO
acebutolol	1	MO	betaxolol oral	1	MO
ADALAT CC	3	MO	BIDIL	2	MO
ALDACTAZIDE	3	MO	bisoprolol fumarate	1	MO
ALDACTONE	3	MO	bisoprolol-hydrochlorothiazide	1	MO
aliskiren	1	MO	bumetanide	1	MO
ALTACE	3	MO	BYSTOLIC	2	MO
amiloride	1	MO	CALAN ORAL TABLET 120 MG	3	MO
amiloride-hydrochlorothiazide	1	MO	CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 240 MG	3	MO
amlodipine	1	MO	candesartan	1	MO
amlodipine-benazepril	1	MO	candesartan-hydrochlorothiazid	1	MO
amlodipine-olmesartan	1	MO	captotril	1	MO
amlodipine-valszartan	1	MO	captotril-hydrochlorothiazide	1	MO
amlodipine-valszartan-hcthiazid	1	MO	CARDIZEM CD	3	MO
ATACAND	3	ST; MO	CARDIZEM LA	3	MO
ATACAND HCT	3	ST; MO	CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	3	MO
atenolol	1	MO			
atenolol-chlorthalidone	1	MO			
AVALIDE	3	ST; MO			
AVAPRO	3	ST; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG	3	ST; MO; QL (30 per 30 days)	<i>diltiazem hcl oral capsule, extended release 12 hr</i>	1	MO
CARDURA ORAL TABLET 8 MG	3	ST; MO; QL (60 per 30 days)	<i>diltiazem hcl oral capsule, extended release 24 hr 360 mg, 420 mg</i>	1	MO
CARDURA XL	3	ST; MO; QL (30 per 30 days)	<i>diltiazem hcl oral capsule, extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	1	MO
CAROSPIR	3	MO	<i>diltiazem hcl oral tablet</i>	1	MO
<i>cartia xt</i>	1	MO	<i>dilt-xr</i>	1	MO
<i>carvedilol</i>	1	MO	DIOVAN	3	ST; MO
<i>carvedilol phosphate</i>	1	MO	DIOVAN HCT	3	ST; MO
CATAPRES	3	MO	DIURIL	3	MO
CATAPRES-TTS-1	3	MO; QL (4 per 28 days)	<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	1	MO; QL (30 per 30 days)
CATAPRES-TTS-2	3	MO; QL (4 per 28 days)	<i>doxazosin oral tablet 8 mg</i>	1	MO; QL (60 per 30 days)
CATAPRES-TTS-3	3	MO; QL (4 per 28 days)	DUTOPROL	3	MO
<i>chlorothiazide</i>	1	MO	DYAZIDE	3	MO
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	MO	DYRENIUM	3	MO
<i>clonidine</i>	3	MO; QL (4 per 28 days)	EDARBI	2	MO
<i>clonidine hcl oral tablet</i>	1	MO	EDARBYCLOR	2	MO
COREG	3	MO	EDECRIN	3	MO
COREG CR	3	MO	<i>enalapril maleate</i>	1	MO
CORGARD	3	MO	<i>enalapril-hydrochlorothiazide</i>	1	MO
COZAAR	3	ST; MO	<i>eplerenone</i>	1	MO
DEM SER	2	PA; MO	<i>eprosartan</i>	1	MO
DIBENZYLINE	3	PA; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>ethacrynic acid</i>	1	MO	LOPRESSOR ORAL TABLET 100 MG	3	MO
EXFORGE	3	ST; MO	<i>losartan</i>	1	MO
EXFORGE HCT	3	ST; MO	<i>losartan-hydrochlorothiazide</i>	1	MO
<i>felodipine</i>	1	MO	LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	3	MO
<i>fosinopril</i>	1	MO	LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG	3	MO
<i>fosinopril-hydrochlorothiazide</i>	1	MO	<i>matzim la</i>	1	MO
<i>furosemide injection</i>	1	MO	MAXZIDE	3	MO
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	MO	MAXZIDE-25MG	3	MO
<i>furosemide oral tablet</i>	1	MO	<i>methyclothiazide</i>	1	MO
<i>hydralazine oral</i>	1	MO	<i>methyldopa</i>	1	MO
<i>hydrochlorothiazide</i>	1	MO	<i>metolazone</i>	1	MO
HYZAAR	3	ST; MO	<i>metoprolol succinate</i>	1	MO
<i>indapamide</i>	1	MO	<i>metoprolol tar- hydrochlorothiaz</i>	1	MO
INDERAL LA	3	MO	<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	MO
INNOPRAN XL	3	MO	MICARDIS	3	ST; MO
INSPRA	3	MO	MICARDIS HCT	3	ST; MO
<i>irbesartan</i>	1	MO	MINIPRESS	3	MO
<i>irbesartan-hydrochlorothiazide</i>	1	MO	<i>minoxidil oral</i>	1	MO
<i>isradipine</i>	1	MO	<i>moexipril</i>	1	MO
<i>labetalol oral</i>	1	MO	<i>nadolol</i>	1	MO
LASIX	3	MO			
<i>lisinopril</i>	1	MO			
<i>lisinopril-hydrochlorothiazide</i>	1	MO			
LOPRESSOR HCT	3				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>nadolol-</i> <i>bendroflumethiazide</i> <i>oral tablet 40-5 mg</i>	1	MO	QBRELIS	3	MO
<i>nicardipine oral</i>	1	MO	<i>quinapril</i>	1	MO
<i>nifedipine oral tablet</i> <i>extended release</i>	1	MO	<i>quinapril-</i> <i>hydrochlorothiazide</i>	1	MO
<i>nifedipine oral tablet</i> <i>extended release</i> 24hr	1	MO	<i>ramipril</i>	1	MO
<i>nimodipine</i>	1	MO	<i>spironolactone</i>	1	MO
<i>nisoldipine</i>	1	MO	<i>spironolacton-</i> <i>hydrochlorothiaz</i>	1	MO
NORVASC	3	MO	SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	3	MO
NYMALIZE ORAL SOLUTION 60 MG/20 ML	3	MO	TARKA ORAL TABLET, IR - ER, BIPHASIC 24HR 2- 180 MG, 2-240 MG, 4-240 MG	3	MO
<i>olmesartan</i>	1	MO	<i>taztia xt</i>	1	MO
<i>olmesartan-</i> <i>amlodipin-hcthiazid</i>	1	MO	TEKTURNA	3	MO
<i>olmesartan-</i> <i>hydrochlorothiazide</i>	1	MO	TEKTURNA HCT	2	MO
ORENITRAM	3	PA; MO	<i>telmisartan</i>	1	MO
<i>perindopril</i> <i>erbumine</i>	1	MO	<i>telmisartan-</i> <i>amlodipine</i>	1	MO
<i>phenoxybenzamine</i>	1	PA; MO	<i>telmisartan-</i> <i>hydrochlorothiazid</i>	1	MO
<i>pindolol</i>	1	MO	TENORETIC 100	3	MO
<i>prazosin</i>	1	MO	TENORETIC 50	3	MO
PRINIVIL ORAL TABLET 10 MG, 20 MG, 5 MG	3	MO	TENORMIN	3	MO
PROCARDIA XL	3	MO	<i>terazosin oral</i> <i>capsule 1 mg, 2 mg,</i> <i>5 mg</i>	1	MO; QL (30 per 30 days)
<i>propranolol oral</i>	1	MO			
<i>propranolol-</i> <i>hydrochlorothiazid</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>terazosin oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)	ZIAC	3	MO
TIAZAC	3	MO	COAGULATION THERAPY		
<i>timolol maleate oral</i>	1	MO	AGGRENOX	3	MO
TOPROL XL	3	MO	ARIXTRA	3	MO
<i>torsemide oral</i>	1	MO	<i>aspirin-dipyridamole</i>	1	MO
<i>trandolapril</i>	1	MO	BEVYXXA	3	MO
<i>trandolapril-verapamil</i>	1	MO	BRILINTA	2	MO
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	1	MO	CABLIVI INJECTION KIT	2	PA; MO; LA
<i>triamterene-hydrochlorothiazid oral tablet</i>	1	MO	cilostazol	1	MO
TRIBENZOR	3	ST; MO	<i>clopidogrel oral tablet 75 mg</i>	1	MO; QL (30 per 30 days)
TWYNSTA ORAL TABLET 40-10 MG, 40-5 MG, 80-5 MG	3	ST; MO	COUMADIN ORAL	3	MO
UPTRAVI	2	PA; MO; LA	<i>dipyridamole oral</i>	1	MO
<i>valsartan</i>	1	MO	DOPTELET (10 TAB PACK)	2	PA; MO; LA
<i>valsartan-hydrochlorothiazide</i>	1	MO	DOPTELET (15 TAB PACK)	2	PA; MO; LA
VASERETIC	3	MO	EFFIENT	3	MO
VASOTEC	3	MO	ELIQUIS	2	MO
<i>verapamil oral</i>	1	MO	<i>enoxaparin subcutaneous syringe</i>	1	MO
VERELAN	3	MO	<i>fondaparinux</i>	1	MO
VERELAN PM	3	MO	FRAGMIN SUBCUTANEOUS SOLUTION	3	MO
ZESTORETIC	3	MO	FRAGMIN SUBCUTANEOUS SYRINGE	3	MO
ZESTRIL	3	MO	<i>heparin (porcine) injection solution</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
jantoven	1	MO	CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	3	ST; MO; QL (30 per 30 days)
LOVENOX SUBCUTANEOUS SYRINGE	3	MO	<i>cholestyramine (with sugar) oral powder in packet</i>	1	MO
MULPLETA	2	PA; MO	<i>cholestyramine light oral powder</i>	1	MO
pentoxifylline	1	MO	<i>colesevelam</i>	1	MO
PLAVIX ORAL TABLET 75 MG	3	MO; QL (30 per 30 days)	COLESTID ORAL PACKET	3	MO
PRADAXA	3	MO	COLESTID ORAL TABLET	3	MO
prasugrel	1	MO	<i>colestipol oral packet</i>	1	MO
PROMACTA	2	PA; MO; LA	<i>colestipol oral tablet</i>	1	MO
SAVAYSA	3	MO	CRESTOR	3	ST; MO; QL (30 per 30 days)
TAVALISSE	3	PA; MO; LA; QL (60 per 30 days)	EZALLOR SPRINKLE	3	ST; QL (30 per 30 days)
warfarin	1	MO	<i>ezetimibe</i>	1	MO
XARELTO	2	MO	<i>ezetimibe-simvastatin</i>	1	MO; QL (30 per 30 days)
YOSPRALA	3	MO	<i>fenofibrate micronized</i>	1	MO
ZONTIVITY	2	MO	<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	1	MO
LIPID/CHOLESTEROL LOWERING AGENTS					
ALTOPREV	3	ST; MO; QL (30 per 30 days)	FENOFIBRATE ORAL CAPSULE	3	MO
<i>amlodipine-atorvastatin</i>	1	MO; QL (30 per 30 days)			
ANTARA ORAL CAPSULE 30 MG, 90 MG	3	MO			
<i>atorvastatin</i>	1	MO; QL (30 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>fenofibrate oral tablet</i>	1	MO	<i>niacin oral tablet extended release 24 hr</i>	1	MO
<i>fenofibric acid</i>	1	MO	NIACOR	3	MO
<i>fenofibric acid (choline)</i>	1	MO	NIASPAN EXTENDED-RELEASE	3	MO
FENOGLIDE	3	MO	<i>omega-3 acid ethyl esters</i>	3	ST; MO
FIBRICOR	3	MO	PRALUENT PEN	2	PA; MO; QL (2 per 28 days)
FLOLIPID	3	ST; MO; QL (300 per 30 days)	PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG	3	ST; MO; QL (30 per 30 days)
<i>fluvastatin oral capsule 20 mg</i>	1	MO; QL (30 per 30 days)	<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>fluvastatin oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)	<i>prevalite oral powder in packet</i>	1	MO
<i>fluvastatin oral tablet extended release 24 hr</i>	1	MO; QL (30 per 30 days)	QUESTRAN LIGHT ORAL POWDER	3	MO
<i>gemfibrozil</i>	1	MO	QUESTRAN ORAL POWDER IN PACKET	3	MO
JUXTAPIID	2	PA; MO; LA	REPATHA	2	PA; MO; QL (3 per 28 days)
LESCOL XL	3	ST; MO; QL (30 per 30 days)	REPATHA PUSHTRONEX	2	PA; MO; QL (3.5 per 28 days)
LIPITOR	3	ST; MO; QL (30 per 30 days)	REPATHA SURECLICK	2	PA; MO; QL (3 per 28 days)
LIPOFEN	3	MO	<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
LIVALO	2	MO; QL (30 per 30 days)	<i>simvastatin</i>	1	MO; QL (30 per 30 days)
LOPID	3	MO			
<i>lovastatin oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)			
<i>lovastatin oral tablet 20 mg, 40 mg</i>	1	MO; QL (60 per 30 days)			
LOVAZA	3	ST; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
TRICOR	3	MO	ENTRESTO	2	MO; QL (60 per 30 days)
TRIGLIDE ORAL TABLET 160 MG	3	MO	LANOXIN ORAL TABLET 125 MCG, 250 MCG	3	MO
TRILIPIX	3	MO	LANOXIN ORAL TABLET 62.5 MCG	2	MO
VASCEPA	2	MO	RANEXA	3	MO
VYTORIN 10-10	3	ST; MO; QL (30 per 30 days)	<i>ranolazine</i>	1	MO
VYTORIN 10-20	3	ST; MO; QL (30 per 30 days)	VECAMYL	3	
VYTORIN 10-40	3	ST; MO; QL (30 per 30 days)	VYNDAQEL	2	PA; MO
VYTORIN 10-80	3	ST; MO; QL (30 per 30 days)	NITRATES		
WELCHOL	3	MO	GONITRO	3	MO
ZETIA	3	MO	ISORDIL	3	MO
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG	3	ST; MO; QL (30 per 30 days)	ISORDIL TITRADOSE ORAL TABLET 5 MG	3	MO
ZYPITAMAG	3	ST; MO; QL (30 per 30 days)	<i>isosorbide dinitrate oral tablet</i>	1	MO
MISCELLANEOUS CARDIOVASCULAR AGENTS			<i>isosorbide dinitrate oral tablet extended release</i>	1	
CORLANOR	2	PA; MO	<i>isosorbide mononitrate</i>	1	MO
<i>digitek</i>	1	MO	MINITRAN	3	MO
<i>digox</i>	1	MO	<i>nitro-bid</i>	1	MO
<i>digoxin oral solution 50 mcg/ml</i>	1	MO	NITRO-DUR	3	MO
<i>digoxin oral tablet</i>	1	MO	<i>nitroglycerin sublingual</i>	1	MO
			<i>nitroglycerin transdermal patch 24 hour</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits			
<i>nitroglycerin translingual spray, non-aerosol</i>	1	MO	SORIATANE ORAL CAPSULE 10 MG, 25 MG	3	MO			
NITROSTAT	3	MO	SORILUX	3	MO; QL (120 per 30 days)			
DERMATOLOGICALS/TOPICAL THERAPY								
ANTIPSORIATIC / ANTISEBORRHEIC								
acitretin	1	MO	STELARA SUBCUTANEOUS	2	PA; MO			
calcipotriene scalp	1	MO; QL (120 per 30 days)	TACLONEX	3	MO; QL (400 per 30 days)			
calcipotriene topical cream	3	MO; QL (120 per 30 days)	TALTZ AUTOINJECTOR	3	PA; MO			
calcipotriene topical ointment	1	MO; QL (120 per 30 days)	TALTZ SYRINGE	3	PA; MO			
calcipotriene- betamethasone	1	MO; QL (400 per 30 days)	TREMFYA	3	PA; MO			
calcitriol topical	3	MO	VECTICAL	3	MO			
COSENTYX (2 SYRINGES)	2	PA; MO	MISCELLANEOUS DERMATOLOGICALS					
COSENTYX PEN (2 PENS)	2	PA; MO	ALDARA	3	ST; MO			
DOVONEX TOPICAL	3	MO; QL (120 per 30 days)	ammonium lactate	1	MO			
ENSTILAR	3	MO; QL (400 per 30 days)	CARAC	3	ST; MO			
ILUMYA	3	PA; MO	CONDYLOX TOPICAL GEL	2	MO			
selenium sulfide topical lotion	1	MO	diclofenac sodium topical gel 3 %	1	PA; MO; QL (100 per 28 days)			
SILIQ	3	PA; MO	doxepin topical	1	MO; QL (45 per 30 days)			
SKYRIZI SUBCUTANEOUS SYRINGE KIT	2	PA; MO; QL (1 per 28 days)	DUPIXENT	2	PA; MO			
			EFUDEX TOPICAL CREAM	3	ST; MO			
			ELIDEL	3	PA; MO; QL (100 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
EUCRISA	3	PA; MO; QL (120 per 30 days)	PANRETIN	2	MO
FLUOROURACIL TOPICAL CREAM 0.5 %	3	ST; MO	PICATO	2	MO
<i>fluorouracil topical cream 5 %</i>	1	MO	<i>pimecrolimus</i>	1	PA; MO; QL (100 per 30 days)
<i>fluorouracil topical solution</i>	1	MO	PLIAGLIS	3	MO
IMIQUIMOD TOPICAL CREAM IN METERED-DOSE PUMP	3	ST; MO	<i>podofilox</i>	1	MO
<i>imiquimod topical cream in packet</i>	1	MO	PROTOPIC	3	PA; MO; QL (100 per 30 days)
<i>lidocaine hcl mucous membrane jelly</i>	1	MO; QL (60 per 30 days)	<i>prodoxin</i>	1	MO; QL (45 per 30 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	1	MO	REGRANEX	2	MO
<i>lidocaine topical adhesive patch, medicated</i>	1	PA; MO; QL (90 per 30 days)	SANTYL	2	MO
<i>lidocaine topical ointment</i>	3	MO; QL (36 per 30 days)	SILVADENE	3	MO
<i>lidocaine viscous</i>	1	MO	<i>silver sulfadiazine</i>	1	MO
<i>lidocaine-prilocaine topical cream</i>	1	MO; QL (30 per 30 days)	<i>ssd</i>	1	MO
LIDODERM	3	PA; MO; QL (90 per 30 days)	<i>tacrolimus topical</i>	1	PA; MO; QL (100 per 30 days)
<i>methoxsalen</i>	1	MO	TOLAK	3	MO
OXSORALEN ULTRA	3	MO	VALCHLOR	2	MO
THERAPY FOR ACNE					

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ABSORICA	3	MO	CLEOCIN T TOPICAL SWAB	3	MO
ACANYA TOPICAL GEL WITH PUMP	3	MO	<i>clindacin p</i>	1	MO
ACZONE TOPICAL GEL	3	MO	CLINDAGEL	3	MO; QL (150 per 30 days)
<i>adapalene topical cream</i>	1	PA; MO	<i>clindamycin phosphate topical foam</i>	1	MO
<i>adapalene topical gel</i>	1	PA; MO	<i>clindamycin phosphate topical gel</i>	1	MO; QL (120 per 30 days)
<i>adapalene topical solution</i>	1	PA	<i>clindamycin phosphate topical lotion</i>	1	MO; QL (120 per 30 days)
<i>adapalene topical swab</i>	1	PA	<i>clindamycin phosphate topical solution</i>	1	MO; QL (120 per 30 days)
<i>adapalene-benzoyl peroxide</i>	1	PA; MO	<i>clindamycin phosphate topical swab</i>	1	MO
AKTIPAK	3	MO	<i>clindamycin-benzoyl peroxide topical gel</i>	1	MO
ALTRENO	3	PA; MO	<i>clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %</i>	1	MO
amnesteem	1	MO	<i>clindamycin-tretinoin</i>	1	PA; MO
ATRALIN	3	PA; MO	<i>dapsone topical</i>	1	MO
<i>avita topical cream</i>	1	PA; MO	DIFFERIN TOPICAL CREAM	3	PA; MO
AVITA TOPICAL GEL	3	PA; MO	DIFFERIN TOPICAL GEL 0.1 %	3	PA; MO
<i>azelaic acid</i>	1	MO	DIFFERIN TOPICAL GEL WITH PUMP	3	PA; MO
AZELEX	3	MO			
BENZACLIN PUMP	3	MO			
BENZAMYCIN	3	MO			
<i>claravis</i>	3	MO			
CLEOCIN T TOPICAL GEL	3	MO; QL (120 per 30 days)			
CLEOCIN T TOPICAL LOTION	3	MO; QL (120 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits	
DIFFERIN TOPICAL LOTION	3	PA; MO	<i>neuac</i>	1	MO	
DUAC	3	MO	NORITATE	3	ST; MO	
EPIDUO FORTE	3	PA; MO	ONEXTON TOPICAL GEL WITH PUMP	3	MO	
EPIDUO TOPICAL GEL WITH PUMP	3	PA; MO	RETIN-A	3	PA; MO	
<i>ery pads</i>	1	MO	RETIN-A MICRO	3	PA; MO	
<i>erygel</i>	1	MO	RETIN-A MICRO TOPICAL GEL WITH PUMP 0.06 %, 0.08 %	3	PA; MO	
<i>erythromycin with ethanol topical gel</i>	1	MO	RHOFADE	3	PA; MO	
<i>erythromycin with ethanol topical solution</i>	1	MO	SOOLANTRA	3	ST; MO	
<i>erythromycin- benzoyl peroxide</i>	1	MO	<i>tazarotene</i>	1	PA; MO	
EVOCLIN	3	MO	TAZORAC TOPICAL CREAM 0.05 %	2	PA; MO	
FABIOR	3	MO	TAZORAC TOPICAL CREAM 0.1 %	3	PA; MO	
FINACEA	3	ST; MO	TAZORAC TOPICAL GEL	2	PA; MO	
<i>isotretinoin</i>	1		<i>tretinoi n microspheres topical gel</i>	1	PA; MO	
METROCREAM	3	ST; MO	<i>tretinoi n topical</i>	1	PA; MO	
METROGEL TOPICAL GEL 1 %	3	ST; MO	<i>zenatane</i>	3	MO	
METROLOTION	3	ST; MO	ZIANA	3	PA; MO	
<i>metronidazole topical cream</i>	1	MO	TOPICAL ANTIBACTERIALS			
<i>metronidazole topical gel</i>	1	MO	BACTROBAN TOPICAL CREAM	3	QL (30 per 30 days)	
<i>metronidazole topical lotion</i>	1	MO	CORTISPORIN TOPICAL	3	MO	
MIRVASO TOPICAL GEL WITH PUMP	3	PA; MO				
<i>myorisan</i>	1	MO				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>gentamicin topical</i>	1	MO	<i>clotrimazole-betamethasone topical lotion</i>	1	MO; QL (60 per 28 days)
KLARON	3	MO	<i>econazole</i>	1	MO; QL (85 per 28 days)
<i>mafenide acetate</i>	1	MO	ERTACZO	3	MO; QL (60 per 28 days)
<i>mupirocin</i>	1	MO; QL (30 per 30 days)	EXELDERM	3	MO
<i>mupirocin calcium</i>	1	MO; QL (30 per 30 days)	EXTINA	3	MO; QL (100 per 28 days)
NEO-SYNALAR	3	MO	JUBLIA	3	MO
<i>sulfacetamide sodium (acne)</i>	1	MO	KERYDIN	3	MO
SULFAMYLYON TOPICAL CREAM	2	MO	<i>ketoconazole topical cream</i>	1	MO; QL (60 per 28 days)
SULFAMYLYON TOPICAL PACKET	3	MO	<i>ketoconazole topical foam</i>	1	MO; QL (100 per 28 days)
XEPI	3	MO; QL (30 per 30 days)	<i>ketoconazole topical shampoo</i>	1	MO; QL (120 per 28 days)
TOPICAL ANTIFUNGALS					
<i>ciclopirox topical cream</i>	1	MO; QL (90 per 28 days)	LOPROX (AS OLAMINE) TOPICAL CREAM	3	MO; QL (90 per 28 days)
<i>ciclopirox topical gel</i>	1	MO; QL (45 per 28 days)	LOPROX TOPICAL SHAMPOO	3	MO; QL (120 per 28 days)
<i>ciclopirox topical shampoo</i>	1	MO; QL (120 per 28 days)	LOTRISONE TOPICAL CREAM	3	MO; QL (45 per 28 days)
<i>ciclopirox topical solution</i>	1	MO	LULICONAZOLE	3	MO; QL (60 per 28 days)
<i>ciclopirox topical suspension</i>	1	MO; QL (60 per 28 days)	LUZU	3	MO; QL (60 per 28 days)
<i>clotrimazole topical cream</i>	1	MO; QL (45 per 28 days)	MENTAX	3	MO
<i>clotrimazole topical solution</i>	1	MO; QL (30 per 28 days)	<i>naftifine topical cream</i>	1	MO; QL (60 per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	1	MO; QL (45 per 28 days)	NAFTIN TOPICAL CREAM 2 %	3	MO; QL (60 per 28 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
NAFTIN TOPICAL GEL	2	MO; QL (60 per 28 days)	ALA-SCALP	3	MO
NIZORAL TOPICAL SHAMPOO	3	MO; QL (120 per 28 days)	<i>alclometasone</i>	1	MO
<i>nyamyc</i>	1	MO	<i>amcinonide topical cream</i>	1	MO
<i>nystatin topical cream</i>	1	MO; QL (30 per 28 days)	<i>amcinonide topical lotion</i>	1	MO
<i>nystatin topical ointment</i>	1	MO; QL (30 per 28 days)	<i>amcinonide topical ointment</i>	1	
<i>nystatin topical powder</i>	1	MO	<i>apexicon e</i>	1	MO; QL (120 per 30 days)
<i>nystatin-triamcinolone</i>	1	MO; QL (60 per 28 days)	<i>beser</i>	1	
<i>nystop</i>	1	MO	<i>betamethasone dipropionate</i>	1	MO
<i>oxiconazole</i>	1	MO	<i>betamethasone valerate</i>	1	MO
OXISTAT	3	MO	<i>betamethasone, augmented</i>	1	MO
TOPICAL ANTIVIRALS					
<i>acyclovir topical cream</i>	1	PA; MO; QL (5 per 30 days)	BRYHALI	3	MO
<i>acyclovir topical ointment</i>	3	PA; MO; QL (30 per 30 days)	CAPEX	2	MO
DENAVIR	2	MO	<i>clobetasol scalp</i>	1	MO; QL (100 per 28 days)
XERESE	3	MO	<i>clobetasol topical cream</i>	1	MO; QL (120 per 28 days)
ZOVIRAX TOPICAL CREAM	3	PA; MO; QL (5 per 30 days)	<i>clobetasol topical foam</i>	1	MO; QL (100 per 28 days)
ZOVIRAX TOPICAL OINTMENT	3	PA; MO; QL (30 per 30 days)	<i>clobetasol topical gel</i>	1	MO; QL (120 per 28 days)
TOPICAL CORTICOSTEROIDS					
<i>ala-cort topical cream</i>	1	MO	<i>clobetasol topical lotion</i>	1	MO; QL (118 per 28 days)
			<i>clobetasol topical ointment</i>	1	MO; QL (120 per 28 days)
			<i>clobetasol topical shampoo</i>	1	MO; QL (236 per 28 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>clobetasol topical spray, non-aerosol</i>	1	MO; QL (125 per 28 days)	ELOCON TOPICAL OINTMENT	3	
<i>clobetasol-emollient topical cream</i>	1	MO; QL (120 per 28 days)	<i>fluocinolone and shower cap</i>	1	MO
<i>clobetasol-emollient topical foam</i>	1	MO; QL (100 per 28 days)	<i>fluocinolone topical cream</i>	1	MO
CLOBEX TOPICAL LOTION	3	MO; QL (118 per 28 days)	<i>fluocinolone topical ointment</i>	1	MO
CLOBEX TOPICAL SHAMPOO	3	MO; QL (236 per 28 days)	<i>fluocinolone topical solution</i>	1	MO
CLOBEX TOPICAL SPRAY, NON-AEROSOL	3	MO; QL (125 per 28 days)	<i>fluocinonide topical cream 0.1 %</i>	1	MO; QL (120 per 30 days)
<i>clodan</i>	1	MO; QL (236 per 28 days)	<i>fluocinonide topical gel</i>	1	MO; QL (120 per 30 days)
CORDRAN TAPE LARGE ROLL	3	MO	<i>fluocinonide topical ointment</i>	1	MO; QL (120 per 30 days)
CUTIVATE TOPICAL LOTION	3	MO	<i>fluocinonide topical solution</i>	1	MO; QL (120 per 30 days)
DESONATE	3	MO	<i>fluocinonide-e</i>	1	MO; QL (120 per 30 days)
<i>desonide</i>	3	MO	<i>flurandrenolide</i>	1	MO; QL (120 per 30 days)
DESOWEN	3	MO	<i>fluticasone propionate topical</i>	1	MO
<i>desoximetasone</i>	1	MO	<i>halobetasol propionate topical cream</i>	1	MO
<i>diflorasone</i>	1	MO; QL (120 per 30 days)	HALOBETASOL PROPIONATE TOPICAL FOAM	3	MO
DIPROLENE TOPICAL OINTMENT	3	MO	<i>halobetasol propionate topical ointment</i>	1	MO
DUOBRII	3	MO; QL (200 per 30 days)	HALOG	3	MO
ELOCON TOPICAL CREAM	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
hydrocortisone butyrate	1	MO	<i>prednicarbate</i>	1	MO
hydrocortisone topical cream 1 %, 2.5 %	1	MO	PSORCON	3	QL (120 per 30 days)
hydrocortisone topical lotion 2.5 %	1	MO	SYNALAR TOPICAL CREAM	3	MO
hydrocortisone topical ointment 2.5 %	1	MO	TEXACORT	3	MO
hydrocortisone valerate	1	MO	TOPICORT	3	MO
IMPOYZ	3	MO; QL (120 per 28 days)	<i>triamcinolone acetonide topical aerosol</i>	1	MO; QL (126 per 28 days)
KENALOG TOPICAL	3	MO; QL (126 per 28 days)	<i>triamcinolone acetonide topical cream</i>	1	MO
LEXETTE	3	MO	<i>triamcinolone acetonide topical lotion</i>	1	MO
LOCOID LIPOCREAM	3	MO	<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	1	MO
LOCOID TOPICAL LOTION	3	MO	<i>trianex</i>	1	MO
LOCOID TOPICAL SOLUTION	3	MO	<i>triderm topical cream 0.1 %</i>	1	MO
LUXIQ	3	MO	TRIDESILON	3	MO
<i>mometasone topical</i>	1	MO	ULTRAVATE	3	MO
<i>nolix topical cream</i>	1	QL (120 per 30 days)	VANOS	3	MO; QL (120 per 30 days)
<i>nolix topical lotion</i>	1	MO; QL (120 per 30 days)	TOPICAL SCABICIDES / PEDICULICIDES		
OLUX	3	MO; QL (100 per 28 days)	ELIMITE	3	
OLUX-E	3	MO; QL (100 per 28 days)	EURAX	3	MO
PANDEL	3	MO	<i>lindane topical shampoo</i>	1	MO
			<i>malathion</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
NATROBA	3	MO	<i>d2.5 %-0.45 % sodium chloride</i>	1	
OVIDE	3	MO	<i>d5 % and 0.9 % sodium chloride</i>	1	MO
<i>permethrin topical cream</i>	1	MO	<i>d5 %-0.45 % sodium chloride</i>	1	MO
SKLICE	2	MO	<i>deferasirox</i>	1	PA; MO
DIAGNOSTICS / MISCELLANEOUS AGENTS			<i>dextrose 10 % and 0.2 % nacl</i>	1	
MISCELLANEOUS AGENTS			<i>dextrose 10 % in water (d10w)</i>	1	MO
<i>acamprosate</i>	3	MO	<i>dextrose 5 % in water (d5w)</i>	1	MO
AGRYLIN	3	MO	<i>intravenous parenteral solution</i>		
<i>alendronate oral tablet 40 mg</i>	1	MO; QL (30 per 30 days)	<i>dextrose 5%-0.2 % sod chloride</i>	1	
<i>anagrelide</i>	1	MO	<i>dextrose 5%-0.3 % sod.chloride</i>	1	
ANTABUSE	3	MO	<i>dextrose with sodium chloride</i>	1	
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	2	MO; LA	<i>disulfiram</i>	1	MO
AURYXIA	3	PA; MO	ENDARI	3	PA; MO
BUPHENYL	3	PA; MO	EVOXAC	3	MO
CARBAGLU	2	PA; MO; LA	EXJADE	2	PA; MO; LA
CARNITOR ORAL	3	MO	FERRIPROX	2	PA; MO
<i>cevimeline</i>	1	MO	FOSRENOL	3	MO
CHEMET	2	PA; MO	GLASSIA	3	MO; LA
CLINIMIX 4.25%/D5W SULFIT FREE	2	PA	INCRELEX	2	MO; LA
CLINIMIX E 2.75%/D5W SULF FREE	3	PA	JADENU	3	PA; MO
<i>d10 %-0.45 % sodium chloride</i>	1		JADENU SPRINKLE	3	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
kionex (with sorbitol)	1	MO	risedronate oral tablet 30 mg	1	MO; QL (30 per 30 days)
lanthanum	1	MO	SALAGEN (PILOCARPINE)	3	MO
levocarnitine (with sugar)	1	MO	sevelamer carbonate	1	MO
levocarnitine oral tablet	1	MO	sevelamer hcl	1	MO
LITHOSTAT	3	MO	sodium chloride 0.9 % intravenous parenteral solution	1	MO
LOKELMA	2	MO	sodium chloride irrigation	1	MO
midodrine	1	MO	sodium phenylbutyrate	1	PA; MO
NITYR	3	PA; MO; LA	sodium polystyrene sulfonate oral	1	MO
NORTHERA	3	PA; MO	sps (with sorbitol) oral	1	MO
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG	2	PA; LA	SYPRINE	3	PA; MO
ORFADIN ORAL CAPSULE 20 MG	2	PA; MO; LA	THIOLA	2	MO
ORFADIN ORAL SUSPENSION	2	PA; MO; LA	TIGLUTIK	3	MO
pilocarpine hcl oral	1	MO	trientine	1	PA; MO
PROLASTIN-C INTRAVENOUS RECON SOLN	2	LA	VELPHORO	3	MO
PROLASTIN-C INTRAVENOUS SOLUTION	2	MO; LA	VELTASSA	2	MO
RAVICTI	2	PA; MO	XURIDEN	2	MO
RENAGEL ORAL TABLET 800 MG	3	MO	ZEMAIRA	3	MO; LA
RENVELA	3	MO	SMOKING DETERRENTS		
RILUTEK	3	MO	bupropion hcl (smoking deter)	1	MO
riluzole	1	MO	CHANTIX	2	MO
			CHANTIX CONTINUING MONTH BOX	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits			
CHANTIX STARTING MONTH BOX	2	MO	<i>flac otic oil</i>	1				
NICOTROL	3	MO	<i>fluocinolone acetonide oil</i>	1	MO			
NICOTROL NS	3	MO	<i>hydrocortisone- acetic acid</i>	1	MO			
ZYBAN	3	MO	<i>ofloxacin otic (ear)</i>	1	MO			
EAR, NOSE / THROAT MEDICATIONS								
MISCELLANEOUS AGENTS								
ASTEPRO NASAL SPRAY, NON- AEROSOL	3	MO; QL (60 per 30 days)	CIPRO HC	3	MO			
<i>azelastine nasal</i>	1	MO; QL (60 per 30 days)	CIPRODEX	2	MO			
BACTROBAN NASAL	2	MO; QL (30 per 30 days)	<i>neomycin- polymyxin-hc otic (ear)</i>	1	MO			
<i>chlorhexidine gluconate mucous membrane</i>	1	MO	OTOVEL	2	MO			
<i>ipratropium bromide nasal</i>	1	MO; QL (30 per 30 days)	ENDOCRINE/DIABETES					
<i>olopatadine nasal</i>	1	MO; QL (30.5 per 30 days)	ADRENAL HORMONES					
PATANASE	3	MO; QL (30.5 per 30 days)	ACTHAR	3	PA; MO			
<i>triamcinolone acetonide dental</i>	1	MO	CORTEF	3	MO			
MISCELLANEOUS OTIC PREPARATIONS			<i>cortisone</i>	1	MO			
<i>acetic acid otic (ear)</i>	1	MO	<i>dexamethasone intensol</i>	1	MO			
CETRAXAL	3	MO	<i>dexamethasone oral elixir</i>	1	MO			
<i>ciprofloxacin hcl otic (ear)</i>	1	MO	<i>dexamethasone oral tablet</i>	1	MO			
			<i>dexamethasone oral tablets, dose pack</i>	1	MO			
			DEXPAK 13 DAY	3	MO			
			EMFLAZA	3	PA; MO; LA			
			<i>fludrocortisone</i>	1	MO			
			<i>hydrocortisone oral</i>	1	MO			
			MEDROL	3	PA; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
MEDROL (PAK)	3	MO	TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (27 TABS), 1.5 MG (49 TABS)	3	
<i>methylprednisolone oral tablet</i>	1	PA; MO			
<i>methylprednisolone oral tablets,dose pack</i>	1	MO			
<i>millipred oral tablet</i>	3	PA; MO			
ORAPRED ODT	3	PA; MO			
<i>prednisolone oral solution 15 mg/5 ml</i>	1	MO			
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	1	MO			
<i>prednisolone sodium phosphate oral tablet,disintegrating</i>	1	PA; MO			
<i>prednisone intensol</i>	1	PA; MO			
<i>prednisone oral solution</i>	1	MO			
<i>prednisone oral tablet</i>	1	PA; MO			
<i>prednisone oral tablets,dose pack</i>	1	MO			
RAYOS	3	PA; MO			
TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (21 TABS)	3	MO			
			ANTITHYROID AGENTS		
			<i>methimazole oral tablet 10 mg, 5 mg</i>	1	MO
			<i>propylthiouracil</i>	1	MO
			<i>TAPAZOLE</i>	3	MO
			DIABETES THERAPY		
			<i>acarbose oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
			<i>acarbose oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
			<i>acarbose oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
			<i>ACTOPLUS MET</i>	3	MO; QL (90 per 30 days)
			<i>ACTOS</i>	3	MO; QL (30 per 30 days)
			<i>ADLYXIN SUBCUTANEOUS PEN INJECTOR 10 MCG/0.2 ML- 20 MCG/0.2 ML</i>	3	PA; MO; QL (6 per 180 days)
			<i>ADLYXIN SUBCUTANEOUS PEN INJECTOR 20 MCG/0.2 ML</i>	3	PA; MO; QL (6 per 30 days)
			<i>ADMELOG SOLOSTAR U-100 INSULIN</i>	3	ST; MO
			<i>ADMELOG U-100 INSULIN LISPRO</i>	3	ST; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at **express-scripts.com**.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT, 8 UNIT (90)/ 12 UNIT (90)	3	MO	BYDUREON BCISE	2	PA; MO; QL (4 per 28 days)
ALCOHOL PADS	2	MO	BYDUREON SUBCUTANEOUS PEN INJECTOR	2	PA; MO; QL (4 per 28 days)
ALOGLIPTIN	3	ST; MO; QL (30 per 30 days)	BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	2	PA; MO; QL (2.4 per 30 days)
ALOGLIPTIN-METFORMIN	3	ST; MO; QL (60 per 30 days)	BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	2	PA; MO; QL (1.2 per 30 days)
ALOGLIPTIN-PIOGLITAZONE	3	MO; QL (30 per 30 days)	CYCLOSET	3	MO; QL (180 per 30 days)
AMARYL ORAL TABLET 1 MG	3	MO; QL (240 per 30 days)	DUETACT	3	MO; QL (30 per 30 days)
AMARYL ORAL TABLET 2 MG	3	MO; QL (120 per 30 days)	FARXIGA ORAL TABLET 10 MG	2	MO; QL (30 per 30 days)
AMARYL ORAL TABLET 4 MG	3	MO; QL (60 per 30 days)	FARXIGA ORAL TABLET 5 MG	2	MO; QL (60 per 30 days)
APIDRA SOLOSTAR U-100 INSULIN	3	ST; MO	FIASP FLEXTOUCH U-100 INSULIN	3	ST; MO
APIDRA U-100 INSULIN	3	ST; MO	FIASP U-100 INSULIN	3	ST; MO
AVANDIA ORAL TABLET 2 MG, 4 MG	3	MO; QL (60 per 30 days)	FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 1,000 MG	3	MO; QL (60 per 30 days)
BASAGLAR KWIKPEN U-100 INSULIN	3	ST; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 500 MG	3	MO; QL (150 per 30 days)	GLUCAGON EMERGENCY KIT (HUMAN)	2	MO
GAUZE PADS 2 X 2	2	MO	GLUCOPHAGE ORAL TABLET 1,000 MG	3	MO; QL (75 per 30 days)
<i>glimepiride oral tablet 1 mg</i>	1	MO; QL (240 per 30 days)	GLUCOPHAGE ORAL TABLET 500 MG	3	MO; QL (150 per 30 days)
<i>glimepiride oral tablet 2 mg</i>	1	MO; QL (120 per 30 days)	GLUCOPHAGE ORAL TABLET 850 MG	3	MO; QL (90 per 30 days)
<i>glimepiride oral tablet 4 mg</i>	1	MO; QL (60 per 30 days)	GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG	3	MO; QL (120 per 30 days)
<i>glipizide oral tablet 10 mg</i>	1	MO; QL (120 per 30 days)	GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR 750 MG	3	MO; QL (60 per 30 days)
<i>glipizide oral tablet 5 mg</i>	1	MO; QL (240 per 30 days)	GLUCOTROL ORAL TABLET 10 MG	3	MO; QL (120 per 30 days)
<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	MO; QL (60 per 30 days)	GLUCOTROL ORAL TABLET 5 MG	3	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 2.5 mg</i>	1	MO; QL (240 per 30 days)	GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG	3	MO; QL (60 per 30 days)
<i>glipizide oral tablet extended release 24hr 5 mg</i>	1	MO; QL (120 per 30 days)	GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 2.5 MG	3	MO; QL (240 per 30 days)
<i>glipizide-metformin oral tablet 2.5-250 mg</i>	1	MO; QL (240 per 30 days)			
<i>glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1	MO; QL (120 per 30 days)			
GLUCAGEN HYPOKIT	2	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 5 MG	3	MO; QL (120 per 30 days)	HUMALOG MIX 75-25(U-100)INSULN	2	MO
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 1,000 MG	3	MO; QL (60 per 30 days)	HUMALOG U-100 INSULIN	2	MO
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG	3	MO; QL (120 per 30 days)	HUMULIN 70/30 U-100 INSULIN	2	MO
GLYSET ORAL TABLET 100 MG	3	MO; QL (90 per 30 days)	HUMULIN 70/30 U-100 KWIKPEN	2	MO
GLYSET ORAL TABLET 25 MG	3	MO; QL (360 per 30 days)	HUMULIN N NPH INSULIN KWIKPEN	2	MO
GLYSET ORAL TABLET 50 MG	3	MO; QL (180 per 30 days)	HUMULIN N NPH U-100 INSULIN	2	MO
GLYXAMBI	3	ST; MO; QL (30 per 30 days)	HUMULIN R REGULAR U-100 INSULN	2	MO
HUMALOG JUNIOR KWIKPEN U-100	2	MO	HUMULIN R U-500 (CONC) INSULIN	2	MO
HUMALOG KWIKPEN INSULIN	2	MO	HUMULIN R U-500 (CONC) KWIKPEN	2	MO
HUMALOG MIX 50-50 INSULN U-100	2	MO	INSULIN LISPRO	3	ST; MO
HUMALOG MIX 50-50 KWIKPEN	2	MO	INSULIN PEN NEEDLE	2	MO
HUMALOG MIX 75-25 KWIKPEN	2	MO	INSULIN SYRINGE (DISP) U-100 0.3 ML, 1 ML, 1/2 ML	2	MO
			INVOKAMET	2	MO; QL (60 per 30 days)
			INVOKAMET XR	2	MO; QL (60 per 30 days)
			INVOKANA	2	MO; QL (30 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
JANUMET	2	MO; QL (60 per 30 days)	KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	2	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	2	MO; QL (30 per 30 days)	LANTUS SOLOSTAR U-100 INSULIN	2	MO
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	2	MO; QL (60 per 30 days)	LANTUS U-100 INSULIN	2	MO
JANUVIA	2	MO; QL (30 per 30 days)	LEVEMIR FLEXTOUCH U-100 INSULN	3	ST; MO
JARDIANCE	3	ST; MO; QL (30 per 30 days)	LEVEMIR U-100 INSULIN	3	ST; MO
JENTADUETO	3	ST; MO; QL (60 per 30 days)	<i>metformin oral tablet 1,000 mg</i>	1	MO; QL (75 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	ST; MO; QL (60 per 30 days)	<i>metformin oral tablet 500 mg</i>	1	MO; QL (150 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	ST; MO; QL (30 per 30 days)	<i>metformin oral tablet 850 mg</i>	1	MO; QL (90 per 30 days)
KAZANO	3	ST; MO; QL (60 per 30 days)	<i>metformin oral tablet extended release 24 hr 500 mg</i>	1	MO; QL (120 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	2	MO; QL (60 per 30 days)	<i>metformin oral tablet extended release 24 hr 750 mg</i>	1	MO; QL (60 per 30 days)
			<i>metformin oral tablet extended release (osm) 24 hr 1,000 mg</i>	1	MO; QL (60 per 30 days)
			<i>metformin oral tablet extended release (osm) 24 hr 500 mg</i>	1	MO; QL (150 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg</i>	1	MO; QL (60 per 30 days)	NOVOLOG MIX 70-30 U-100 INSULN	3	ST; MO
<i>metformin oral tablet,er gast.retention 24 hr 500 mg</i>	1	MO; QL (120 per 30 days)	NOVOLOG MIX 70-30FLEXPEN U-100	3	ST; MO
<i>miglitol oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)	NOVOLOG PENFILL U-100 INSULIN	3	ST; MO
<i>miglitol oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)	NOVOLOG U-100 INSULIN ASPART	3	ST; MO
<i>miglitol oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)	OMNIPOD INSULIN MANAGEMENT	2	MO
<i>nateglinide oral tablet 120 mg</i>	1	MO; QL (90 per 30 days)	ONGLYZA	2	MO; QL (30 per 30 days)
<i>nateglinide oral tablet 60 mg</i>	1	MO; QL (180 per 30 days)	OSENI	3	MO; QL (30 per 30 days)
NEEDLES, INSULIN DISP.,SAFETY	2	MO	OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	2	PA; MO; QL (1.5 per 28 days)
NESINA	3	ST; MO; QL (30 per 30 days)	OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (2 MG/1.5 ML)	2	PA; MO; QL (3 per 28 days)
NOVOFINE 32	2	MO	pioglitazone	1	MO; QL (30 per 30 days)
NOVOLIN 70/30 U-100 INSULIN	3	ST; MO	pioglitazone- glimepiride	1	MO; QL (30 per 30 days)
NOVOLIN N NPH U-100 INSULIN	3	ST; MO	pioglitazone- metformin	1	MO; QL (90 per 30 days)
NOVOLIN R REGULAR U-100 INSULN	3	ST; MO	PRANDIN ORAL TABLET 1 MG	3	MO; QL (480 per 30 days)
NOVOLOG FLEXPEN U-100 INSULIN	3	ST; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
PRANDIN ORAL TABLET 2 MG	3	MO; QL (240 per 30 days)	STARLIX ORAL TABLET 60 MG	3	MO; QL (180 per 30 days)
PRECOSE ORAL TABLET 100 MG	3	MO; QL (90 per 30 days)	STEGLATRO	2	MO; QL (30 per 30 days)
PRECOSE ORAL TABLET 25 MG	3	MO; QL (360 per 30 days)	STEGLUJAN	3	ST; MO; QL (30 per 30 days)
PRECOSE ORAL TABLET 50 MG	3	MO; QL (180 per 30 days)	SYMLINPEN 120	2	PA; MO; QL (10.8 per 30 days)
PROGLYCEM	2	MO	SYMLINPEN 60	2	PA; MO; QL (6 per 30 days)
QTERN ORAL TABLET 10-5 MG	2	MO; QL (30 per 30 days)	SYNJARDY	3	ST; MO; QL (60 per 30 days)
QTERN ORAL TABLET 5-5 MG	2	QL (30 per 30 days)	SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	3	ST; MO; QL (60 per 30 days)
<i>repaglinide oral tablet 0.5 mg</i>	1	MO; QL (960 per 30 days)	SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	3	ST; MO; QL (30 per 30 days)
<i>repaglinide oral tablet 1 mg</i>	1	MO; QL (480 per 30 days)	<i>tolazamide oral tablet 250 mg</i>	1	MO; QL (120 per 30 days)
<i>repaglinide oral tablet 2 mg</i>	1	MO; QL (240 per 30 days)	<i>tolazamide oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)
<i>repaglinide-metformin</i>	1	MO; QL (150 per 30 days)	<i>tolbutamide</i>	1	MO; QL (180 per 30 days)
RIOMET	2	MO; QL (765 per 30 days)	TOUJEO MAX U-300 SOLOSTAR	2	MO
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5-1,000 MG, 7.5-500 MG	2	MO; QL (60 per 30 days)	TOUJEO SOLOSTAR U-300 INSULIN	2	MO
SEGLUROMET ORAL TABLET 2.5-500 MG	2	MO; QL (120 per 30 days)			
SOLIQUA 100/33	2	MO			
STARLIX ORAL TABLET 120 MG	3	MO; QL (90 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
TRADJENTA	3	ST; MO; QL (30 per 30 days)	V-GO 30	2	MO
TRESIBA FLEXTOUCH U-100	3	ST; MO	V-GO 40	2	MO
TRESIBA FLEXTOUCH U-200	3	ST; MO	VICTOZA 3-PAK	2	PA; MO; QL (9 per 30 days)
TRESIBA U-100 INSULIN	3	ST; MO	XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	2	MO; QL (30 per 30 days)
TRUEPLUS INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	2		XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	2	MO; QL (60 per 30 days)
TRUEPLUS INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16	2	MO	XULTOPHY 100/3.6	2	MO; QL (15 per 30 days)
MISCELLANEOUS HORMONES					
TRUEPLUS PEN NEEDLE	2	MO	ANADROL-50	3	PA; MO
TRULICITY	2	PA; MO; QL (2 per 28 days)	ANDRODERM	2	PA; MO; QL (30 per 30 days)
V-GO 20	2	MO	ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	3	PA; MO; QL (150 per 30 days)
			ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (25 MG/2.5GRAM), 1 % (50 MG/5 GRAM)	3	PA; MO; QL (300 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM)	3	PA; MO; QL (37.5 per 30 days)	GALAFOLD	3	PA; MO; LA; QL (15 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (40.5 MG/2.5 GRAM)	3	PA; MO; QL (150 per 30 days)	JYNARQUE ORAL TABLET	3	PA; LA
AVEED	3	PA; MO; LA	JYNARQUE ORAL TABLETS, SEQUENTIAL	3	PA; MO; LA
<i>cabergoline</i>	1	MO	KORLYM	3	PA; MO
<i>calcitonin (salmon)</i>	1	MO	KUVAN	2	PA; MO
<i>calcitriol oral</i>	1	MO	METHITEST	3	MO
CERDELGA	2	MO	<i>methyltestosterone oral capsule</i>	1	MO
<i>cinacalcet</i>	1	MO	<i> miglustat</i>	1	MO; LA
<i>danazol</i>	3	MO	MYALEPT	2	PA; MO; LA
DDAVP NASAL SOLUTION	2	MO	NATPARA	2	PA; MO; LA
DDAVP NASAL SPRAY WITH PUMP	3	MO	NOCDURNA (MEN)	3	PA; MO; QL (30 per 30 days)
DDAVP ORAL	3	MO	NOCDURNA (WOMEN)	3	PA; MO; QL (30 per 30 days)
DEPO- TESTOSTERONE	3	PA; MO	NOCTIVA	3	PA; MO; QL (3.8 per 30 days)
<i>desmopressin nasal spray, non-aerosol</i>	1	MO	ORILISSA	3	MO
<i>desmopressin oral</i>	1	MO	<i> oxandrolone</i>	1	PA; MO
<i>doxercalciferol oral</i>	1	MO	PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	2	PA; MO; LA; QL (15 per 30 days)
FORTESTA	3	PA; MO; QL (120 per 30 days)	PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	2	PA; MO; LA; QL (4 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	2	PA; MO; LA; QL (60 per 30 days)	TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP 12.5 MG/ 1.25 GRAM (1 %)	3	PA; MO; QL (300 per 30 days)
<i>paricalcitol oral</i>	3	MO	<i>testosterone</i> <i>transdermal gel in metered-dose pump</i> <i>20.25 mg/1.25 gram (1.62 %)</i>	1	PA; MO; QL (150 per 30 days)
RAYALDEE	3	MO	<i>testosterone</i> <i>transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	1	PA; MO; QL (300 per 30 days)
ROCALTROL	3	MO	<i>testosterone</i> <i>transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	1	PA; MO; QL (37.5 per 30 days)
SAMSCA	2	PA; MO	<i>testosterone</i> <i>transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	1	PA; MO; QL (150 per 30 days)
SENSIPAR	3	MO	<i>testosterone</i> <i>transdermal solution in metered pump w/app</i>	1	PA; MO; QL (180 per 30 days)
SOMAVERT	2	MO	VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	3	PA; MO; QL (300 per 30 days)
STIMATE	2	MO	VOGELXO TRANSDERMAL GEL IN PACKET	3	PA; MO; QL (300 per 30 days)
STRIANT	3	PA; MO; QL (60 per 30 days)	XYOSTED	3	PA; MO; QL (2 per 28 days)
SYNAREL	2	MO			
TESTIM	3	PA; MO; QL (300 per 30 days)			
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	1	PA; MO			
<i>testosterone cypionate intramuscular oil 200 mg/ml (1 ml)</i>	1	PA			
<i>testosterone enanthate</i>	1	PA; MO			
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation</i>	1	PA; MO; QL (120 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits			
ZAVESCA	3	MO; LA	<i>dicyclomine oral capsule</i>	1	MO			
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	3	MO	<i>dicyclomine oral solution</i>	1	MO			
THYROID HORMONES								
CYTOMEL	3	MO	<i>dicyclomine oral tablet</i>	1	MO			
LEVO-T	3		<i>diphenoxylate-atropine</i>	1	MO			
<i>levothyroxine oral</i>	1	MO	<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	MO			
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO	LOMOTIL	3	MO			
<i>liothyronine oral</i>	1	MO	<i>loperamide oral capsule</i>	1	MO			
SYNTHROID	3	MO	<i>methscopolamine</i>	1	MO			
THYROLAR-1	3	MO	MOTOFEN	3	MO			
THYROLAR-1/2	3	MO	MYTESI	3	MO			
THYROLAR-1/4	3	MO	MISCELLANEOUS GASTROINTESTINAL AGENTS					
THYROLAR-2	3	MO	ACTIGALL	3	MO			
THYROLAR-3	3	MO	AKYNZEO (FOSNETUPITANT)	3	MO			
TIROSINT	3	MO	<i>alosetron</i>	1	MO			
TIROSINT-SOL	3	MO	AMITIZA	3	ST; MO			
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO	ANUSOL-HC TOPICAL	3	MO			
GASTROENTEROLOGY								
ANTIDIARRHEALS / ANTISPASMODICS			<i>aprepitant</i>	1	PA; MO			
CUVPOSA	3	MO	APRISO	3	MO			
			ASACOL HD	3	MO			
			AZULFIDINE	3	MO			
			AZULFIDINE EN-TABS	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
balsalazide	1	MO	DICLEGIS	3	MO
BONJESTA	3	MO	DIPENTUM	3	MO
budesonide oral	1	MO	<i>doxylamine-pyridoxine (vit b6)</i>	1	MO
CANASA	3	MO	<i>dronabinol oral capsule 10 mg</i>	1	PA; MO
CESAMET	3	PA; MO	<i>dronabinol oral capsule 2.5 mg, 5 mg</i>	3	PA; MO
CHENODAL	2	PA; LA	EMEND ORAL CAPSULE	3	PA; MO
CHOLBAM ORAL CAPSULE 250 MG	2	PA; MO	EMEND ORAL CAPSULE,DOSE PACK	3	PA; MO
CHOLBAM ORAL CAPSULE 50 MG	2	PA; MO; QL (120 per 30 days)	EMEND ORAL SUSPENSION FOR RECONSTITUTION	2	PA; MO
CIMZIA	3	PA; MO	ENTOCORT EC	3	MO
CIMZIA POWDER FOR RECONST	3	PA; MO	<i>enulose</i>	1	MO
CLENPIQ	3	MO	GASTROCROM	3	MO
COLAZAL	3	MO	GATTEX 30-VIAL	3	PA; MO
colocort	1	MO	<i>gavilyte-c</i>	1	MO
COLYTE WITH FLAVOR PACKS ORAL RECON SOLN 240-22.72-6.72 -5.84 GRAM	3	MO	<i>gavilyte-g</i>	1	MO
compro	1	MO	<i>gavilyte-n</i>	1	MO
constulose	1	MO	<i>generlac</i>	1	MO
CORTIFOAM	2	MO	GOLYTEL	3	MO
CREON	2	MO	<i>gransetron hcl oral</i>	1	PA; MO
cromolyn oral	1	MO	<i>hydrocortisone rectal</i>	1	MO
CYSTADANE	2		<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	1	MO
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	3	MO	INFLECTRA	3	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
KRISTALOSE	3	MO	<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	PA; MO
<i>lactulose oral packet</i>	1		OSMOPREP	3	MO
<i>lactulose oral solution 10 gram/15 ml</i>	1	MO	PANCREAZE ORAL CAPSULE,DELAY ED	3	ST; MO
LIALDA	3	MO	RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800-		
LINZESS	3	ST; MO	98,400 UNIT, 2,600- 6,200- 10,850 UNIT, 21,000-54,700-		
LOTRONEX	3	MO	83,900 UNIT, 4,200- 14,200- 24,600		
MARINOL	3	PA; MO	UNIT		
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	1	MO	<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	1	MO
<i>mesalamine</i>	1	MO	<i>peg 3350-electrolytes oral recon soln 240-22.72-6.72 -5.84 gram</i>	1	
<i>metoclopramide hcl oral</i>	1	MO	<i>peg-electrolyte</i>	1	
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	3	MO	PENTASA	2	MO
MOTEGRITY	3	ST; MO	PERTZYE ORAL CAPSULE,DELAY ED	3	ST; MO
MOVANTIK	2	MO	RELEASE(DR/EC) 16,000-57,500- 60,500 UNIT, 4,000-		
MOVIPREP	3	MO	14,375- 15,125 UNIT, 8,000- 28,750- 30,250		
NULYTELY WITH FLAVOR PACKS	3	MO	UNIT		
OCALIVA	2	PA; MO; LA; QL (30 per 30 days)			
<i>ondansetron</i>	1	PA; MO			
<i>ondansetron hcl oral solution</i>	1	PA; MO			
<i>ondansetron hcl oral tablet 24 mg</i>	1	PA			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
PLENVU	3	MO	<i>trilyte with flavor packets</i>	1	MO
PREPOPIK	3	MO	TRULANCE	2	MO
<i>prochlorperazine</i>	1	MO	UCERIS	3	MO
<i>prochlorperazine maleate oral</i>	1	MO	URSO 250	3	MO
<i>procto-med hc</i>	1	MO	URSO FORTE	3	MO
<i>procto-pak</i>	1	MO	<i>ursodiol</i>	1	MO
<i>proctosol hc topical</i>	1	MO	VARUBI INTRAVENOUS	2	
<i>proctozone-hc</i>	1	MO	VARUBI ORAL	2	PA; MO
RECTIV	2	MO	VIBERZI	2	MO
REGLAN ORAL	3	MO	VIOKACE	2	MO
RELISTOR ORAL	3	MO	ZENPEP ORAL CAPSULE,DELAY ED RELEASE(DR/EC)	2	MO
RELISTOR SUBCUTANEOUS SOLUTION	3	MO	10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT		
REMICADE	2	PA; MO	ZOFRAN ORAL TABLET 8 MG	3	PA; MO
ROWASA RECTAL ENEMA KIT	3	MO	ZUPLENZ	3	PA; MO
SANCUSO	2	MO	ULCER THERAPY		
<i>scopolamine base</i>	1	MO	ACIPHEX	3	MO
SUCRAID	2	PA; MO			
<i>sulfasalazine</i>	1	MO			
SUPREP BOWEL PREP KIT	2	MO			
SYMPROIC	2	MO			
SYNDROS	3	PA; MO			
TRANSDERM-SCOP	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>amoxicil-clarithromy-lansopraz</i>	1	MO; QL (112 per 30 days)	<i>lansoprazole oral capsule,delayed release(dr/ec) 30 mg</i>	1	MO
CARAFATE	3	MO	<i>lansoprazole oral tablet,disintegrat, delay rel 15 mg</i>	1	MO; QL (30 per 30 days)
<i>cimetidine</i>	1	MO	<i>lansoprazole oral tablet,disintegrat, delay rel 30 mg</i>	1	MO
<i>cimetidine hcl oral</i>	1	MO	<i>misoprostol</i>	1	MO
CYTOTEC	3	MO	<i>NEXIUM ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 20 MG</i>	3	MO; QL (30 per 30 days)
DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 30 MG	3	MO; QL (30 per 30 days)	<i>NEXIUM ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 40 MG</i>	3	MO
DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 60 MG	3	MO	<i>NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG</i>	2	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)	<i>NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 40 MG</i>	2	MO
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg</i>	1	MO	<i>nizatidine</i>	1	MO
ESOMEPRAZOLE STRONTIUM ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 49.3 MG	3	MO	<i>OMECLAMOX-PAK</i>	3	MO; QL (80 per 28 days)
<i>famotidine oral suspension</i>	1	MO	<i>omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	MO			
<i>lansoprazole oral capsule,delayed release(dr/ec) 15 mg</i>	1	MO; QL (30 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>omeprazole oral capsule,delayed release(dr/ec) 40 mg</i>	1	MO	PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG	3	MO; QL (30 per 30 days)
<i>omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram</i>	1	MO; QL (30 per 30 days)	PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 30 MG	3	MO
<i>omeprazole-sodium bicarbonate oral capsule 40-1.1 mg-gram</i>	1	MO	PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON	3	MO
<i>omeprazole-sodium bicarbonate oral packet 20-1,680 mg</i>	1	MO; QL (30 per 30 days)	PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET	3	MO
<i>omeprazole-sodium bicarbonate oral packet 40-1,680 mg</i>	1	MO	PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 20 MG	3	MO; QL (30 per 30 days)
<i>pantoprazole oral tablet,delayed release (dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)	PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 40 MG	3	MO
<i>pantoprazole oral tablet,delayed release (dr/ec) 40 mg</i>	1	MO	PYLERA	3	MO
<i>PEPCID ORAL TABLET</i>	3	MO	<i>rabeprazole oral tablet,delayed release (dr/ec)</i>	1	MO
<i>PREVACID ORAL CAPSULE,DELAYED RELEASE(DR/EC) 15 MG</i>	3	MO; QL (30 per 30 days)	<i>ranitidine hcl oral capsule</i>	1	MO
<i>PREVACID ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 MG</i>	3	MO	<i>ranitidine hcl oral syrup</i>	1	MO
			<i>ranitidine hcl oral tablet 150 mg, 300 mg</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
sucralfate oral tablet	1	MO	AVONEX	2	PA; MO; QL (4 per 28 days)
ZEGERID ORAL CAPSULE 20-1.1 MG-GRAM	3	MO; QL (30 per 30 days)	INTRAMUSCULAR PEN INJECTOR KIT		
ZEGERID ORAL CAPSULE 40-1.1 MG-GRAM	3	MO	AVONEX	2	PA; MO; QL (4 per 28 days)
ZEGERID ORAL PACKET 20-1,680 MG	3	MO; QL (30 per 30 days)	BETASERON SUBCUTANEOUS KIT	3	PA; MO; QL (14 per 28 days)
ZEGERID ORAL PACKET 40-1,680 MG	3	MO	EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY					
BIOTECHNOLOGY DRUGS					
ACTIMMUNE	2	PA; MO	EXTAVIA SUBCUTANEOUS KIT	3	PA; MO; QL (15 per 28 days)
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	3	PA; MO	FULPHILA	2	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	3	PA; MO	GENOTROPIN	3	PA; MO
ARCALYST	2	PA; MO	GENOTROPIN MINIQUICK	3	PA; MO
AVONEX (WITH ALBUMIN)	2	PA; MO; QL (4 per 28 days)	GRANIX	2	PA; MO
			HUMATROPE	3	PA; MO
			INTRON A INJECTION	2	PA; MO
			LEUKINE INJECTION RECON SOLN	2	PA; MO
			NEULASTA SUBCUTANEOUS SYRINGE	2	PA; MO
			NEUPOGEN	2	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
NIVESTYM INJECTION	3	PA	PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	2	PA; MO; QL (1 per 180 days)
NIVESTYM SUBCUTANEOUS	3	PA; MO	PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML	2	PA; MO
NORDITROPIN FLEXPRO	2	PA; MO	OMNITROPE	2	PA; MO
NUTROPIN AQ NUSPIN	3	PA; MO	PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	2	MO; QL (2 per 28 days)
OMNITROPE	2	PA; MO	PEGASYS SUBCUTANEOUS SOLUTION	2	MO; QL (4 per 28 days)
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	2	MO; QL (2 per 28 days)	PEGASYS SUBCUTANEOUS SYRINGE	2	MO; QL (2 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	2	PA; MO; QL (1 per 28 days)	PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	2	PA; MO; QL (1 per 180 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	2	PA; MO; QL (1 per 28 days)	REBIF (WITH ALBUMIN)	2	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	2	PA; MO; QL (6 per 28 days)	REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	2	PA; MO; QL (4.2 per 180 days)
REBIF TITRATION PACK	2	PA; MO; QL (4.2 per 180 days)	REBIF TITRATION PACK	2	PA; MO; QL (4.2 per 180 days)
RETACRIT	2	PA; MO	SAIZEN	3	PA; MO
SAIZEN	3	PA; MO	SAIZEN SAIZENPREP	3	PA; MO
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	3	PA; MO	SYLATRON	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
UDENYCA	3	PA; MO	GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	3	PA; MO
ZARXIO	2	PA; MO	GAMMAPLEX	3	PA; MO
ZOMACTON	3	PA; MO	GAMMAPLEX (WITH SORBITOL)	3	PA; MO
ZORBTIVE	3	PA; MO	GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	3	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS			GARDASIL 9 (PF)	2	MO
ACTHIB (PF)	2	MO	HAVRIX (PF) INTRAMUSCULA R SUSPENSION	2	MO
ADACEL(TDAP ADOLESN/ADULT (PF))	2	MO	HAVRIX (PF) INTRAMUSCULA R SYRINGE 1,440 ELISA UNIT/ML	2	MO
BCG VACCINE, LIVE (PF)	2	MO	HAVRIX (PF) INTRAMUSCULA R SYRINGE 720 ELISA UNIT/0.5 ML	2	
BEXSERO	2	MO	HIBERIX (PF)	2	MO
BIVIGAM	3	PA; MO	IMOVAX RABIES VACCINE (PF)	2	MO
BOOSTRIX TDAP	2	MO	INFANRIX (DTAP) (PF) INTRAMUSCULA R SUSPENSION	2	MO
DAPTACEL (DTAP PEDIATRIC) (PF)	2	MO	IPOP	2	MO
ENGERIX-B (PF) INTRAMUSCULA R SYRINGE	2	PA; MO	IXIARO (PF)	2	MO
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULA R SYRINGE	2	PA; MO			
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	3	PA; MO			
GAMMAGARD LIQUID	3	PA; MO			
GAMMAGARD S- D (IGA < 1 MCG/ML)	3	PA; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
KINRIX (PF) INTRAMUSCULAR SUSPENSION	2		RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	2	PA; MO
KINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO	RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML	2	PA; MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	2	MO	RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	2	PA
MENVEO A-C-Y-W-135-DIP (PF)	2	MO	ROTARIX	2	
M-M-R II (PF)	2	MO	ROTAQUE VACCINE	2	MO
OCTAGAM	3	PA; MO	SHINGRIX (PF)	2	MO
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	3	PA; MO	TDVAX	2	MO
PANZYGA INTRAVENOUS SOLUTION 10 %	3	PA; MO	TENIVAC (PF) INTRAMUSCULAR SYRINGE	2	MO
PANZYGA INTRAVENOUS SOLUTION 10 % (100 ML), 10 % (200 ML), 10 % (25 ML), 10 % (300 ML), 10 % (50 ML)	3	PA	TETANUS,DIPHTHERIA TOX PED(PF)	2	MO
PEDIARIX (PF)	2	MO	TRUMENBA	2	MO
PEDVAX HIB (PF)	2	MO	TWINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
PRIVIGEN	2	PA; MO	TYPHIM VI INTRAMUSCULAR SOLUTION	2	
PROQUAD (PF)	2	MO	TYPHIM VI INTRAMUSCULAR SYRINGE	2	MO
QUADRACEL (PF)	2	MO			
RABAVERT (PF)	2	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
VAQTA (PF)	2	MO	<i>alendronate oral tablet 35 mg, 70 mg</i>	1	MO; QL (4 per 28 days)
VARIVAX (PF)	2	MO	ATELVIA	3	ST; MO; QL (4 per 28 days)
VARIZIG INTRAMUSCULAR SOLUTION	2	MO	BINOSTO	3	ST; MO; QL (4 per 28 days)
YF-VAX (PF)	2	MO	BONIVA ORAL	3	ST; MO; QL (1 per 30 days)
ZOSTAVAX (PF)	2	MO	EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	3	PA; MO; QL (2.34 per 30 days)
MUSCULOSKELETAL / RHEUMATOLOGY			EVISTA	3	MO
GOUT THERAPY			FORTEO	2	PA; MO; QL (2.4 per 28 days)
<i>allopurinol</i>	1	MO	FOSAMAX ORAL TABLET 70 MG	3	ST; MO; QL (4 per 28 days)
COLCHICINE	3	ST; MO	FOSAMAX PLUS D	3	ST; MO; QL (4 per 28 days)
COLCRYS	2	MO	<i>ibandronate oral</i>	1	MO; QL (1 per 30 days)
MITIGARE	2	MO	PROLIA	2	PA; MO
<i>probenecid</i>	1	MO	<i>raloxifene</i>	1	MO
<i>probenecid-colchicine</i>	1	MO	<i>risedronate oral</i>	1	MO; QL (1 per 30 days)
ULORIC	2	ST; MO	<i>risedronate oral</i>	1	MO; QL (4 per 28 days)
ZYLOPRIM	3	MO	<i>risedronate oral</i>	1	MO; QL (30 per 30 days)
OSTEOPOROSIS THERAPY			<i>risedronate oral tablet 5 mg</i>	1	MO; QL (30 per 30 days)
ACTONEL ORAL TABLET 150 MG	3	ST; MO; QL (1 per 30 days)			
ACTONEL ORAL TABLET 35 MG	3	ST; MO; QL (4 per 28 days)			
ACTONEL ORAL TABLET 5 MG	3	ST; MO; QL (30 per 30 days)			
<i>alendronate oral solution</i>	1	MO; QL (1286 per 30 days)			
<i>alendronate oral tablet 10 mg, 5 mg</i>	1	MO; QL (30 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
risedronate oral tablet,delayed release (dr/ec)	1	MO; QL (4 per 28 days)	HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	2	PA; MO; QL (6 per 180 days)
TYMLOS	2	PA; MO; QL (1.56 per 30 days)	HUMIRA PEN	2	PA; MO; QL (4 per 28 days)
OTHER RHEUMATOLOGICALS					
ACTEMRA	3	PA; MO	HUMIRA PEN CROHNS-UC-HS START	2	PA; MO; QL (6 per 180 days)
ACTEMRA ACTPEN	3	PA; MO; QL (4 per 28 days)	HUMIRA PEN PSOR-UVEITS-ADOL HS	2	PA; MO; QL (4 per 180 days)
ARAVA	3	MO; QL (30 per 30 days)	HUMIRA PEN SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	2	PA; MO; QL (2 per 28 days)
BENLYSTA SUBCUTANEOUS	2	PA; MO	HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	2	PA; MO; QL (4 per 28 days)
CUPRIMINE	3	MO	HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	2	PA; MO; QL (3 per 180 days)
DEPEN TITRATABS	2	MO	HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	2	PA; MO; QL (2 per 180 days)
ENBREL MINI	2	PA; MO; QL (8 per 28 days)			
ENBREL SUBCUTANEOUS RECON SOLN	2	PA; MO; QL (16 per 28 days)			
ENBREL SUBCUTANEOUS SYRINGE	2	PA; MO; QL (8 per 28 days)			
ENBREL SURECLICK	2	PA; MO; QL (8 per 28 days)			
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	2	PA; MO; QL (3 per 180 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
HUMIRA(CF) PEN CROHNS-UC-HS	2	PA; MO; QL (3 per 180 days)	OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	2	PA; MO
HUMIRA(CF) PEN PSOR-UV-ADOL HS	2	PA; MO; QL (3 per 180 days)	OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG(19)	2	PA
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	2	PA; MO; QL (4 per 28 days)	OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML	3	MO
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	2	PA; MO; QL (2 per 28 days)	<i>penicillamine</i>	1	MO
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	2	PA; MO; QL (4 per 28 days)	RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	2	MO
KEVZARA	3	PA; MO; QL (2.28 per 28 days)	ORENCIA	2	PA; MO
KINERET	3	PA; MO	ORENCIA (WITH MALTOSE)	2	PA; MO
<i>leflunomide</i>	1	MO; QL (30 per 30 days)	ORENCIA CLICKJECT	2	PA; MO
OLUMIANT	3	PA; MO; QL (30 per 30 days)	OTEZLA	2	PA; MO
ORENCIA	2	PA; MO	RIDAURA	3	MO
ORENCIA (WITH MALTOSE)	2	PA; MO	SAVELLA ORAL TABLET	2	MO; QL (60 per 30 days)
ORENCIA CLICKJECT	2	PA; MO			
OTEZLA	2	PA; MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
SAVELLA ORAL TABLETS,DOSE PACK	2	MO; QL (55 per 30 days)	DELESTROGEN	3	MO
SIMPONI	3	PA; MO	DEPO-ESTRADIOL	3	MO
XELJANZ	2	PA; MO; QL (60 per 30 days)	DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	3	MO
XELJANZ XR	2	PA; MO; QL (30 per 30 days)	DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	2	MO
OBSTETRICS / GYNECOLOGY					
ESTROGENS / PROGESTINS					
ACTIVELLA ORAL TABLET 1-0.5 MG	3	PA; MO	DIVIGEL TRANSDERMAL GEL IN PACKET 1 MG/GRAM (0.1 %)	3	PA; MO; QL (30 per 30 days)
ALORA	3	PA; MO; QL (8 per 28 days)	<i>dotti</i>	1	PA; QL (8 per 28 days)
<i>amabelz</i>	1	PA; MO	DUAVEE	2	MO
ANGELIQ	3	PA; MO	ELESTRIN	3	PA; MO
AYGESTIN	3	MO	<i>errin</i>	1	MO
BIJUVA	3	PA; MO	ESTRACE ORAL	3	PA; MO
<i>camila</i>	1	MO	ESTRACE VAGINAL	3	MO
CLIMARA	3	PA; MO; QL (4 per 28 days)	<i>estradiol oral</i>	3	PA; MO
CLIMARA PRO	3	PA; MO	<i>estradiol transdermal patch semiweekly</i>	1	PA; MO; QL (8 per 28 days)
COMBIPATCH	3	PA; MO	<i>estradiol transdermal patch weekly</i>	1	PA; MO; QL (4 per 28 days)
CRINONE VAGINAL GEL 4 %	3	MO	<i>estradiol vaginal</i>	1	MO
CRINONE VAGINAL GEL 8 %	3	PA; MO	<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	1	MO
<i>deblitane</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits	
<i>estradiol-norethindrone acet</i>	1	PA; MO	<i>norethindrone (contraceptive)</i>	1	MO	
ESTRING	2	MO	<i>norethindrone acetate</i>	1	MO	
EVAMIST	3	PA; MO; QL (16.2 per 30 days)	<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	3	PA; MO	
FEMHRT LOW DOSE	3	PA; MO	<i>norlyroc</i>	1		
FEMRING	3	MO	ORTHO MICRONOR	3	MO	
<i>fyavolv</i>	1	PA; MO	PREFEST	3	PA; MO	
IMVEXXY MAINTENANCE PACK	3	MO	PREMARIN ORAL	2	MO	
IMVEXXY STARTER PACK	3	MO	PREMARIN VAGINAL	2	MO	
<i>incassia</i>	1	MO	PREMPHASE	3	PA; MO	
<i>jinteli</i>	1	PA; MO	PREMPRO	3	PA; MO	
<i>jolivette</i>	1	MO	<i>progesterone micronized</i>	1	MO	
<i>lopreeza oral tablet 1-0.5 mg</i>	1	PA; MO	PROMETRIUM	3	MO	
<i>lyza</i>	1	MO	PROVERA	3	MO	
<i>medroxyprogesterone</i>	1	MO	<i>sharobel</i>	1	MO	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	2	PA; MO	VAGIFEM	3	MO	
MENOSTAR	3	PA; MO; QL (4 per 28 days)	VIVELLE-DOT	3	PA; MO; QL (8 per 28 days)	
<i>mimvey</i>	1	PA; MO	<i>yuvafem</i>	1	MO	
<i>mimvey lo</i>	1	PA; MO	MISCELLANEOUS OB/GYN			
MINIVELLE	3	PA; MO; QL (8 per 28 days)	AVC	3	MO	
<i>nora-be</i>	1	MO	CLEOCIN VAGINAL CREAM	3	MO	
			CLEOCIN VAGINAL SUPPOSITORY	2	MO	

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>clindamycin phosphate vaginal</i>	1	MO	<i>aubra</i>	1	MO
CLINDESSE	3	MO	<i>aviane</i>	1	MO
GYNAZOLE-1	3	MO	<i>balziva (28)</i>	1	MO
INTRAROSA	3	MO	BEYAZ	3	MO
LUPANETA PACK (1 MONTH)	3	PA; MO	<i>blisovi 24 fe</i>	1	MO
LUPANETA PACK (3 MONTH)	3	PA; MO	<i>blisovi fe 1.5/30 (28)</i>	1	MO
LYSTEDA	3	MO	<i>brielllyn</i>	1	MO
METROGEL VAGINAL	3	MO	<i>camrese lo</i>	1	MO
<i>metronidazole vaginal</i>	1	MO	<i>caziant (28)</i>	1	MO
<i>miconazole-3 vaginal suppository</i>	1	MO	<i>cryselle (28)</i>	1	MO
NUVARING	3	MO	<i>cyclafem 1/35 (28)</i>	1	MO
OSPHENA	3	MO	<i>cyclafem 7/7/7 (28)</i>	1	MO
<i>terconazole</i>	1	MO	<i>cyred</i>	1	MO
<i>tranexamic acid oral</i>	1	MO	<i>delyla (28)</i>	1	
<i>vandazole</i>	1	MO	<i>desog-</i> <i>e.estradiol/e.estradio</i> <i>l</i>	1	MO
<i>xulane</i>	1	MO	<i>desogestrel-ethinyl</i> <i>estradiol</i>	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS			<i>drospirenone-</i> <i>e.estradiol-lm.fa</i> <i>oral tablet 3-0.02-</i> <i>0.451 mg (24) (4)</i>	1	MO
<i>altavera (28)</i>	1	MO	<i>drospirenone-ethinyl</i> <i>estradiol</i>	1	MO
<i>alyacen 1/35 (28)</i>	1	MO	<i>emoquette</i>	1	MO
<i>amethia</i>	1	MO	<i>enpresse</i>	1	MO
<i>amethia lo</i>	1	MO	<i>enskyce</i>	1	MO
<i>apri</i>	1	MO	<i>estarrylla</i>	1	MO
<i>aranelle (28)</i>	1	MO	<i>ethynodiol diac-eth</i> <i>estradiol</i>	1	
<i>ashlyna</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>falmina</i> (28)	1	MO	<i>lessina</i>	1	MO
<i>fayosim</i>	1	MO	<i>levonest</i> (28)	1	MO
<i>femynor</i>	1	MO	<i>levonorgestrel-</i> <i>ethinyl estrad</i>	1	MO
GENERESS FE	3	MO	<i>levonorg-eth estrad</i> <i>triphasic</i>	1	MO
<i>gianvi</i> (28)	1	MO	<i>levora-28</i>	1	MO
<i>hailey</i> 24 fe	1	MO	LO LOESTRIN FE	3	MO
<i>introvale</i>	1	MO	LOESTRIN 1.5/30 (21)	3	MO
<i>isibloom</i>	1	MO	LOESTRIN 1/20 (21)	3	MO
<i>jasmiel</i> (28)	1		LOESTRIN FE 1.5/30 (28-DAY)	3	MO
<i>juleber</i>	1	MO	LOESTRIN FE 1/20 (28-DAY)	3	MO
<i>junel</i> 1.5/30 (21)	1	MO	<i>loryna</i> (28)	1	MO
<i>junel</i> 1/20 (21)	1	MO	LOSEASONIQUE	3	MO
<i>junel fe</i> 1.5/30 (28)	1	MO	<i>low-ogestrel</i> (28)	1	MO
<i>junel fe</i> 1/20 (28)	1	MO	<i>lutera</i> (28)	1	MO
<i>junel fe</i> 24	1	MO	<i>marlissa</i> (28)	1	MO
<i>kaitlib fe</i>	1	MO	<i>melodetta</i> 24 fe	1	MO
<i>kariva</i> (28)	1	MO	<i>mibelas</i> 24 fe	1	MO
<i>kelnor</i> 1/35 (28)	1	MO	<i>microgestin</i> 1.5/30 (21)	1	MO
<i>kelnor</i> 1-50	1	MO	<i>microgestin</i> 1/20 (21)	1	MO
<i>kurvelo</i> (28)	1	MO	<i>microgestin fe</i> 1.5/30 (28)	1	MO
<i>l norgest/e.estradiol-</i> <i>e.estrad</i>	1	MO	<i>microgestin fe</i> 1/20 (28)	1	MO
<i>larin</i> 1.5/30 (21)	1	MO	<i>mil</i>	1	MO
<i>larin</i> 1/20 (21)	1	MO			
<i>larin fe</i> 1.5/30 (28)	1	MO			
<i>larin fe</i> 1/20 (28)	1	MO			
<i>larissia</i>	1	MO			
<i>layolis fe</i>	1	MO			
<i>leena</i> 28	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
MINASTRIN 24 FE	3	MO	<i>portia 28</i>	1	MO
NATAZIA	3	MO	<i>previfem</i>	1	MO
<i>necon 0.5/35 (28)</i>	1	MO	QUARTETTE	3	MO
<i>nikki (28)</i>	1	MO	<i>reclipsen (28)</i>	1	MO
<i>noreth-ethinyl estradiol-iron</i>	1	MO	<i>rivilsa</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	1	MO	SAFYRAL	3	MO
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (24)/75 mg (4)</i>	1	MO	SEASONIQUE	3	MO
<i>norethindrone-e.estradiol-iron oral tablet, chewable</i>	1	MO	<i>setlakin</i>	1	MO
<i>norgestimate-ethinyl estradiol</i>	1	MO	<i>sprintec (28)</i>	1	MO
<i>nortrel 0.5/35 (28)</i>	1	MO	<i>sronyx</i>	1	MO
<i>nortrel 1/35 (21)</i>	1	MO	<i>syeda</i>	1	MO
<i>nortrel 1/35 (28)</i>	1	MO	<i>tarina 24 fe</i>	1	
<i>nortrel 7/7/7 (28)</i>	1	MO	<i>tarina fe 1/20 (28)</i>	1	MO
<i>ocella</i>	1	MO	<i>tri-estarrylla</i>	1	MO
<i>orsythia</i>	1	MO	<i>tri-legest fe</i>	1	MO
<i>ORTHO TRI-CYCLEN LO (28)</i>	3	MO	<i>tri-lo-estarrylla</i>	1	MO
<i>ORTHO-NOVUM 1/35 (28)</i>	3	MO	<i>tri-lo-sprintec</i>	1	MO
<i>ORTHO-NOVUM 7/7/7 (28)</i>	3	MO	<i>tri-mili</i>	1	MO
<i>pimtrea (28)</i>	1	MO	<i>tri-previfem (28)</i>	1	MO
<i>pirmella oral tablet 1-35 mg-mcg</i>	1	MO	<i>tri-sprintec (28)</i>	1	MO
			<i>trivora (28)</i>	1	MO
			<i>tri-vylibra</i>	1	MO
			<i>tri-vylibra lo</i>	1	MO
			<i>tydemy</i>	1	MO
			<i>velivet triphasic regimen (28)</i>	1	MO
			<i>vienna</i>	1	MO
			<i>vyfemla (28)</i>	1	MO
			<i>vylibra</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits			
wymzyafe	1	MO	<i>neomycin-bacitracin-polymyxin</i>	1	MO			
YASMIN (28)	3	MO	<i>neomycin-polymyxin-gramicidin</i>	1	MO			
YAZ (28)	3	MO	OCUFLOX	3	MO			
zarah	1	MO	<i>ofloxacin ophthalmic (eye)</i>	1	MO			
zovia 1/35e (28)	1	MO	<i>polymyxin b sulf-trimethoprim</i>	1	MO			
OPHTHALMOLOGY								
ANTIBIOTICS								
AZASITE	2	MO	POLYTRIM	3	MO			
<i>bacitracin ophthalmic (eye)</i>	1	MO	<i>tobramycin</i>	1	MO			
<i>bacitracin-polymyxin b ophthalmic (eye)</i>	1	MO	TOBREX	3	MO			
BESIVANCE	2	MO	VIGAMOX	3	MO			
CILOXAN	3	MO	ZYMAXID	3	MO			
<i>ciprofloxacin hcl ophthalmic (eye)</i>	1	MO	ANTIVIRALS					
<i>erythromycin ophthalmic (eye)</i>	1	MO	<i>trifluridine</i>	1	MO			
<i>gatifloxacin</i>	1	MO	ZIRGAN	3	MO			
<i>gentak ophthalmic (eye) ointment</i>	1	MO	BETA-BLOCKERS					
<i>gentamicin ophthalmic (eye) drops</i>	1	MO	<i>betaxolol ophthalmic (eye)</i>	1	MO			
<i>levofloxacin ophthalmic (eye)</i>	1	MO	BETIMOL	3	MO			
MOXEZA	3	MO	BETOPTIC S	3	MO			
<i>moxifloxacin ophthalmic (eye)</i>	1	MO	<i>carteolol</i>	1	MO			
NATACYN	2	MO	ISTALOL	3	MO			
			<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	1	MO			
			<i>timolol maleate ophthalmic (eye)</i>	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits			
TIMOPTIC OCUDOSE (PF)	3	MO	PHOSPHOLINE IODIDE	2	MO			
TIMOPTIC-XE	3	MO	<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	1	MO			
MISCELLANEOUS OPHTHALMOLOGICS								
ALOCRIL	3	MO	RESTASIS	2	MO; QL (60 per 30 days)			
ALOMIDE	3	MO	RESTASIS MULTIDOSE	2	MO; QL (5.5 per 30 days)			
<i>atropine ophthalmic (eye) drops</i>	1	MO	<i>sulfacetamide sodium ophthalmic (eye)</i>	1	MO			
<i>azelastine ophthalmic (eye)</i>	1	MO	<i>sulfacetamide-prednisolone</i>	1	MO			
BEPREVE	3	MO	XIIDRA	3	MO; QL (60 per 30 days)			
BLEPH-10	3	MO	NON-STEROIDAL ANTI-INFLAMMATORY AGENTS					
BLEPHAMIDE	3	MO	ACULAR	3	MO			
BLEPHAMIDE S.O.P.	3	MO	ACULAR LS	3	MO			
CEQUA	3	MO; QL (60 per 30 days)	ACUVAIL (PF)	3	MO			
<i>cromolyn ophthalmic (eye)</i>	1	MO	<i>bromfenac</i>	1	MO			
CYSTARAN	2	PA; MO	BROMSITE	2	MO			
<i>epinastine</i>	1	MO	<i>diclofenac sodium ophthalmic (eye)</i>	1	MO			
ISOPTO CARPINE	3	MO	<i>flurbiprofen sodium</i>	1	MO			
LACRISERT	3	MO	ILEVRO	2	MO			
LASTACAFT	3	MO	<i>ketorolac ophthalmic (eye)</i>	1	MO			
<i>olopatadine ophthalmic (eye)</i>	1	MO	NEVANAC	3	MO			
OXERVATE	2	PA; MO	PROLENSA	2	MO			
PATADAY	3	MO	ORAL DRUGS FOR GLAUCOMA					
PATANOL	3	MO	<i>acetazolamide</i>	1	MO			
PAZEO	2	MO						

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits			
<i>methazolamide</i>	1	MO	<i>neomycin-bacitracin-poly-hc</i>	1	MO			
OTHER GLAUCOMA DRUGS								
AZOPT	3	MO	<i>neomycin-polymyxin b-dexameth</i>	1	MO			
<i>bimatoprost ophthalmic (eye)</i>	1	MO	<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	1	MO			
COMBIGAN	2	MO	PRED-G	3	MO			
COSOPT	3	MO	PRED-G S.O.P.	3	MO			
COSOPT (PF)	3	MO	TOBRADEX	3	MO			
<i>dorzolamide</i>	1	MO	TOBRADEX ST	3	MO			
<i>dorzolamide-timolol</i>	1	MO	<i>tobramycin-dexamethasone</i>	1	MO			
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>			ZYLET	2	MO			
<i>latanoprost</i>	1	MO	STEROIDS					
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	2	MO	ALREX	3	MO			
RHOPRESSA	2	MO	<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	1	MO			
ROCKLATAN	3	MO	DUREZOL	3	MO			
SIMBRINZA	3	MO	FLAREX	3	MO			
TRAVATAN Z	2	MO	<i>fluorometholone</i>	1	MO			
TRUSOPT	3	MO	FML FORTE	3	MO			
VYZULTA	3	MO	FML LIQUIFILM	3	MO			
XALATAN	3	ST; MO	FML S.O.P.	3	MO			
XELPROS	3	ST; MO	INVELTYS	3	MO			
ZIOPTAN (PF)	3	ST; MO	LOTEMAX OPHTHALMIC (EYE) DROPS,GEL	2	MO			
STEROID-ANTIBIOTIC COMBINATIONS								
MAXITROL	3	MO						

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
LOTEMAX OPHTHALMIC (EYE) DROPS,SUSPENSION	3	MO	RESPIRATORY AND ALLERGY		
LOTEMAX OPHTHALMIC (EYE) OINTMENT	2	MO	ANTIHISTAMINE / ANTIALLERGENIC AGENTS		
LOTEMAX SM	2	MO	AUVI-Q	3	ST; MO; QL (2 per 30 days)
<i>loteprednol etabonate</i>	1	MO	<i>cetirizine oral solution 1 mg/ml</i>	1	MO
MAXIDEX	3	MO	CLARINEX ORAL SYRUP	3	MO
OMNIPRED	3	MO	CLARINEX ORAL TABLET	3	MO; QL (30 per 30 days)
PRED FORTE	3	MO	CLARINEX-D 12 HOUR	3	MO; QL (60 per 30 days)
PRED MILD	3	MO	<i>desloratadine</i>	1	MO; QL (30 per 30 days)
<i>prednisolone acetate</i>	1	MO	EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.15 ML, 0.3 % NOT MADE BY MYLAN	3	ST; MO; QL (2 per 30 days)
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	1	MO	EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML (MANUFACTURED BY MYLAN SPECIALTY)	2	MO; QL (2 per 30 days)
SYMPATHOMIMETICS			<i>epinephrine injection auto-injector 0.3 mg/0.3 ml (manufactured by mylan specialty)</i>	1	MO; QL (2 per 30 days)
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	2	MO	EPIPEN 2-PAK	2	MO; QL (2 per 30 days)
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.15 %	3	MO			
<i>apraclonidine</i>	1	MO			
<i>brimonidine</i>	1	MO			
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	3	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
EPIPEN JR 2-PAK	2	MO; QL (2 per 30 days)	ALBUTEROL SULFATE INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION (NDA020503)	3	ST; MO; QL (13.4 per 30 days)
<i>hydroxyzine hcl oral tablet</i>	1	PA; MO			
<i>levocetirizine oral solution</i>	1	MO			
<i>levocetirizine oral tablet</i>	1	MO; QL (30 per 30 days)			
<i>promethazine oral</i>	3	PA; MO			
SEMPREX-D	3	MO			
PULMONARY AGENTS					
ACCOLATE	3	MO			
<i>acetylcysteine</i>	1	PA; MO			
ADCIRCA	3	PA; MO; QL (60 per 30 days)			
ADEMPAS	2	PA; MO; LA	<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	1	PA; MO
ADVAIR DISKUS	2	MO; QL (60 per 30 days)	<i>albuterol sulfate oral syrup</i>	1	MO
ADVAIR HFA	2	MO; QL (12 per 30 days)	<i>albuterol sulfate oral tablet</i>	3	MO
AIRDUO RESPICLICK	3	MO; QL (60 per 30 days)	<i>albuterol sulfate oral tablet extended release 12 hr</i>	3	MO
ALBUTEROL SULFATE INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION	3	ST; MO; QL (17 per 30 days)	ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION	3	MO; QL (12.2 per 30 days)
			ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	3	MO; QL (6.1 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
alyq	1	PA; MO; QL (60 per 30 days)	BERINERT INTRAVENOUS KIT	3	PA; MO
ambrisentan	1	PA; MO; LA	BEVESPI AEROSPHERE	2	MO; QL (10.7 per 30 days)
ANORO ELLIPTA	2	MO; QL (60 per 30 days)	bosentan	1	PA; MO; LA
ARCAPTA NEOHALER	3	MO; QL (30 per 30 days)	BREO ELLIPTA	2	MO; QL (60 per 30 days)
ARNUITY ELLIPTA	2	MO; QL (30 per 30 days)	BROVANA	3	PA; MO
ASMANEX HFA	2	MO; QL (13 per 30 days)	<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	1	PA; MO; QL (120 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	2	MO; QL (1 per 30 days)	<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	1	PA; MO; QL (60 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	2	MO; QL (2 per 30 days)	CINRYZE	2	PA; MO
ATROVENT HFA	2	MO; QL (25.8 per 30 days)	COMBIVENT RESPIMAT	2	MO; QL (8 per 30 days)
BECONASE AQ	3	MO; QL (50 per 30 days)	<i>cromolyn inhalation</i>	1	PA; MO
			DALIRESP ORAL TABLET 250 MCG	3	PA; MO; QL (30 per 30 days)
			DALIRESP ORAL TABLET 500 MCG	3	PA; MO
			DULERA	2	MO; QL (13 per 30 days)
			DYMISTA	2	MO; QL (23 per 30 days)
			ESBRIET ORAL CAPSULE	2	PA; MO; QL (270 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
ESBRIET ORAL TABLET 267 MG	2	PA; MO; QL (270 per 30 days)	FLUTICASONE PROPION-SALMETEROL INHALATION AEROSOL POWDR BREATH ACTIVATED	3	MO; QL (60 per 30 days)
ESBRIET ORAL TABLET 801 MG	2	PA; MO; QL (90 per 30 days)	<i>fluticasone propion-salmeterol inhalation blister with device</i>	3	ST; MO; QL (60 per 30 days)
FASENRA	2	PA; MO	HAEGARDA	3	PA; MO; LA
FIRAZYR	2	PA; MO	INCRUSE ELLIPTA	2	MO; QL (30 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION , 50 MCG/ACTUATION	2	MO; QL (60 per 30 days)	<i>ipratropium bromide inhalation</i>	1	PA; MO
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	2	MO; QL (240 per 30 days)	<i>ipratropium-albuterol</i>	1	PA; MO
FLOVENT HFA AEROSOL INHALER 110 MCG/ACTUATION	2	MO; QL (12 per 30 days)	KALYDECO ORAL GRANULES IN PACKET	2	PA; MO; QL (56 per 28 days)
FLOVENT HFA AEROSOL INHALER 220 MCG/ACTUATION	2	MO; QL (24 per 30 days)	KALYDECO ORAL TABLET	2	PA; MO; QL (60 per 30 days)
FLOVENT HFA AEROSOL INHALER 44 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)	LETAIRIS	2	PA; MO; LA
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	1	MO; QL (50 per 30 days)	<i>levalbuterol hcl</i>	1	PA; MO
<i>fluticasone propionate nasal</i>	1	MO; QL (16 per 30 days)	LEVALBUTEROL TARTRATE	3	ST; MO; QL (30 per 30 days)
			LONHALA MAGNAIR REFILL	3	MO; QL (60 per 30 days)
			<i>metaproterenol</i>	1	MO
			<i>mometasone nasal</i>	1	MO; QL (34 per 30 days)
			<i>montelukast</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
NASONEX	3	MO; QL (34 per 30 days)	PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	2	MO; QL (1 per 30 days)
NUCALA	3	PA; MO; LA; QL (3 per 28 days)	PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML	3	PA; MO; QL (120 per 30 days)
OFEV	2	PA; MO; QL (60 per 30 days)	PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 1 MG/2 ML	3	PA; MO; QL (60 per 30 days)
OMNARIS	3	MO; QL (12.5 per 30 days)	PULMOZYME	2	PA; MO
OPSUMIT	2	PA; MO; LA	QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	2	MO; QL (4.9 per 30 days)
ORKAMBI ORAL GRANULES IN PACKET	2	PA; MO; QL (56 per 28 days)	QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	2	MO; QL (8.7 per 30 days)
ORKAMBI ORAL TABLET	2	PA; MO; QL (112 per 28 days)	QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)
PERFOROMIST	2	PA; MO			
PROAIR HFA	2	MO; QL (17 per 30 days)			
PROAIR RESPICLICK	2	MO; QL (2 per 30 days)			
PROVENTIL HFA	3	ST; MO; QL (13.4 per 30 days)			
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	2	MO; QL (2 per 30 days)			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	2	MO; QL (21.2 per 30 days)	STRIVERDI RESPIMAT	2	MO; QL (4 per 30 days)
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	3	PA; MO; QL (224 per 30 days)	SYMBICORT	2	MO; QL (10.2 per 30 days)
REVATIO ORAL TABLET	3	PA; MO; QL (90 per 30 days)	SYMDEKO ORAL TABLETS, SEQUENTIAL 100- 150 MG (D)/ 150 MG (N)	2	PA; MO; QL (56 per 28 days)
RUCONEST	3	PA; MO	<i>tadalafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	1	PA; MO; QL (60 per 30 days)
SEEBRI NEOHALER	3	ST; MO; QL (60 per 30 days)	TAKHYRO	3	PA; MO; LA
SEREVENT DISKUS	2	MO; QL (60 per 30 days)	<i>terbutaline oral</i>	1	MO
<i>sildenafil (pulmonary arterial hypertension) oral suspension for reconstitution 10 mg/ml</i>	1	PA; MO; QL (224 per 30 days)	THEO-24	2	MO
<i>sildenafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	1	PA; MO; QL (90 per 30 days)	<i>theophylline oral solution</i>	1	MO
SINGULAIR	3	MO	<i>theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg</i>	1	MO
SPIRIVA RESPIMAT	2	MO; QL (4 per 30 days)	<i>theophylline oral tablet extended release 24 hr</i>	1	MO
SPIRIVA WITH HANDIHALER	2	MO; QL (90 per 90 days)	TRACLEER	3	PA; MO; LA
STIOLTO RESPIMAT	2	MO; QL (4 per 30 days)	TRELEGY ELLIPTA	3	PA; MO; QL (60 per 30 days)
			TUDORZA PRESSAIR	3	ST; MO; QL (1 per 30 days)
			UTIBRON NEOHALER	3	MO; QL (60 per 30 days)
			VENTAVIS	3	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
VENTOLIN HFA	3	ST; MO; QL (36 per 30 days)	ANTICHOLINERGICS / ANTISPASMODICS		
wixela inhub	3	ST; MO; QL (60 per 30 days)	<i>darifenacin</i>	1	MO
XHANCE	3	MO; QL (32 per 30 days)	DETROL	3	MO
XOLAIR SUBCUTANEOUS RECON SOLN	2	PA; MO; LA; QL (6 per 28 days)	DETROL LA	3	MO
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML	2	PA; MO; LA; QL (4 per 28 days)	DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 5 MG	3	MO
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	2	PA; MO; LA; QL (1 per 28 days)	ENABLEX	3	MO
XOPENEX	3	PA; MO	<i>flavoxate</i>	1	MO
XOPENEX CONCENTRATE	3	PA; MO	GELNIQUE TRANSDERMAL GEL IN METERED-DOSE PUMP 100 MG/GRAM (10 %)	3	MO; QL (30 per 30 days)
XOPENEX HFA	3	ST; MO; QL (30 per 30 days)	MYRBETRIQ	2	MO
YUPELRI	3	PA; MO; QL (90 per 30 days)	<i>oxybutynin chloride</i>	1	MO
<i>zafirlukast</i>	1	MO	OXYTROL	3	MO; QL (8 per 28 days)
ZETONNA	3	MO; QL (6.1 per 30 days)	<i>solifenacin</i>	1	MO
<i>zileuton</i>	1	MO	<i>tolterodine</i>	1	MO
ZYFLO	3	MO	TOVIAZ	2	MO
ZYFLO CR	3	MO	<i>trospium</i>	1	MO
UROLOGICALS					
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY					
			<i>alfuzosin</i>	1	MO
			AVODART	3	MO
			<i>dutasteride</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
dutasteride- tamsulosin	1	MO	calcium acetate oral tablet 667 mg	1	MO
finasteride oral tablet 5 mg	1	MO	klor-con	1	MO
FLOMAX	3	ST; MO	klor-con 10	1	MO
JALYN	3	MO	klor-con 8	1	MO
PROSCAR	3	MO	klor-con m10	1	MO
RAPAFLO	3	ST; MO	klor-con m15	1	MO
silodosin	1	MO	klor-con m20	1	MO
tamsulosin	1	MO	klor-con sprinkle oral capsule, extended release 8 meq	1	MO
UROXATRAL	3	ST; MO	K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	3	MO
MISCELLANEOUS UROLOGICALS					
bethanechol chloride	1	MO	k-tab oral tablet extended release 8 meq	1	MO
CIALIS ORAL TABLET 2.5 MG, 5 MG	3	PA; MO; QL (30 per 30 days)	magnesium sulfate injection solution	1	MO
CYSTAGON	2	PA; MO; LA	magnesium sulfate injection syringe	1	
ELMIRON	2	MO	NORMOSOL-R IN 5 % DEXTROSE	2	
potassium citrate	1	MO	PHOSLYRA	3	MO
tadalafil oral tablet 2.5 mg, 5 mg	1	PA; MO; QL (30 per 30 days)	potassium chlorid- d5-0.45%nacl intravenous parenteral solution 10 meq/l, 30 meq/l, 40 meq/l	1	
URECHOLINE	3	MO			
UROCIT-K 10	3	MO			
UROCIT-K 15	3	MO			
UROCIT-K 5	3	MO			
VITAMINS, HEMATINICS / ELECTROLYTES					
ELECTROLYTES					
calcium acetate oral capsule	1	MO			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride-d5-0.45%nacl intravenous parenteral solution 20 meq/l</i>	1	MO	<i>potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l</i>	1	
<i>potassium chloride</i>	1	MO	<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	1	MO
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l</i>	1		<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 40 meq/l</i>	1	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	1	MO	<i>sodium chloride 0.45 % intravenous parenteral solution</i>	1	MO
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml</i>	1	MO	<i>sodium chloride 3 %</i>	1	MO
<i>potassium chloride in water intravenous piggyback 20 meq/100 ml, 40 meq/100 ml</i>	1		<i>sodium chloride 5 %</i>	1	MO
<i>potassium chloride-0.45 % nacl</i>	1		<i>sodium lactate intravenous</i>	1	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	1	MO	TPN	3	
ELECTROLYTES					
MISCELLANEOUS NUTRITION PRODUCTS					
			<i>AMINOSYN II 10 %</i>	2	PA
			<i>AMINOSYN II 15 %</i>	2	PA
			<i>AMINOSYN-PF 10 %</i>	2	PA
			<i>AMINOSYN-PF 7 % (SULFITE-FREE)</i>	2	PA

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits	
CLINIMIX 5%/D15W SULFITE FREE	2	PA	NEPHRAMINE 5.4 %	2	PA	
CLINIMIX 4.25%/D10W SULF FREE	2	PA	NORMOSOL-M IN 5 % DEXTROSE	3		
CLINIMIX 5%- D20W(SULFITE- FREE)	2	PA	NORMOSOL-R PH 7.4	2		
CLINIMIX E 4.25%/D10W SUL FREE	3	PA	NUTRILIPID	3	PA	
CLINIMIX E 4.25%/D5W SULF FREE	3	PA	PLASMA-LYTE 148	2		
CLINIMIX E 5%/D15W SULFIT FREE	3	PA	PLASMA-LYTE A	2		
CLINIMIX E 5%/D20W SULFIT FREE	3	PA	<i>plenamine</i>	1	PA	
CLINISOL SF 15 %	3	PA; MO	<i>premasol 10 %</i>	1	PA; MO	
FREAMINE HBC 6.9 %	3	PA	PREMASOL 6 %	2	PA	
HEPATAMINE 8%	2	PA	PROCALAMINE 3%	3	PA	
<i>intralipid</i> <i>intravenous</i> <i>emulsion 20 %</i>	1	PA	PROSOL 20 %	3	PA; MO	
INTRALIPID INTRAVENOUS EMULSION 30 %	3	PA	<i>travasol 10 %</i>	3	PA; MO	
IONOSOL-MB IN D5W	2		TROPHAMINE 10 %	2	PA; MO	
ISOLYTE-P IN 5 % DEXTROSE	2		TROPHAMINE 6%	2	PA	
ISOLYTE-S	2		VITAMINS / HEMATINICS			
			<i>fluoride (sodium)</i> <i>oral tablet</i>	1	MO	
			<i>prenatal vitamin</i> <i>oral tablet</i>	1	MO	

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

Index

A

abacavir	1
abacavir-lamivudine	1
abacavir-lamivudine-zidovudine	1
ABELCET	1
ABILIFY	34
ABILIFY MAINTENA.....	34
abiraterone	13
ABSORICA.....	53
ABSTRAL.....	27
acamprosate.....	59
ACANYA.....	53
acarbose	62
ACCOLATE.....	94
ACCUPRIL	43
ACCURETIC	43
acebutolol	43
acetaminophen-codeine.....	27
acetazolamide	91
acetic acid.....	61
acetylcysteine	94
ACIPHEX	75
acitretin.....	51
ACTEMRA	83
ACTEMRA ACTPEN.....	83
ACTHAR	61
ACTHIB (PF).....	80
ACTIGALL.....	72
ACTIMMUNE	78
ACTIQ.....	27
ACTIVELLA	85
ACTONEL	82
ACTOPLUS MET	62
ACTOS.....	62
ACULAR	91
ACULAR LS.....	91
ACUVAIL (PF).....	91
acyclovir	1, 56
acyclovir sodium	1
ACZONE.....	53

ADACEL(TDAP	
ADOLESN/ADULT)(PF)	80
ADALAT CC	43
adapalene	53
adapalene-benzoyl peroxide	.53
ADCIRCA	94
ADDERALL	34
ADDERALL XR.....	34
adefovir.....	1
ADEMPAS.....	94
ADLYXIN.....	62
ADMELOG SOLOSTAR U-100 INSULIN	
100 INSULIN	62
ADMELOG U-100 INSULIN LISPRO	62
ADVAIR DISKUS	94
ADVAIR HFA	94
ADZENYS ER	34
ADZENYS XR-ODT	34
AFINITOR	13
AFINITOR DISPERZ	13
AFREZZA	63
AGGRENOX.....	47
AGRYLIN	59
AIMOVIG AUTOINJECTOR	23
AIRDUO RESPICLICK.....	94
AJOVY	23
AKTIPAK	53
AKYNZEO (FOSNETUPITANT)	72
ala-cort	56
ALA-SCALP	56
albendazole	7
albuterol sulfate	94
ALBUTEROL SULFATE....	94
alclometasone	56
ALCOHOL PADS.....	63
ALDACTAZIDE	43
ALDACTONE.....	43
ALDARA	51
ALECENSA	14

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

AMINOSYN-PF 10 %	101	aprepitant	72	ATRIPLA	2
AMINOSYN-PF 7 %		apri.....	87	atropine.....	91
(SULFITE-FREE)	101	APRISO.....	72	ATROVENT HFA.....	95
amiodarone	42	APTENSIO XR	34	AUBAGIO.....	25
AMITIZA	72	APTIOM.....	19	aubra	87
amitriptyline	34	APTIVUS	1, 2	AUGMENTIN	10
amlodipine	43	ARALAST NP	59	AURYXIA.....	59
amlodipine-atorvastatin.....	48	aranelle (28).....	87	AUSTEDO	25
amlodipine-benazepril.....	43	ARANESP (IN POLYSORBATE)	78	AUVI-Q.....	93
amlodipine-olmesartan	43	ARAVA.....	83	AVALIDE	43
amlodipine-valsartan	43	ARCALYST.....	78	AVANDIA	63
amlodipine-valsartan-hctiazid	43	ARCAPTA NEOHALER.....	95	AVAPRO.....	43
ammonium lactate	51	ARICEPT	25	AVC.....	86
amnesteem.....	53	ARIKAYCE	7	AVEED.....	70
amoxapine	34	ARIMIDEX	14	AVELOX.....	11
amoxicil-clarithromy-lansopraz	76	ariPIPRAZOLE.....	34	aviane.....	87
amoxicillin.....	10	ARISTADA	34	avita	53
amoxicillin-pot clavulanate ..	10	ARISTADA INITIO.....	34	AVITA.....	53
amphetamine sulfate.....	34	ARIIXTRA	47	AVODART	99
amphotericin b.....	1	armodafinil	34	AVONEX	78
ampicillin.....	10	ARNUITY ELLIPTA.....	95	AVONEX (WITH ALBUMIN)	78
ampicillin sodium.....	10	AROMASIN.....	14	AVYCAZ	5
ampicillin-sulbactam	10	ARTHROTEC 50	31	AYGESTIN	85
AMPYRA.....	25	ARTHROTEC 75	31	AZACTAM	7
ANADROL-50	69	ARYMO ER	27	AZASAN	14
ANAFRANIL.....	34	ASACOL HD	72	AZASITE	90
anagrelide	59	ashlyna.....	87	azathioprine	14
anastrozole.....	14	ASMANEX HFA	95	azelaic acid	53
ANCOBON	1	ASMANEX TWISTHALER	95	azelastine	61, 91
ANDRODERM	69	aspirin-dipyridamole	47	AZELEX.....	53
ANDROGEL.....	69, 70	ASTAGRAF XL.....	14	AZILECT	22
ANGELIQ	85	ASTEPRO	61	azithromycin	6
ANORO ELLIPTA	95	ATACAND	43	AZOPT	92
ANTABUSE.....	59	ATACAND HCT	43	AZOR	43
ANTARA	48	atazanavir.....	2	aztreonam	7
ANUSOL-HC.....	72	ATELVIA.....	82	AZULFIDINE	72
apexicon e.....	56	atenolol	43	AZULFIDINE EN-TABS ..	72
APIDRA SOLOSTAR U-100 INSULIN	63	atenolol-chlorthalidone.....	43	B	
APIDRA U-100 INSULIN...63		ATIVAN.....	34	bacitracin	90
APLENZIN	34	atomoxetine	34	bacitracin-polymyxin b.....	90
APOKYN	22	atorvastatin	48	baclofen	26
apraclonidine	93	atovaquone.....	7	BACLOFEN	26
		atovaquone-proguanil.....	7	BACTRIM	12
		ATRALIN	53	BACTRIM DS	12

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

BACTROBAN	54	BICILLIN L-A	10	buspirone	35
BACTROBAN NASAL.....	61	BIDIL	43	butorphanol tartrate	31
balsalazide	73	BIJUVA.....	85	BUTRANS	27
BALVERSA.....	14	BIKTARVY	2	BYDUREON	63
balziva (28).....	87	BILTRICIDE.....	7	BYDUREON BCISE.....	63
BANZEL	19	bimatoprost.....	92	BYETTA	63
BARACLUE	2	BINOSTO.....	82	BYSTOLIC.....	43
BASAGLAR KWIKPEN U- 100 INSULIN.....	63	bisoprolol fumarate.....	43	C	
BAXDELA.....	11	bisoprolol-hydrochlorothiazide	43	cabergoline	70
BCG VACCINE, LIVE (PF)	80	BIVIGAM	80	CABLIVI.....	47
BECONASE AQ	95	BLEPH-10	91	CABOMETYX.....	14
BELBUCA	27	BLEPHAMIDE	91	CADUET	48
BELSOMRA	34	BLEPHAMIDE S.O.P.....	91	CAFERGOT	23
benazepril	43	blisovi 24 fe	87	CALAN	43
benazepril-hydrochlorothiazide	43	blisovi fe 1.5/30 (28)	87	CALAN SR	43
BENICAR	43	BONIVA	82	calcipotriene	51
BENICAR HCT	43	BONJESTA	73	calcipotriene-betamethasone	51
BENLYSTA	83	BOOSTRIX TDAP.....	80	calcitonin (salmon)	70
BENZACLIN PUMP	53	bosentan.....	95	calcitriol.....	51, 70
BENZAMYCIN	53	BOSULIF	14	calcium acetate	100
BENZNIDAZOLE	7	BRAFTOVI	14	CALQUENCE	14
benztropine	22	BREO ELLIPTA	95	CAMBIA	31
BEPREVE	91	briellyn.....	87	camila	85
BERINERT	95	BRILINTA	47	camrese lo	87
beser	56	brimonidine	93	CANASA.....	73
BESIVANCE	90	BRISDELLE	34	CANCIDAS.....	1
betamethasone dipropionate	56	BRIVIACT	19	candesartan	43
betamethasone valerate	56	bromfenac	91	candesartan-hydrochlorothiazid	43
betamethasone, augmented...	56	bromocriptine	22	CAPEX	56
BETAPACE AF	42	BROMSITE.....	91	CAPRELSA.....	14
BETASERON	78	BROVANA	95	captopril	43
betaxolol	43, 90	BRYHALI	56	captopril-hydrochlorothiazide	43
bethanechol chloride	100	budesonide.....	73, 95	CARAC	51
BETHKIS	7	bumetanide	43	CARAFATE	76
BETIMOL	90	BUNAVAIL	31	CARBAGLU	59
BETOPTIC S	90	BUPHENYL.....	59	carbamazepine	19
BEVESPI AEROSPHERE	95	buprenorphine.....	27	CARBATROL	19
BEVYXXA	47	BUPRENORPHINE.....	27	carbidopa	22
bexarotene	14	buprenorphine hcl.....	27	carbidopa-levodopa	22
BEXSERO.....	80	buprenorphine-naloxone.....	31	carbidopa-levodopa- entacapone	22
BEYAZ	87	bupropion hcl.....	34, 35	CARDIZEM	43
bicalutamide	14	BUPROPION HCL	35	CARDIZEM CD.....	43
BICILLIN C-R	10	bupropion hcl (smoking deter)	60		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

CARDIZEM LA.....	43	CHANTIX CONTINUING MONTH BOX.....	60	CLIMARA.....	85
CARDURA	44	CHANTIX STARTING MONTH BOX.....	61	CLIMARA PRO.....	85
CARDURA XL.....	44	CHEMET.....	59	clindacin p	53
CARNITOR	59	CHENODAL	73	CLINDAGEL	53
CAROSPIR	44	chlorhexidine gluconate	61	clindamycin hcl	8
carteolol.....	90	chloroquine phosphate.....	7	clindamycin in 5 % dextrose ..	8
cartia xt.....	44	chlorothiazide	44	clindamycin pediatric	8
carvedilol.....	44	chlorpromazine.....	35	clindamycin phosphate	8, 53,
carvedilol phosphate.....	44	chlorthalidone.....	44	87	
CASODEX	14	CHOLBAM.....	73	clindamycin-benzoyl peroxide	
caspofungin	1	cholestyramine (with sugar)	48	.....	53
CATAPRES	44	cholestyramine light	48	clindamycin-tretinooin	53
CATAPRES-TTS-1.....	44	CIALIS	100	CLINDESSE.....	87
CATAPRES-TTS-2.....	44	ciclopirox.....	55	CLINIMIX 5%/D15W SULFITE FREE	102
CATAPRES-TTS-3.....	44	cilostazol.....	47	CLINIMIX 4.25%/D10W SULF FREE.....	102
CAYSTON	7	CILOXAN	90	CLINIMIX 4.25%/D5W SULFIT FREE.....	59
caziant (28).....	87	CIMDUO.....	2	CLINIMIX 5%- D20W(SULFITE-FREE)102	
cefaclor.....	5	cimetidine	76	CLINIMIX E 2.75%/D5W SULF FREE.....	59
cefadroxil.....	5	cimetidine hcl	76	CLINIMIX E 4.25%/D10W SUL FREE.....	102
cefazolin	5	CIMZIA	73	CLINIMIX E 4.25%/D5W SULF FREE.....	102
cefdinir	5	CIMZIA POWDER FOR RECONST	73	CLINIMIX E 5%/D15W SULFIT FREE.....	102
cefepime	5	cinacalcet	70	CLINIMIX E 5%/D20W SULFIT FREE.....	102
cefixime	5	CINRYZE.....	95	CLINISOL SF 15 %	102
cefotetan	5	CIPRO	11	clobazam.....	19
cefoxitin.....	5	CIPRO HC.....	61	clobetasol	56, 57
cefpodoxime	5	CIPRODEX	61	clobetasol-emollient	57
cefprozil.....	5	ciprofloxacin	12	CLOBEX	57
ceftazidime	5	ciprofloxacin hcl.....	11, 61, 90	clodan	57
ceftriaxone	5	ciprofloxacin in 5 % dextrose		clomipramine	35
cefuroxime axetil.....	5	.....	11	clonazepam	19
cefuroxime sodium.....	5, 6	citalopram	35	clonidine	44
CELEBREX	31	claravis.....	53	clonidine hcl	35, 44
celecoxib.....	31	CLARINEX	93	clopidogrel	47
CELEXA	35	CLARINEX-D 12 HOUR	93	clorazepate dipotassium.....	35
CELLCEPT	14	clarithromycin	6	clotrimazole	1, 55
CELONTIN	19	CLENPIQ	73	clotrimazole-betamethasone .55	
cephalexin.....	6	CLEOCIN	7, 86		
CEQUA	91	CLEOCIN HCL.....	7		
CERDELGA.....	70	CLEOCIN IN 5 % DEXTROSE	7		
CESAMET	73	CLEOCIN PEDIATRIC.....	7		
cetirizine	93	CLEOCIN T	53		
CETRAXAL.....	61				
cevimeline	59				
CHANTIX.....	60				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

clozapine.....	35	COTEMPLA XR-ODT	35
CLOZAPINE.....	35	COUMADIN	47
CLOZARIL	35	COZAAR.....	44
COARTEM	8	CREON	73
codeine sulfate.....	27	CRESEMBIA	1
COLAZAL	73	CRESTOR	48
COLCHICINE.....	82	CRINONE	85
COLCRYS	82	CRIXIVAN	2
colesevelam	48	cromolyn.....	73, 91, 95
COLESTID	48	cryselle (28).....	87
colestipol	48	CUBICIN.....	8
colistin (colistimethate na)	8	CUPRIMINE	83
colocort.....	73	CUTIVATE	57
COLYTE WITH FLAVOR PACKS.....	73	CUVPOSA	72
COMBIGAN	92	cyclafem 1/35 (28).....	87
COMBIPATCH.....	85	cyclafem 7/7/7 (28)	87
COMBIVENT RESPIMAT .	95	cyclobenzaprine.....	26
COMBIVIR.....	2	cyclophosphamide	14
COMETRIQ.....	14	CYCLOSET	63
COMPLERA	2	cyclosporine.....	14
compro.....	73	cyclosporine modified	14
COMTAN	22	CYMBALTA.....	35
CONCERTA	35	cyred	87
CONDYLOX	51	CYSTADANE.....	73
constulose.....	73	CYSTAGON	100
CONZIP	31	CYSTARAN	91
COPAXONE	25	CYTOMEL.....	72
COPIKTRA.....	14	CYTOTEC.....	76
CORDRAN TAPE LARGE ROLL	57	D	
COREG	44	d10 %-0.45 % sodium chloride	59
COREG CR.....	44	d2.5 %-0.45 % sodium chloride	59
CORGARD	44	d5 % and 0.9 % sodium chloride	59
CORLANOR.....	50	d5 %-0.45 % sodium chloride	59
CORTEF	61	DAKLINZA	2
CORTIFOAM	73	dalfampridine.....	25
cortisone	61	DALIRESP	95
CORTISPORIN.....	54	DALVANCE	8
COSENTYX (2 SYRINGES)	51	danazol.....	70
COSENTYX PEN (2 PENS)	51	DANTRIUM	26
COSOPT	92	dantrolene	26
COSOPT (PF)	92	dapsone	8, 53
COTELLIC.....	14		
		DAPTACEL (DTAP PEDIATRIC) (PF).....	80
		daptomycin	8
		DAPTONMYCIN	8
		DARAPRIM	8
		darifenacin	99
		DAURISMO	14
		DAYPRO	31
		DAYTRANA	35
		DDAVP	70
		deblitane	85
		deferasirox	59
		DELESTROGEN	85
		DELSTRIGO	2
		delyla (28).....	87
		DELZICOL.....	73
		demeclocycline	12
		DEMSER	44
		DENAVIR	56
		DEPAKOTE	19
		DEPAKOTE ER	19
		DEPAKOTE SPRINKLES..	19
		DEPEN TITRATABS	83
		DEPO-ESTRADIOL	85
		DEPO-PROVERA.....	85
		DEPO-SUBQ PROVERA 104	85
		DEPO-TESTOSTERONE....	70
		DESCOVERY	2
		desipramine	35
		desloratadine	93
		desmopressin	70
		desog-e.estradiol/e.estradiol.	87
		desogestrel-ethinyl estradiol.	87
		DESONATE	57
		desonide	57
		DESOWEN	57
		desoximetasone	57
		DESOXYN	35
		DESVENLAFAXINE	35
		desvenlafaxine succinate	35
		DETROL	99
		DETROL LA	99
		dexamethasone	61
		dexamethasone intensol.....	61

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

dexamethasone sodium phosphate.....	92	DILANTIN EXTENDED 100 MG.....	19	drospirenone-e.estriadiol-lm.fa	87
DEXEDRINE SPANSULE..	35	DILANTIN INFATABS 50 MG.....	19	drospirenone-ethinyl estradiol	87
DEXILANT.....	76	DILANTIN-125 125 MG/5 ML.....	19	DROXIA.....	14
dexmethylphenidate	35	DILAUDID	27	DUAC.....	54
DEXPAK 13 DAY	61	diltiazem hcl	44	DUAVEE.....	85
dextroamphetamine	35	dilt-xr	44	DUETACT	63
dextroamphetamine-amphetamine	36	DIOVAN	44	DUEXIS	32
dextrose 10 % and 0.2 % nacl	59	DIOVAN HCT	44	DULERA	95
dextrose 10 % in water (d10w)	59	DIPENTUM	73	duloxetine	36
dextrose 5 % in water (d5w)	59	DIPROLENE.....	57	DUOBRII	57
dextrose 5%-0.2 % sod chloride.....	59	dipyridamole.....	47	DUOPA	22
dextrose 5%-0.3 % sod.chloride	59	disulfiram.....	59	DUPIXENT	51
dextrose with sodium chloride	59	DITROPAN XL	99	DURAGESIC	28
DIASTAT	19	DIURIL	44	duramorph (pf).....	28
DIASTAT ACUDIAL.....	19	divalproex	20	DUREZOL	92
diazepam.....	36	DIVIGEL.....	85	dutasteride	99
DIBENZYLINE	44	dofetilide.....	42	dutasteride-tamsulosin.....	100
DICLEGIS.....	73	DOLOPHINE	27	DUTOPROL	44
DICLOFENAC EPOLAMINE	31	donepezil	25	dvorah	28
diclofenac potassium.....	31	DOPTELET (10 TAB PACK)	47	DYANAVEL XR	36
diclofenac sodium ...	31, 32, 51, 91	DOPTELET (15 TAB PACK)	47	DYAZIDE	44
diclofenac-misoprostol	32	DORYX	12	DYMISTA	95
dicloxacillin.....	10	DORYX MPC	12	DYRENIUM.....	44
dicyclomine	72	dorzolamide	92	E	
didanosine.....	2	dorzolamide-timolol	92	e.e.s. 400	6
DIFFERIN	53, 54	dorzolamide-timolol (pf)	92	E.E.S. GRANULES.....	6
DIFICID	6	dotti.....	85	econazole	55
diflorasone	57	DOVATO	2	EDARBI	44
DIFLUCAN.....	1	DOVONEX	51	EDARBYCLOR	44
diflunisal.....	32	doxazosin.....	44	EDECRIN	44
digitek.....	50	doxepin	36, 51	EDURANT	2
digox.....	50	doxercalciferol.....	70	efavirenz	2
digoxin.....	50	doxy-100.....	12	EFFEXOR XR.....	36
dihydroergotamine	23	doxycycline hyclate	12	EFFIENT	47
DILANTIN 30 MG	19	doxycycline monohydrate	12	EFUDEX	51
		doxylamine-pyridoxine (vit b6)	73	ELESTRIN	85
		dronabinol.....	73	eletriptan	23
				ELIDEL	51
				ELIGARD	14
				ELIGARD (3 MONTH)	14
				ELIGARD (4 MONTH)	14
				ELIGARD (6 MONTH)	14
				ELIMITE	58

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

ELIQUIS	47	EPIVIR	2	ethynodiol diac-eth estradiol	87
ELMIRON.....	100	EPIVIR HBV.....	2	etodolac.....	32
ELOCON.....	57	eplerenone	44	EUCRISA	52
EMBEDA.....	28	EPOGEN	78	EURAX	58
EMCYT.....	15	eprosartan	44	EVAMIST	86
EMEND.....	73	EPZICOM	2	EVEKEO	36
EMFLAZA	61	EQUETRO	20	EVENITY	82
EMGALITY PEN	23	ERAXIS(WATER DILUENT)		EVISTA.....	82
EMGALITY SYRINGE.....	23	.....	1	EVOCLIN.....	54
emoquette	87	ergoloid.....	36	EVOTAZ	2
EMSAM	36	ergotamine-caffeine.....	24	EVOXAC	59
EMTRIVA.....	2	ERIVEDGE	15	EVZIO	32
EMVERM	8	ERLEADA	15	EXELDERM	55
ENABLEX	99	erlotinib	15	EXELON	25
enalapril maleate	44	errin	85	exemestane	15
enalapril-hydrochlorothiazide	44	ERTACZO.....	55	EXFORGE	45
ENBREL	83	ertapenem	8	EXFORGE HCT.....	45
ENBREL MINI	83	ery pads.....	54	EXJADE	59
ENBREL SURECLICK	83	erygel	54	EXTAVIA	78
ENDARI.....	59	ERYPED 200	6	EXTINA	55
endocet	28	ERYPED 400	6	EZALLOR SPRINKLE.....	48
ENGERIX-B (PF)	80	ery-tab.....	6	ezetimibe	48
ENGERIX-B PEDIATRIC (PF).....	80	ERY-TAB.....	6	ezetimibe-simvastatin	48
enoxaparin	47	ERYTHROCIN	7	F	
enpresse	87	erythrocin (as stearate)	6	FABIOR	54
enskyce.....	87	erythromycin	7, 90	falmina (28)	88
ENSTILAR	51	erythromycin ethylsuccinate...7		famciclovir.....	2
entacapone	22	erythromycin with ethanol....54		famotidine.....	76
entecavir	2	erythromycin-benzoyl peroxide	54	FANAPT	36
ENTOCORT EC	73	ESBRIET	95, 96	FARESTON	15
ENTRESTO	50	escitalopram oxalate	36	FARXIGA	63
enulose.....	73	esomeprazole magnesium....76		FARYDAK	15
ENVARSUS XR	15	ESOMEPRAZOLE		FASENRA	96
EPCLUSA	2	STRONTIUM.....	76	fayosim	88
EPIDIOLEX	20	estarrylla	87	FAZACLO	36
EPIDUO	54	ESTRACE	85	felbamate	20
EPIDUO FORTE.....	54	estradiol	85	FELBATOL	20
epinastine.....	91	estradiol valerate.....	85	FELDENE	32
epinephrine	93	estradiol-norethindrone acet.	86	felodipine.....	45
EPINEPHRINE	93	ESTRING	86	FEMARA	15
EPIPEN 2-PAK.....	93	eszopiclone	36	FEMHRT LOW DOSE	86
EPIPEN JR 2-PAK.....	94	ethacrynic acid.....	45	FEMRING	86
epitol.....	20	ethambutol	8	femynor.....	88
		ethosuximide	20	fenofibrate.....	49
				FENOFIBRATE	48

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

fenofibrate micronized	48	fluocinonide.....	57	fyavolv.....	86
fenofibrate nanocrystallized .	48	fluocinonide-e.....	57	FYCOMPA.....	20
fenofibric acid	49	fluoride (sodium).....	102	G	
fenofibric acid (choline).....	49	fluorometholone	92	gabapentin.....	20
FENOGLIDE	49	fluorouracil	52	GABITRIL	20
fenoprofen	32	FLUOROURACIL	52	GALAFOLD.....	70
FENOPROFEN	32	fluoxetine.....	36	galantamine.....	25
fentanyl.....	28	fluphenazine decanoate	37	GAMMAGARD LIQUID ...	80
fentanyl citrate.....	28	fluphenazine hcl	37	GAMMAGARD S-D (IGA < 1	
FENTANYL CITRATE	28	flurandrenolide	57	MCG/ML).....	80
FENTORA	28	flurbiprofen.....	32	GAMMAKED	80
FERRIPROX.....	59	flurbiprofen sodium.....	91	GAMMAPLEX	80
FETZIMA	36	flutamide.....	15	GAMMAPLEX (WITH	
FEXMID	27	fluticasone propionate	57, 96	SORBITOL)	80
FIASP FLEXTOUCH U-100 INSULIN	63	fluticasone propion-salmeterol		GAMUNEX-C.....	80
FIASP U-100 INSULIN.....	63	.....	96	GARDASIL 9 (PF).....	80
FIBRICOR	49	FLUTICASONE PROPION-		GASTROCROM	73
FINACEA	54	SALMETEROL.....	96	gatifloxacin	90
finasteride	100	fluvastatin	49	GATTEX 30-VIAL	73
FIRAZYR.....	96	fluvoxamine.....	37	GAUZE PAD.....	64
FIRDAPSE	25	FML FORTE	92	gavilyte-c	73
FIRMAGON KIT W DILUENT SYRINGE	15	FML LIQUIFILM	92	gavilyte-g	73
FIRVANQ	8	FML S.O.P.	92	gavilyte-n	73
flac otic oil.....	61	FOCALIN.....	37	GELNIQUE	99
FLAGYL	8	FOCALIN XR	37	gemfibrozil	49
FLAREX	92	fondaparinux.....	47	GENERESS FE	88
flavoxate	99	FORFIVO XL.....	37	generlac.....	73
FLEBOGAMMA DIF	80	FORTAMET	63, 64	gengraf.....	15
flecainide	42	FORTEO	82	GENOTROPIN	78
FLECTOR	32	FORTESTA.....	70	GENOTROPIN MINIQUICK	
FLOLIPID	49	FOSAMAX	82	.....	78
FLOMAX	100	FOSAMAX PLUS D.....	82	gentak	90
FLOVENT DISKUS	96	fosamprenavir	2	gentamicin	8, 55, 90
FLOVENT HFA.....	96	fosinopril	45	gentamicin in nacl (iso-osm) ..	8
fluconazole	1	fosinopril	45	GENVOYA	2
fluconazole in nacl (iso-osm) .	1	FOSRENOL	59	GEDON	37
flucytosine	1	FRAGMIN.....	47	gianvi (28)	88
fludrocortisone	61	FREAMINE HBC 6.9 %....	102	GILENYA	25
FLUMADINE	2	FROVA	24	GILOTrif	15
flunisolide.....	96	frovatriptan	24	GLASSIA	59
fluocinolone.....	57	FULPHILA.....	78	glatiramer	25
fluocinolone acetonide oil	61	FURADANTIN	13	glatopa	25
fluocinolone and shower cap	57	furosemide	45	GLEEVEC	15
		FUZEON	2	GLEOSTINE	15
				glimepiride	64

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

glipizide	64
glipizide-metformin.....	64
GLUCAGEN HYPOKIT	64
GLUCAGON EMERGENCY KIT (HUMAN)	64
GLUCOPHAGE.....	64
GLUCOPHAGE XR	64
GLUCOTROL.....	64
GLUCOTROL XL	64, 65
GLUMETZA.....	65
glycopyrrolate.....	72
GLYSET	65
GLYXAMBI	65
GOCOVRI.....	22, 23
GOLYTELY.....	73
GONITRO.....	50
GRALISE	20
GRALISE 30-DAY STARTER PACK	20
granisetron hcl.....	73
GRANIX	78
griseofulvin microsize	1
griseofulvin ultramicrosize....	1
guanidine	37
GYNAZOLE-1.....	87
H	
HAEGARDA	96
hailey 24 fe	88
HALDOL	37
HALDOL DECANOATE	37
halobetasol propionate.....	57
HALOBETASOL PROPIONATE	57
HALOG	57
haloperidol.....	37
haloperidol decanoate.....	37
haloperidol lactate	37
HARVONI	2
HAVRIX (PF)	80
heparin (porcine)	47
HEPATAMINE 8%	102
HEPSERA	2
HETLIOZ	37
HIBERIX (PF)	80
HIPREX	13
HORIZANT.....	25
HUMALOG JUNIOR KWIKPEN U-100	65
HUMALOG KWIKPEN INSULIN	65
HUMALOG MIX 50-50 INSULN U-100	65
HUMALOG MIX 50-50 KWIKPEN.....	65
HUMALOG MIX 75-25 KWIKPEN.....	65
HUMALOG MIX 75-25(U- 100)INSULN	65
HUMALOG U-100 INSULIN	65
HUMATROPE	78
HUMIRA	83
HUMIRA PEDIATRIC CROHNS START	83
HUMIRA PEN	83
HUMIRA PEN CROHNS-UC- HS START	83
HUMIRA PEN PSOR- UVEITS-ADOL HS	83
HUMIRA(CF)	84
HUMIRA(CF) PEDI CROHNS STARTER	83
HUMIRA(CF) PEN	84
HUMIRA(CF) PEN CROHNS-UC-HS	84
HUMIRA(CF) PEN PSOR- UV-ADOL HS.....	84
HUMULIN 70/30 U-100 INSULIN	65
HUMULIN 70/30 U-100 KWIKPEN.....	65
HUMULIN N NPH INSULIN KWIKPEN.....	65
HUMULIN N NPH U-100 INSULIN	65
HUMULIN R REGULAR U- 100 INSULN	65
HUMULIN R U-500 (CONC) INSULIN	65
HUMULIN R U-500 (CONC)	
KWIKPEN.....	65
hydralazine	45
HYDREA	15
hydrochlorothiazide	45
hydrocodone-acetaminophen	28
hydrocodone-ibuprofen	28
hydrocortisone	58, 61, 73
hydrocortisone butyrate	58
hydrocortisone valerate	58
hydrocortisone-acetic acid....	61
hydrocortisone-pramoxine....	73
hydromorphone.....	28
hydromorphone (pf).....	28
hydroxychloroquine.....	8
hydroxyurea.....	15
hydroxyzine hcl	94
HYSINGLA ER.....	28
HYZAAR	45
I	
ibandronate	82
IBRANCE.....	15
ibu	32
ibuprofen.....	32
ibuprofen-oxycodone.....	28
ICLUSIG	15
IDHIFA.....	15
ILEVRO	91
ILUMYA	51
imatinib.....	15
IMBRUVICA	15
imipenem-cilastatin	8
imipramine hcl.....	37
imipramine pamoate	37
imiquimod.....	52
IMIQUIMOD	52
IMITREX	24
IMITREX STATDOSE PEN	24
IMITREX STATDOSE REFILL.....	24
IMOVAZ RABIES VACCINE (PF).....	80
IMPOYZ.....	58
IMURAN	15

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

IMVEXXY MAINTENANCE	
PACK	86
IMVEXXY STARTER PACK	
.....	86
INBRIJA	23
incassia	86
INCRELEX	59
INCRUSE ELLIPTA	96
indapamide	45
INDERAL LA	45
INFANRIX (DTAP) (PF)	80
INFLECTRA.....	73
INGREZZA.....	25
INGREZZA INITIATION	
PACK	25
INLYTA	15, 16
INNOPRAN XL.....	45
INSPRA.....	45
INSULIN LISPRO	65
INSULIN PEN NEEDLE....	65
INSULIN SYRINGE-	
NEEDLE U-100	65
INTELENCE.....	2
intralipid	102
INTRALIPID	102
INTRAROSA	87
INTRON A	78
introvale.....	88
INVANZ.....	8
INVEGA.....	37
INVEGA SUSTENNA.....	37
INVEGA TRINZA.....	37
INVELTYS	92
INVIRASE	2
INVOKAMET.....	65
INVOKAMET XR	65
INVOKANA	65
IONOSOL-MB IN D5W ...	102
IOPIDINE.....	93
IPOL	80
ipratropium bromide.....	61, 96
ipratropium-albuterol	96
irbesartan	45
irbesartan-hydrochlorothiazide	
.....	45
IRESSA	16
ISENTRESS	2
ISENTRESS HD	2
isibloom.....	88
ISOLYTE-P IN 5 %	
DEXTROSE	102
ISOLYTE-S.....	102
isoniazid.....	8
ISOPTO CARPINE	91
ISORDIL	50
ISORDIL TITRADOSE	50
isosorbide dinitrate	50
isosorbide mononitrate	50
isotretinoin.....	54
isradipine	45
ISTALOL	90
itraconazole	1
ivermectin.....	8
IXIARO (PF).....	80
J	
JADENU	59
JADENU SPRINKLE	59
JAKAFI	16
JALYN	100
jantoven	48
JANUMET	66
JANUMET XR	66
JANUVIA.....	66
JARDIANC.....	66
jasmiel (28).....	88
JENTADUETO	66
JENTADUETO XR.....	66
jinteli.....	86
jolivette.....	86
JUBLIA	55
juleber.....	88
JULUCA.....	2
junel 1.5/30 (21)	88
junel 1/20 (21)	88
junel fe 1.5/30 (28)	88
junel fe 1/20 (28)	88
junel fe 24.....	88
JUXTAPID	49
JYNARQUE	70
K	
KADIAN	28
kaitlib fe.....	88
KALETRA	2
KALYDECO	96
KAPVAY	37
kariva (28)	88
KAZANO	66
kelnor 1/35 (28)	88
kelnor 1-50.....	88
KENALOG.....	58
KEPPRA	20
KEPPRA XR	20
KERYDIN	55
ketoconazole	1, 55
ketoprofen.....	32
ketorolac	91
KEVEYIS	25
KEVZARA	84
KHEDEZLA	37
KINERET	84
KINRIX (PF).....	81
kionex (with sorbitol)	60
KISQALI	16
KISQALI FEMARA CO-	
PACK	16
KITABIS PAK	8
KLARON	55
KLONOPIN.....	20
klor-con.....	100
klor-con 10.....	100
klor-con 8.....	100
klor-con m10	100
klor-con m15	100
klor-con m20	100
klor-con sprinkle.....	100
KOMBIGLYZE XR	66
KORLYM	70
KRINTAFEL	8
KRISTALOSE.....	74
k-tab	100
K-TAB	100
kurvelo (28)	88
KUVAN.....	70

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

L		
1 norgest/e.estradiol-e.estrad.	88	LESCOL XL.....49
labetalol	45	lessina .....88
LACRISERT	91	LETAIRIS .....96
lactulose.....	74	letrozole .....16
LAMICTAL	20	leucovorin calcium ..13
LAMICTAL ODT	20	LEUKERAN .....16
LAMICTAL STARTER (BLUE) KIT	20	LEUKINE.....78
LAMICTAL STARTER (GREEN) KIT	20	leuprolide.....16
LAMICTAL STARTER (ORANGE) KIT	20	levalbuterol hcl ..96
LAMICTAL XR.....	20	LEVALBUTEROL
LAMICTAL XR STARTER (BLUE).....	20	TARTRATE .....96
LAMICTAL XR STARTER (GREEN).....	20	LEVEMIR FLEXTOUCH U-
LAMICTAL XR STARTER (ORANGE).....	21	100 INSULN .....66
lamivudine.....	2	LEVEMIR U-100 INSULIN 66
lamivudine-zidovudine.....	2	levetiracetam .....21
lamotrigine	21	levobunolol.....90
LANOXIN.....	50	levocarnitine .....60
lansoprazole.....	76	levocarnitine (with sugar)....60
lanthanum	60	levocetirizine .....94
LANTUS SOLOSTAR U-100 INSULIN.....	66	levofloxacin .....12, 90
LANTUS U-100 INSULIN..66		levofloxacin in d5w ..12
larin 1.5/30 (21).....	88	levonest (28).....88
larin 1/20 (21).....	88	levonorgestrel-ethinyl estrad 88
larin fe 1.5/30 (28).....	88	levonorg-eth estrad triphasic 88
larin fe 1/20 (28).....	88	levora-28.....88
larissia.....	88	levorphanol tartrate.....29
LASIX.....	45	LEVORPHANOL
LASTACAFT.....	91	TARTRATE .....29
latanoprost	92	LEVO-T.....72
LATUDA	37	levothyroxine.....72
layolis fe	88	levoxyl.....72
LAZANDA.....	29	LEXAPRO.....37
LEDIPASVIR-SOFOSBUVIR	3	LEXETTE .....58
leena 28	88	LEXIVA .....3
leflunomide.....	84	LIALDA .....74
LENVIMA	16	lidocaine .....52
		lidocaine hcl
		52
		lidocaine viscous
		52
		lidocaine-prilocaine
		52
		LIDODERM.....52
		lindane
		58
		linezolid
		8
		linezolid in dextrose 5%
		8
		LINZESS .....74
		liothyronine
		72
		LIPITOR.....49
		LIPOFEN.....49
		lisinopril.....45
		lisinopril-hydrochlorothiazide.....45
		lithium carbonate
		38
		lithium citrate.....38
		LITHOBID
		38
		LITHOSTAT
		60
		LIVALO
		49
		LO LOESTRIN FE.....88
		LOCOID
		58
		LOCOID LIPOCREAM
		58
		LODINE
		32
		LODOSYN
		23
		LOESTRIN 1.5/30 (21).....88
		LOESTRIN 1/20 (21).....88
		LOESTRIN FE 1.5/30 (28- DAY)
		88
		LOESTRIN FE 1/20 (28-DAY) .....88
		LOKELMA.....60
		LOMOTIL
		72
		LONHALA MAGNAIR REFILL.....96
		LONSURF
		16
		loperamide
		72
		LOPID
		49
		lopinavir-ritonavir.....3
		lopreeza.....86
		LOPRESSOR
		45
		LOPRESSOR HCT
		45
		LOPROX
		55
		LOPROX (AS OLAMINE) ..55
		lorazepam
		38
		LORBRENA.....16
		lorcet (hydrocodone)
		29
		lorcet hd
		29
		lorcet plus
		29
		loryna (28)
		88
		losartan
		45
		losartan-hydrochlorothiazide 45
		LOSEASONIQUE.....88
		LOTEMAX.....92, 93
		LOTEMAX SM.....93

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

LOTENSIN	45	MARPLAN	38	MENVEO A-C-Y-W-135-DIP (PF).....	81
loteprednol etabonate	93	MATULANE.....	16	MEPRON	8
LOTREL.....	45	matzim la	45	mercaptopurine	16
LOTRISONE.....	55	MAVENCLAD (10 TABLET PACK).....	26	meropenem	8
LOTRONEX	74	MAVENCLAD (4 TABLET PACK).....	26	MERREM.....	8
lovastatin	49	MAVENCLAD (5 TABLET PACK).....	26	mesalamine	74
LOVAZA	49	MAVENCLAD (6 TABLET PACK).....	26	MESNEX.....	13
LOVENOX.....	48	MAVENCLAD (7 TABLET PACK).....	26	MESTINON	27
low-ogestrel (28)	88	MAVENCLAD (8 TABLET PACK).....	26	MESTINON TIMESPAN	27
loxapine succinate	38	MAVENCLAD (9 TABLET PACK).....	26	metadate er.....	38
LUCEMYRA	32	MAVYRET	3	metaproterenol.....	96
LULICONAZOLE	55	MAXALT	24	metformin	66, 67
LUMIGAN	92	MAXALT-MLT	24	methadone.....	29
LUNESTA.....	38	MAXIDEX	93	methamphetamine.....	38
LUPANETA PACK (1 MONTH).....	87	MAXIPIME.....	6	methazolamide.....	92
LUPANETA PACK (3 MONTH).....	87	MAXITROL	92	methenamine hippurate	13
LUPRON DEPOT	16	MAXZIDE.....	45	methimazole	62
LUPRON DEPOT (3 MONTH).....	16	MAXZIDE-25MG.....	45	METHITEST	70
LUPRON DEPOT (4 MONTH).....	16	MAYZENT	26	methotrexate sodium	16
LUPRON DEPOT (6 MONTH).....	16	meclizine	74	methotrexate sodium (pf)	16
lutera (28)	88	meclofenamate.....	32	methoxsalen	52
LUXIQ	58	MEDROL	61	methscopolamine	72
LUZU	55	MEDROL (PAK)	62	methyclothiazide.....	45
LYNPARZA.....	16	medroxyprogesterone	86	methyldopa	45
LYRICA	21	mefenamic acid.....	32	METHYLIN	38
LYRICA CR.....	21	mefloquine.....	8	methylphenidate hcl.....	38
LYSODREN.....	16	megestrol	16	METHYLPHENIDATE HCL	38
LYSTEDA.....	87	MEKINIST	16	methylprednisolone	62
lyza	86	MEKTOVI.....	16	methyltestosterone	70
M		melodetta 24 fe	88	metoclopramide hcl	74
MACROBID	13	meloxicam	32	metolazone.....	45
MACRODANTIN	13	memantine	26	metoprolol succinate.....	45
mafénide acetate.....	55	MEMANTINE.....	26	metoprolol ta-hydrochlorothiaz	45
magnesium sulfate.....	100	MENACTRA (PF)	81	metoprolol tartrate	45
MALARONE	8	MENEST	86	METROCREAM.....	54
MALARONE PEDIATRIC ...	8	MENOSTAR	86	METROGEL	54
malathion.....	58	MENTAX.....	55	METROGEL VAGINAL	87
maprotiline	38			METROLOTION	54
MARINOL	74			metronidazole	9, 54, 87
marlissa (28)	88			metronidazole in nacl (iso-os)	9
				mexiletine	42
				mibelas 24 fe.....	88

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

MICARDIS	45	MOTOFEN.....	72	NASONEX	97
MICARDIS HCT	45	MOVANTIK	74	NATACYN.....	90
miconazole-3	87	MOVIPREP.....	74	NATAZIA	89
MICORT-HC	74	MOXEZA.....	90	nateglinide	67
microgestin 1.5/30 (21)	88	moxifloxacin.....	12, 90	NATPARA	70
microgestin 1/20 (21)	88	moxifloxacin-sod.chloride(iso)	12	NATROBA	59
microgestin fe 1.5/30 (28)	88	.....	12	NEBUPENT	9
microgestin fe 1/20 (28)	88	MS CONTIN	29	necon 0.5/35 (28).....	89
midodrine	60	MULPLETA.....	48	NEEDLES, INSULIN	
migergot	24	MULTAQ.....	42	DISP.,SAFETY	67
miglitol	67	mupirocin.....	55	nefazodone	38
miglustat	70	mupirocin calcium	55	neomycin	9
MIGRANAL	24	MYALEPT	70	neomycin-bacitracin-poly-hc	92
mili	88	MYAMBUTOL.....	9	neomycin-bacitracin-	
millipred	62	MYCAMINE.....	1	polymyxin.....	90
mimvey	86	MYCOBUTIN.....	9	neomycin-polymyxin b-	
mimvey lo	86	mycophenolate mofetil	16	dexameth.....	92
MINASTRIN 24 FE	89	mycophenolate sodium	16	neomycin-polymyxin-	
MINIPRESS	45	MYDAYIS	38	gramicidin.....	90
MINITRAN	50	MYFORTIC	16	neomycin-polymyxin-hc.	61, 92
MINIVELLE	86	myorisan	54	NEORAL	16
MINOCIN	12	MYRBETRIQ	99	NEO-SYNALAR.....	55
minocycline	12	MYSOLINE	21	NEPHRAMINE 5.4 %.....	102
minoxidil	45	MYTESI	72	NERLYNX	16
MIRAPEX	23	N		NESINA	67
MIRAPEX ER.....	23	nabumetone	32	neuac	54
mirtazapine	38	nadolol	45	NEULASTA	78
MIRVASO	54	nadolol-bendroflumethiazide	46	NEUPOGEN.....	78
misoprostol	76	nafcillin.....	10	NEUPRO	23
MITIGARE	82	naftifine	55	NEURONTIN	21
M-M-R II (PF).....	81	NAFTIN	55, 56	NEVANAC	91
MOBIC.....	32	NALFON.....	32	nevirapine	3
modafinil	38	naloxone	32	NEXAVAR.....	16
moexipril	45	naltrexone	32	NEXIUM	76
molindone.....	38	NAMENDA.....	26	NEXIUM PACKET.....	76
mometasone.....	58, 96	NAMENDA TITRATION		niacin	49
mondoxyne nl	13	PAK	26	NIACOR	49
montelukast	96	NAMENDA XR	26	NIASPAN EXTENDED-	
MONUROL.....	13	NAMZARIC.....	26	RELEASE.....	49
morgidox	13	NAPRELAN CR	32	nicardipine	46
MORPHABOND ER	29	naproxen	32	NICOTROL	61
morphine.....	29	naproxen sodium	32	NICOTROL NS.....	61
MORPHINE	29	naratriptan.....	24	nifedipine	46
morphine concentrate	29	NARCAN	32	nikki (28)	89
MOTEGRITY	74	NARDIL	38	NILANDRON	16

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

nilutamide.....	16	nortrel 7/7/7 (28)	89	OCTAGAM	81
nimodipine.....	46	nortriptyline	38	octreotide acetate	17
NINLARO.....	17	NORVASC	46	OCUFLOX	90
nisoldipine	46	NORVIR.....	3	ODEFSEY	3
nitro-bid.....	50	NOVOFINE 32.....	67	ODOMZO.....	17
NITRO-DUR.....	50	NOVOLIN 70/30 U-100 INSULIN	67	OFEV.....	97
nitrofurantoin.....	13	NOVOLIN N NPH U-100 INSULIN	67	ofloxacin	12, 61, 90
nitrofurantoin macrocrystal..	13	NOVOLIN R REGULAR U- 100 INSULN	67	olanzapine.....	39
nitrofurantoin monohyd/m- cryst	13	NOVOLOG FLEXPEN U-100 INSULIN	67	olanzapine-fluoxetine	39
nitroglycerin	50, 51	NOVOLOG MIX 70-30 U-100 INSULN	67	olmesartan.....	46
NITROSTAT.....	51	NOVOLOG MIX 70- 30FLEXPEN U-100	67	olmesartan-amlodipin- hctiazid	46
NITYR.....	60	NOVOLOG PENFILL U-100 INSULIN	67	olmesartan- hydrochlorothiazide	46
NIVESTYM	79	NOVOLOG U-100 INSULIN ASPART	67	olopatadine	61, 91
nizatidine	76	NOXAFL	1	OLUMIANT	84
NIZORAL	56	NUCALA	97	OLUX	58
NOCDURNA (MEN).....	70	NUCYNTA	33	OLUX-E	58
NOCDURNA (WOMEN)....	70	NUCYNTA ER	32	OMECLAMOX-PAK.....	76
NOCTIVA	70	NUEDEXTA	26	omega-3 acid ethyl esters	49
nolix.....	58	NULYTLY WITH FLAVOR PACKS	74	omeprazole	76, 77
nora-be.....	86	NUPLAZID	38, 39	omeprazole-sodium bicarbonate	77
NORCO	29	NUTRILIPID.....	102	OMNARIS	97
NORDITROPIN FLEXPRO	79	NUTROPIN AQ NUSPIN....	79	OMNIPOD INSULIN MANAGEMENT	67
noreth-ethinyl estradiol-iron.	89	NUVARING.....	87	OMNIPRED	93
norethindrone (contraceptive)		NUVIGIL	39	OMNITROPE	79
.....	86	NUZYRA	13	ondansetron	74
norethindrone acetate	86	NUZYRA (7 DAY WITH LOAD DOSE)	13	ondansetron hcl.....	74
norethindrone ac-eth estradiol		NUZYRA (7 DAY)	13	ONEXTON	54
.....	86, 89	nyamyc	56	ONFI.....	21
norethindrone-e.estradiol-iron		NYMALIZE	46	ONGLYZA	67
.....	89	nystatin	1, 56	ONZETRA XSAIL.....	24
norgestimate-ethinyl estradiol		nystatin-triamcinolone.....	56	OPANA	30
.....	89	nystop	56	OPSUMIT	97
NORITATE.....	54	O		ORACEA	13
norlyroc	86	OCALIVA	74	ORALAIR	81
NORMOSOL-M IN 5 %		ocella	89	ORAPRED ODT	62
DEXTROSE	102			ORAVIG	1
NORMOSOL-R IN 5 %				ORENCIA	84
DEXTROSE.....	100			ORENCIA (WITH MALTOSE).....	84
NORMOSOL-R PH 7.4	102			ORENCIA CLICKJECT	84
NORPRAMIN.....	38			ORENITRAM	46
NORTHERA	60				
nortrel 0.5/35 (28)	89				
nortrel 1/35 (21)	89				
nortrel 1/35 (28)	89				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

ORFADIN	60	PAMELOR	39	PERTZYE.....	74
ORILISSA.....	70	PANCREAZE	74	PEXEVA	39
ORKAMBI	97	PANDEL	58	phenelzine.....	39
orsythia.....	89	PANRETIN	52	phenobarbital	21
ORTHO MICRONOR.....	86	pantoprazole	77	phenoxybenzamine	46
ORTHO TRI-CYCLEN LO (28).....	89	PANZYGA.....	81	PHENYTEK	21
ORTHO-NOVUM 1/35 (28)	89	paricalcitol	71	phenytoin	21, 22
ORTHO-NOVUM 7/7/7 (28)	89	PARLODEL	23	phenytoin sodium extended..	22
oseltamivir.....	3	PARNATE.....	39	PHOSLYRA	100
OSENI.....	67	paromomycin.....	9	PHOSPHOLINE IODIDE	91
OSMOLEX ER	23	paroxetine hcl	39	PICATO.....	52
OSMOPREP.....	74	paroxetine		PIFELTRO	3
OSPHERA	87	mesylate(menop.sym).....	39	pilocarpine hcl	60, 91
OTEZLA	84	PASER.....	9	pimecrolimus	52
OTEZLA STARTER	84	PATADAY	91	pimozide	39
OTOVEL.....	61	PATANASE	61	pimtrex (28)	89
OTREXUP (PF)	84	PATANOL	91	pindolol.....	46
OVIDE	59	PAXIL	39	pioglitazone	67
oxacillin.....	10	PAXIL CR.....	39	pioglitazone-glimepiride.....	67
oxacillin in dextrose(iso-osm)	10	PAZEO	91	pioglitazone-metformin	67
oxandrolone.....	70	PEDIARIX (PF)	81	piperacillin-tazobactam	11
oxaprozin.....	33	PEDVAX HIB (PF).....	81	PIQRAY	17
OXAYDO	30	peg 3350-electrolytes	74	pirmella.....	89
oxcarbazepine.....	21	PEGANONE	21	piroxicam	33
OXERVATE	91	PEGASYS	79	PLAQUENIL.....	9
oxiconazole.....	56	PEGASYS PROCLICK	79	PLASMA-LYTE 148	102
OXISTAT	56	peg-electrolyte	74	PLASMA-LYTE A	102
OXSORALEN ULTRA	52	penicillamine	84	PLAVIX	48
OXTELLAR XR	21	PENICILLIN G POT IN DEXTROSE	11	PLEGRIDY	79
oxybutynin chloride.....	99	penicillin g potassium.....	11	plenamine	102
oxycodone	30	penicillin g procaine	11	PLENVU	75
OXYCODONE	30	penicillin g sodium	11	PLIAGLIS	52
oxycodone-acetaminophen...30		penicillin v potassium.....	11	podofilox.....	52
oxycodone-aspirin	30	PENNSAID	33	polymyxin b sulfate	9
OXYCONTIN	30	PENTAM.....	9	polymyxin b sulf-trimethoprim	90
oxymorphone.....	30	PENTASA	74	POLYTRIM.....	90
OXYTROL.....	99	pentoxifylline.....	48	POMALYST.....	17
OZEMPIC	67	PEPCID	77	portia 28	89
P		PERCOCET	30	potassium chlorid-d5- 0.45%nacl	100, 101
pacerone	42	PERFOROMIST	97	potassium chloride	101
paliperidone.....	39	perindopril erbumine	46	potassium chloride in 0.9%nacl	101
PALYNZIQ.....	70, 71	permethrin	59		
		perphenazine.....	39		
		PERSERIS.....	39		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

potassium chloride in 5 % dex	89	PROTONIX	77
.....101		PROTOPIC	52
potassium chloride in lr-d5.101		protriptyline	39
potassium chloride in water101		PROVENTIL HFA	97
potassium chloride-0.45 % nacl		PROVERA	86
.....101		PROVIGIL	39
potassium chloride-d5-		PROZAC	39
0.2%nacl.....101		prudoxin	52
potassium chloride-d5-		PSORCON	58
0.3%nacl.....101		PULMICORT	97
potassium chloride-d5-		PULMICORT FLEXHALER	97
0.9%nacl.....101		PULMOZYME	97
potassium citrate.....100		PURIXAN	17
PRADAXA .....48		PYLERA	77
PRALUENT PEN .....49		pyrazinamide	9
pramipexole.....23		pyridostigmine bromide	27
PRANDIN .....67, 68		PYRIDOSTIGMINE BROMIDE	27
prasugrel.....48		Q	
PRAVACHOL .....49		QBRELIS	46
pravastatin .....49		QMIZ ODT	33
praziquantel .....9		QNDSL	97
prazosin .....46		QTERN	68
PRECOSE .....68		QUADRACEL (PF)	81
PRED FORTE .....93		QUALAQUIN	9
PRED MILD .....93		QUARTETTE	89
PRED-G .....92		QUDEXY XR	22
PRED-G S.O.P. .....92		QUESTRAN	49
prednicarbate .....58		QUESTRAN LIGHT	49
prednisolone .....62		quetiapine	39, 40
prednisolone acetate .....93		QUILLICHEW ER	40
prednisolone sodium phosphate		QUILLIVANT XR	40
.....62, 93		quinapril	46
prednisone .....62		quinapril-hydrochlorothiazide	46
prednisone intensol.....62		quinidine gluconate	42
PREFEST .....86		quinidine sulfate	42
PREMARIN .....86		quinine sulfate	9
premasol 10 %.....102		QVAR REDIHALER	97, 98
PREMASOL 6 %102		R	
PREMPHASE .....86		RABAVERT (PF)	81
PREMPRO .....86		rabeprazole	77
prenatal vitamin oral tablet.102		raloxifene	82
PREPOPIK .....75		ramipril	46
PREVACID .....77			
PREVACID SOLUTAB .....77			
prevalite .....49			

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

RANEXA	50	REXULTI.....	40	S	
ranitidine hcl.....	77	REYATAZ	3	SABRIL.....	22
ranolazine	50	RHOFADE	54	SAFYRAL	89
RAPAFLO.....	100	RHOPRESSA	92	SAIZEN	79
RAPAMUNE	17	ribasphere	3	SAIZEN SAIZENPREP	79
rasagiline	23	ribasphere ribapak	3	SALAGEN (PILOCARPINE)	60
RASUVO (PF)	84	ribavirin	3	SAMSCA.....	71
RAVICTI.....	60	RIDAURA.....	84	SANCUSO	75
RAYALDEE	71	rifabutin	9	SANDIMMUNE.....	17
RAYOS	62	RIFADIN	9	SANDOSTATIN	17
RAZADYNE	26	RIFAMATE.....	9	SANTYL	52
RAZADYNE ER.....	26	rifampin	9	SAPHRIS	40
REBETOL	3	RIFATER	9	SARAFEM	40
REBIF (WITH ALBUMIN).....	79	RILUTEK.....	60	SAVAYSA	48
REBIF REBIDOSE	79	riluzole.....	60	SAVELLA	84, 85
REBIF TITRATION PACK	79	rimantadine	3	scopolamine base.....	75
reclipsen (28).....	89	RIOMET.....	68	SEASONIQUE	89
RECOMBIVAX HB (PF)	81	risedronate	60, 82, 83	SEEBRI NEOHALER	98
RECTIV	75	RISPERDAL	40	SEGLUROMET	68
REGLAN.....	75	RISPERDAL CONSTA	40	selegiline hcl	23
REGRANEX	52	risperidone	40	selenium sulfide.....	51
RELENZA DISKHALER	3	RITALIN	40	SELZENTRY	4
RELEXXII	40	RITALIN LA.....	40	SEMPREX-D	94
RELISTOR.....	75	ritonavir	3	SENSIPAR	71
RELPAX	24	rivastigmine	26	SEREVENT DISKUS	98
REMERON	40	rivastigmine tartrate.....	26	SEROQUEL	40
REMERON SOLTAB.....	40	rivelsa	89	SEROQUEL XR.....	40, 41
REMICADE	75	rizatriptan.....	24	SEROSTIM	79
RENAGEL	60	ROCALTROL	71	sertraline	41
RENVELA	60	ROCKLATAN	92	setlakin.....	89
repaglinide.....	68	ropinirole	23	sevelamer carbonate	60
repaglinide-metformin.....	68	rosuvastatin.....	49	sevelamer hcl	60
REPATHA	49	ROTARIX	81	sharobel.....	86
REPATHA PUSHTRONEX	49	ROTATEQ VACCINE.....	81	SHINGRIX (PF)	81
REPATHA SURECLICK	49	ROWASA.....	75	SIGNIFOR.....	17
REQUIP XL	23	roweepra	22	sildenafil (pulmonary arterial	
SCRIPTOR.....	3	roweepra xr.....	22	hypertension)	98
RESTASIS	91	ROXICODONE.....	30, 31	SILENOR	41
RESTASIS MULTIDOSE	91	ROXYBOND	31	SILIQ	51
RETACRIT	79	ROZEREM.....	40	silodosin.....	100
RETIN-A	54	RUBRACA.....	17	SILVADENE.....	52
RETIN-A MICRO.....	54	RUCONEST	98	silver sulfadiazine	52
RETROVIR.....	3	RYDAPT	17	SIMBRINZA	92
REVATIO	98	RYTARY.....	23	SIMPONI.....	85
REVLIMID	17	RYTHMOL SR	42		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

simvastatin.....	49	SPRIX.....	33	SURMONTIL.....	41
SINEMET	23	SPRYCEL	17	SUSTIVA	4
SINEMET CR	23	sps (with sorbitol).....	60	SUTENT	17
SINGULAIR	98	sronyx	89	syeda	89
sirolimus.....	17	ssd.....	52	SYLATRON	79
SIRTURO.....	9	STALEVO 100.....	23	SYMBICORT	98
SIVEXTRO	9	STALEVO 125.....	23	SYMBYAX	41
SKLICE.....	59	STALEVO 150.....	23	SYMDEKO	98
SKYRIZI	51	STALEVO 200.....	23	SYMFIA	4
sodium chloride	60	STALEVO 50.....	23	SYMFIA LO.....	4
sodium chloride 0.45 %.....	101	STALEVO 75.....	23	SYMLINPEN 120	68
sodium chloride 0.9 %.....	60	STARLIX	68	SYMLINPEN 60	68
sodium chloride 3 %.....	101	stavudine.....	4	SYMPAZAN	22
sodium chloride 5 %.....	101	STEGLATRO	68	SYMPROIC	75
sodium lactate intravenous.	101	STEGLUJAN	68	SYMTUZA	4
sodium phenylbutyrate	60	STELARA	51	SYNALAR	58
sodium polystyrene sulfonate	60	STIMATE.....	71	SYNAREL	71
SOFOSBUVIR-		STIOLTO RESPIMAT	98	SYNDROS	75
VELPATASVIR.....	4	STIVARGA.....	17	SYNJARDY	68
solifenacin	99	STRATTERA	41	SYNJARDY XR.....	68
SOLIQUA 100/33	68	STREPTOMYCIN	9	SYNRIBO	17
SOLODYN	13	STRIANT	71	SYNTROID	72
SOLOSEC	9	STRIBILD	4	SYPRINE	60
soloxide	13	STRIVERDI RESPIMAT	98	T	
SOLTAMOX.....	17	STROMECTOL	9	TABLOID.....	17
SOMATULINE DEPOT	17	SUBOXONE	33	TACLONEX.....	51
SOMAVERT	71	SUBSYS	31	tacrolimus	17, 52
SOOLANTRA.....	54	SUCRAID	75	tadalafil	100
SORIATANE	51	sucralfate	78	tadalafil (pulmonary arterial	
SORILUX	51	SULAR	46	hypertension) oral tablet	
sorine	42	sulfacetamide sodium	91	mg	98
sotalol	43	sulfacetamide sodium (acne)	55	TAFINLAR	17
sotalol af	42	sulfacetamide-prednisolone..	91	TAGRISSO	17
SOTYLIZE.....	43	sulfadiazine.....	12	TAKHZYRO	98
SOVALDI	4	sulfamethoxazole-trimethoprim	12	TALTZ AUTOINJECTOR ..	51
SPIRIVA RESPIMAT	98	SULFAMYLYON	55	TALTZ SYRINGE	51
SPIRIVA WITH HANDIHALER.....	98	sulfasalazine	75	TALZENNA	17
spironolactone	46	sulindac.....	33	TAMIFLU	4
spironolacton-hydrochlorothiaz	46	sumatriptan	24	tamoxifen	17
SPORANOX	1	sumatriptan succinate	24	tamsulosin	100
sprintec (28).....	89	sumatriptan-naproxen.....	24	TAPAZOLE	62
SPRITAM	22	SUPRAX	6	TAPERDEX	62
		SUPREP BOWEL PREP KIT	75	TARCEVA	17, 18
				TARGADOX	13
				TARGRETIN	18

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

tarina 24 fe.....	89	thioridazine.....	41	toremifene.....	18
tarina fe 1/20 (28).....	89	thiothixene.....	41	torsemide	47
TARKA	46	THYROLAR-1	72	TOUJEO MAX U-300	
TASIGNA	18	THYROLAR-1/2.....	72	SOLOSTAR	68
TASMAR	23	THYROLAR-1/4.....	72	TOUJEO SOLOSTAR U-300	
TAVALISSE	48	THYROLAR-2	72	INSULIN	68
tazarotene	54	THYROLAR-3	72	TOVIAZ	99
tazicef	6	tiagabine	22	TPN ELECTROLYTES	101
TAZORAC	54	TIAZAC	47	TRACLEER	98
taztia xt.....	46	TIBSOVO.....	18	TRADJENTA	69
TDVAX.....	81	tigecycline	9	tramadol	33
TECFIDERA.....	26	TIGLUTIK	60	TRAMADOL	33
TEFLARO.....	6	TIKOSYN	43	tramadol-acetaminophen	33
TEGRETOL	22	timolol maleate	47, 90	trandolapril	47
TEGRETOL XR.....	22	TIMOPTIC OCUDOSE (PF)		trandolapril-verapamil	47
TEGSEDI.....	26	.....	91	tranexamic acid.....	87
TEKTURNA	46	TIMOPTIC-XE	91	TRANSDERM-SCOP	75
TEKTURNA HCT	46	tinidazole	9	TRANXENE T-TAB	41
telmisartan	46	TIROSINT	72	tranylcypromine.....	41
telmisartan-amlodipine.....	46	TIROSINT-SOL	72	travasol 10 %	102
telmisartan-hydrochlorothiazid		TIVICAY.....	4	TRAVATAN Z.....	92
.....	46	TIVORBEX.....	33	trazodone	41
TENIVAC (PF)	81	tizanidine	27	TRECATOR	9
tenofovir disoproxil fumarate.	4	TOBI.....	9	TRELEGY ELLIPTA.....	98
TENORETIC 100.....	46	TOBI PODHALER	9	TRELSTAR	18
TENORETIC 50.....	46	TOBRADEX	92	TREMFYA	51
TENORMIN.....	46	TOBRADEX ST.....	92	TRESIBA FLEXTOUCH U-	
terazosin	46, 47	tobramycin.....	90	100	69
terbinafine hcl.....	1	tobramycin in 0.225 % nacl....	9	TRESIBA FLEXTOUCH U-	
terbutaline.....	98	tobramycin sulfate	9	200	69
terconazole	87	tobramycin-dexamethasone..	92	TRESIBA U-100 INSULIN .	69
TESTIM	71	TOBREX	90	tretinoin (chemotherapy)	18
testosterone.....	71	TOFRANIL	41	tretinoin microspheres	54
TESTOSTERONE	71	TOLAK	52	tretinoin topical.....	54
testosterone cypionate	71	tolazamide	68	TREXALL	18
testosterone enanthate	71	tolbutamide	68	TREXIMET	24, 25
TETANUS,DIPHTHERIA		tolcapone	23	TREZIX	31
TOX PED(PF).....	81	tolmetin.....	33	triamcinolone acetonide..	58, 61
tetrabenazine.....	26	TOLSURA.....	1	triaterene-hydrochlorothiazid	
tetracycline	13	tolterodine.....	99	.....	47
TEXACORT.....	58	TOPAMAX	22	trianex	58
THALOMID.....	18	TOPICORT	58	TRIBENZOR.....	47
THEO-24	98	topiramate.....	22	TRICOR	50
theophylline.....	98	TOPIRAMATE	22	triderm	58
THIOLA	60	TOPROL XL	47	TRIDESILON.....	58

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

trientine.....	60	UDENYCA	80	VECTICAL	51
tri-estarylla	89	ULORIC	82	velivet triphasic regimen (28)	89
trifluoperazine	41	ULTRACET	33	VELPHORO.....	60
trifluridine.....	90	ULTRAM	33	VELTASSA.....	60
TRIGLIDE	50	ULTRAVATE.....	58	VEMLIDY.....	4
tri-legest fe.....	89	UNASYN	11	VENCLEXTA	18
TRILEPTAL.....	22	unithroid	72	VENCLEXTA STARTING PACK	18
TRILIPPIX	50	UPTRAVI.....	47	venlafaxine	41
tri-lo-estarylla	89	URECHOLINE	100	VENLAFAKINE.....	41
tri-lo-sprintec	89	UROCIT-K 10.....	100	VENTAVIS	98
trilyte with flavor packets.....	75	UROCIT-K 15.....	100	VENTOLIN HFA.....	99
trimethoprim.....	13	UROCIT-K 5.....	100	verapamil	47
tri-mili	89	UROXATRAL	100	VEREGEN	52
trimipramine	41	URSO 250	75	VERELAN	47
TRINTELLIX.....	41	URSO FORTE.....	75	VERELAN PM.....	47
tri-previfem (28).....	89	ursodiol.....	75	VERSACLOZ.....	41
tri-sprintec (28).....	89	UTIBRON NEOHALER.....	98	VERZENIO	18
TRIUMEQ.....	4	V		VESICARE.....	99
trivora (28).....	89	VABOMERE.....	9	VFEND.....	1
tri-vylibra.....	89	VAGIFEM.....	86	VFEND IV.....	1
tri-vylibra lo.....	89	valacyclovir	4	V-GO 20	69
TRIZIVIR.....	4	VALCHLOR	52	V-GO 30	69
TROKENDI XR.....	22	VALCYTE	4	V-GO 40	69
TROPHAMINE 10 %	102	valganciclovir	4	VIBERZI	75
TROPHAMINE 6%	102	VALIUM	41	VIBRAMYCIN	13
trospium.....	99	valproic acid	22	VICTOZA 3-PAK	69
TRUEPLUS INSULIN.....	69	valproic acid (as sodium salt)	22	VIDEX 4 GRAM PEDIATRIC	4
TRUEPLUS PEN NEEDLE	69	valsartan.....	47	VIDEX EC.....	4
TRULANCE.....	75	valsartan-hydrochlorothiazide	47	VIEKIRA PAK.....	4
TRULICITY.....	69	VALTREX	4	vienna	89
TRUMENBA	81	VANCOCIN	9	vigabatrin	22
TRUSOPT	92	vancomycin	9, 10	vigadron	22
TRUVADA	4	VANCOMYCIN	10	VIGAMOX.....	90
TUDORZA PRESSAIR	98	vandazole	87	VIIBRYD	41
TWINRIX (PF)	81	VANOS	58	VIMOVO	33
TWYNSTA	47	VAQTA (PF)	82	VIMPAT	22
TYBOST	4	VARIVAX (PF)	82	VIOKACE	75
tydemy.....	89	VARIZIG	82	VIRACEPT	4
TYGACIL	9	VARUBI.....	75	VIRAMUNE	4
TYKERB	18	VASCEPA.....	50	VIRAMUNE XR	4
TYLENOL-CODEINE #3 ..	31	VASERETIC	47	VIREAD	4
TYMLOS	83	VASOTEC.....	47	VITRAKVI.....	18
TYPHIM VI	81	VECAMYL	50		
U					
UCERIS.....	75				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

VIVELLE-DOT	86	XOFLUZA	4	ZETIA.....	50
VIVITROL	33	XOLAIR	99	ZETONNA	99
VIVLODEX	33	XOPENEX	99	ZIAC.....	47
VIZIMPRO	18	XOPENEX CONCENTRATE	99	ZIAGEN	5
VOGELXO.....	71	XOPENEX HFA	99	ZIANA.....	54
VOLTAREN	34	XOSPATA.....	18	zidovudine	5
voriconazole	1	XTAMPZA ER.....	31	zileuton	99
VOSEVI	4	XTANDI.....	18	ZIOPTAN (PF).....	92
VOTRIENT	18	xulane	87	ziprasidone hcl.....	42
VRAYLAR	41	XULTOPHY 100/3.6	69	ZIPSOR	34
vyfemla (28)	89	XURIDEN	60	ZIRGAN	90
vylibra.....	89	XYOSTED	71	ZITHROMAX	7
VYNDAQEL.....	50	XYREM.....	42	ZITHROMAX TRI-PAK	7
VYTORIN 10-10	50	Y		ZITHROMAX Z-PAK	7
VYTORIN 10-20	50	YASMIN (28).....	90	ZOCOR.....	50
VYTORIN 10-40	50	YAZ (28).....	90	ZOFRAN	75
VYTORIN 10-80	50	YF-VAX (PF).....	82	ZOHYDRO ER	31
VYVANSE.....	41	YONSA	18	ZOLINZA.....	18
VYZULTA	92	YOSPRALA	48	zolmitriptan.....	25
W		YUPELRI	99	ZOLOFT	42
warfarin	48	yuvafem	86	zolpidem	42
WELCHOL	50	Z		ZOMACTON	80
WELLBUTRIN SR	41	zafirlukast	99	ZOMIG	25
WELLBUTRIN XL.....	41, 42	zaleplon	42	ZOMIG ZMT	25
wixela inhulb	99	ZANAFLEX	27	ZONALON.....	52
wymzya fe	90	zarah	90	ZONEGRAN	22
X		ZARONTIN.....	22	zonisamide	22
XADAGO	23	ZARXIO	80	ZONTIVITY.....	48
XALATAN.....	92	ZAVESCA.....	72	ZORBTIVE	80
XALKORI.....	18	ZEGERID	78	ZORTRESS	19
XARELTO	48	ZEJULA	18	ZORVOLEX.....	34
XATMEP	18	ZELAPAR	23	ZOSTAVAX (PF)	82
XELJANZ	85	ZELBORAF	18	ZOSYN.....	11
XELJANZ XR.....	85	ZEMAIRA.....	60	ZOSYN IN DEXTROSE (ISO- OSM).....	11
XELPROS	92	ZEMBRACE SYMTOUCH.	25	zovia 1/35e (28).....	90
XENAZINE.....	26	ZEMPLAR	72	ZOVIRAX	5, 56
XEPI.....	55	zenatane	54	ZTLIDO.....	52
XERESE.....	56	ZENPEP	75	ZUBSOLV	34
XERMELO	18	zenzedi.....	42	ZUPLENZ	75
XGEVA	13	ZENZEDI	42	ZYBAN	61
XHANCE	99	ZEPATIER	5	ZYCLARA	52
XIFAXAN	10	ZERBAXA	6	ZYDELIG	19
XIGDUO XR.....	69	ZESTORETIC	47	ZYFLO	99
XiIDRA.....	91	ZESTRIL	47	ZYFLO CR	99
XIMINO	13				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at express-scripts.com.

ZYKADIA.....	19	ZYPITAMAG	50	ZYTIGA	19
ZYLET	92	ZYPREXA.....	42	ZYVOX.....	10
ZYLOPRIM	82	ZYPREXA RELPREVV	42		
ZYMAXID	90	ZYPREXA ZYDIS.....	42		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at **express-scripts.com**.

This page intentionally left blank

This page intentionally left blank

This page intentionally left blank

You must use network pharmacies to fill your prescriptions to get the most out of your benefit. However, there are emergency circumstances under which you may be reimbursed for a covered prescription that is not filled at a network pharmacy. Limitations, copayments and restrictions may apply.

This formulary was updated on 08/19/2019. For more recent information or to price a medication, you can visit us on the Web at **express-scripts.com**. Or you can contact **Express Scripts Medicare® (PDP)** Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

© 2019 Express Scripts. All Rights Reserved.

F0PA3Z0A